

**ADOLESCENT & YOUTH HEALTH
FOR
HEALTH-CARE SERVICE PROVIDERS**

PARTICIPANT'S MANUAL

April 2017

Table of Contents

Table of Contents	i
Foreword.....	iv
Acknowledgements	vi
Acronyms	vii
Chapter 1: Introduction to the Training Program	1
Session 1.1 Introduction to the Training Manual	2
Session 1.2 Course Syllabus	4
Session 1.3: Agenda of the training	6
Chapter 2: Public Health Significance of Adolescent & Youth Health	9
Session 2.1 Session outline and Learning Objectives	10
Session 2.2: Overview of Adolescent and Youth Health	11
Session 2.3 Epidemiology of selected Priority Health problems of Adolescents and Youth	12
Session 2.4: Why invest in adolescent and youth Health?	15
Chapter 3: Growth and Development during Adolescence and Youth	19
Session 3.1 Session Outline and Learning Objectives	20
Session 3.2: Stages and Domains of Adolescent Development	21
Session 3.3: Adolescent Development, Sexuality and its Implications	25
Session 3.4: Adolescent and Youth Brain Development	27
Chapter 4: Communicating with Adolescents& Motivational Interview (MI)	35
Session 4.1: Session Outline and Learning Objectives	36
Session 4.2: Communicating with Adolescents & youth	37
Session 4.3: Elements of successful and effective communication	39
Session 4.4 Adolescent Psychosocial Assessment-Interview	40
Session 4.5: Motivational interview	42
Session 4.6: Motivational Interview skill and strategies	50
Chapter5: Adolescent Sexual Reproductive Health (ASRH)	56
Session 5.1 Session Outline and Learning Objectives	57
Session 5.2: Definition of Terms and Key concept in Sexual and Reproductive Health	58
Session 5.3: Sexuality Education and Effective Communication with Adolescents and Youth	61
Session 5.4: Indicators for Sexual and Reproductive Health	67
Chapter 6: Prevention of Pregnancy in Adolescents & Youth	71

Session 6.1 Session Outline and Learning Objectives	72
Session 6.2: Child Marriage	73
Session 6.3: Prevention of Pregnancy in Adolescents	75
Session 6.4 Overview of Unsafe Abortion among Adolescents and Youth	92
Session 6.5 Dealing with Unsafe Abortion	98
Chapter 7: Care for Adolescents during Pregnancy, Childbirth, and Postnatal Periods	105
Session 7.1: Session outline and Learning Objectives	106
Session 7.2: Overview of Pregnancy during Adolescence	107
Session 7.3 Care during Pregnancy	112
Session 7.4 Management of labor and delivery	114
Session 7.5 Postpartum care	115
Chapter 8: Sexually Transmitted Infections & HIV-AIDS among Adolescent and Youth	120
Session 8.1 Session Outline and Learning Objectives	121
Session 8.2: Basics on Sexually Transmitted Infections in Adolescents and Youth	122
Session 8.3: STI management in Adolescents and Youth	124
Session 8.4: Basic Facts on HIV/AIDS among Adolescents and Youth	127
Session 8.5: Combination Prevention Intervention for HIV/AIDS in Adolescents and Youth	130
Chapter 9: Gender Based Violence (GBV)	136
Session 9.1 Session Outline and Learning Objectives	137
Session 9.2: Definitions and Epidemiology Gender Based violence	138
Session 9.3: Health system response to GBV	143
Chapter 10: Non-Communicable Diseases (NCD)	148
Session 10.1 Session Outline and Learning Objectives:	149
Session 10.2: Global Overview of Non-Communicable Diseases and the Context in Ethiopia	150
Session 10.3 Prevention of Cervical Cancer in Ethiopia	153
Session 10.4: Injury during Adolescence and Youth	155
Chapter 11: Common Mental Health Problems and Psychoactive Substance Use during Adolescence and Youth	163
Session 11.1 Session Outline and Learning Objectives	164
Session 11.2: Adolescent and Youth Mental Health	165
Session 11.3: Use of Psychoactive Substances by Adolescent and Youth	173
Chapter 12: Adolescent and Youth Nutrition	183

Session 12.1 Session Outline and Learning Objectives	184
Session 12.2: Nutrition Needs in Adolescents	185
Session 12.3: Malnutrition and its Consequences in Adolescents	188
Session 12.4: Nutrition Intervention for adolescents	192
Chapter 13: Bioethics and Autonomous Decision Making in Adolescent & Youth Health	203
Session 13.1 Session Outline and Learning Objectives:	204
Session 13.2 Concepts and Definitions	205
Session 13.3 Applications of Bio-ethics and Ethical Guidelines	208
Session 13.4 : Compassionate, Respectful, and Caring Services to adolescents and youth	212
Chapter 14: Adolescent and Youth Responsive Health System and Services	216
Session 14.1 Session Outline and Learning Objectives	217
Session 14.2: Health-care Services, the Need for Adolescents and Youth	218
Session 14.3: Integrated Management of Common Conditions	224

Foreword

The Federal Ministry of Health has started implementation of the second but the first in its kind, Adolescent and Youth Health Strategic Plan (2016 -2020) with the aim to guide and direct the implementations of initiatives, interventions and programs that are targeting the adolescents and youth in Ethiopia. The strategic Plan has given due attention on the importance of integration and comprehensiveness of the adolescent and youth health; and making the service responsive to the needs of them. As it is also emphasized under the Health Sector Transformation Plan, compassionate, respectful and Caring health-care provider is the center piece of the Adolescent and Youth health Strategic Plan.

The health-care service providers are at the forefront in the making of the services delivered to the adolescent and youth at any service delivery points, be at public or private, are responsive to their needs. The service providers should provide high quality services - information, counseling and clinical care – to all irrespective to their gender, age, creed or any other socio-economic background without discrimination. The service providers should have a knowledge and skill to communicate and respond to the adolescents more effectively and with great sensitivity. This responsibility doesn't rest only in selected health-care providers in the Adolescent and Youth Friendly services; instead it is the duty and responsibility of all health-care providers who are working along the levels of health-care delivery system. Nonetheless, evidences have pointed out that services provided to the adolescents are not to the standard and expectation of the adolescents, and mostly are not responding to the needs and demand of the adolescents and youth.

The overall aim of the training is to orient the health-care provider to the peculiar developmental features of adolescent and youth, and to appropriately respond to their needs. The Ministry of Health has firm belief that this training will reinvigorate the self initiation and commitment of the health-care providers to render quality adolescent and youth health services all level responding to their needs and demands. And also, the health-care management and leadership would be responsive.

Henceforth, the Ministry of Health strongly advice health-care planners, mangers and leaders to give due priority to make available this training to all of the health workers at all levels so that adolescent health-care service is not a responsibility to few, but a piece everybody in the system owns it to make the services provided are responsive to the health needs of the adolescents.

Ephrem T. Lemango (MD, MA)

Director, MNCA-N Health Directorate
FDRE-Ministry of Health

APPROVAL STATEMENT OF THE MINISTRY

The Federal Ministry of health of Ethiopia has been working towards standardization and institutionalization of In-Service Trainings (IST) at national level. As part of this initiative the ministry developed a national in-service training directive and implementation guide for the health sector. The directive requires all in-service training materials fulfill the standards set in the implementation Guide to ensure the quality of in-service training materials. Accordingly, the ministry reviews and approves existing training materials based on the IST standardization checklist annexed on the IST implementation guide.

As per the national IST quality control process, this Adolescent & Youth health For Health-care service providers training package has been reviewed based on the standardization checklist and approved by the ministry in September, 2017.



*Dr Getachew Tollera
Human Resource Development
Directorate Director
Federal Ministry of Health, Ethiopia*

Acknowledgements

The Adolescent and Youth Health Training Manual is the result of serious of consultation and review of experts from Federal Ministry of Health, esteemed Universities, Governmental and Non-governmental Institutions who worked enthusiastically to make the training manual fit to the national context. The Adolescent and Youth Technical Working Group and the W.H.O's Orientation Program on Adolescent Health for Health-care Providers were instrumental in the preparation of this training manual.

The Ministry of Health would like to thank WHO and UNICEF for the technical and financial support made available for the training manual preparation and development. The Ministry is grateful and acknowledges also to organizations who assign experts to be part of the, 'Training Manual Development Panel' – UNFPA, WHO, UNICEF, Pathfinder International, David & Lucile Packard Foundation, Family Guidance Association-Ethiopia, CORHA, Ipas, Ethiopia Pediatric Society, DKT-Ethiopia, Addis Ababa City Administration Health Bureau, Universities: Addis Ababa University-school of Public Health, Haromaya University, Jimma University, Hawassa University. Special appreciation goes to the Adolescent and Youth Health Technical working group members who despite their busy schedule at their respective duty stations have relentlessly worked hard to give the training manual its desired content and shape.

Ephrem T. Lemango (MD, MA)

Director, MNCA-N Health Directorate
FDRE-Ministry of Health

Acronyms

AACSE	Age Appropriate Comprehensive Sexuality Education
ADHD	Attention Deficit Hyperactive Disorder
AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
AYFHS	Adolescent and Youth Friendly Health Services
AYH	Adolescent and Youth Health
AYSRH	Adolescent and Youth Sexual and Reproductive Health
BCC	Behavior Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
CBT	Cognitive Behavior Treatment
CORHA	Consortium of Reproductive Health Association
CPD	Continuous Professional Development
CQI	Continuous Quality Improvement
CSA	Central Statistical Agency
CSE	Comprehensive Sexuality Education
CVD	Cardio Vascular Disease
DHS	Demographic and Health Survey
DSM-IV-TR	Diagnostic and Statistics Manual of Mental Disorder, 4 th Edition Text Revision
EDHS	Ethiopian Demographic and Health Survey
EMDHS	Ethiopian Mini-Demographic and Health Survey
FGEA	Family Guidance Association Ethiopia
FGM/C	Female Genital Mutilation/Cutting
FP	Family Planning
GBV	Gender-Based Violence
GBV	Sexual and Gender-Based Violence
GOE	Government of Ethiopia
GTP	Growth and Transformation Plan
HC	Health Centre
HDA	Health Development Army
HEP	Health Extension Program
HMIS	Health Management Information System
HP	Health Post
HPV	Human Papilloma Virus
HSDP	Health Sector Development Program
HTP	Harmful Traditional Practice
HIV	Human Immunodeficiency Virus
IEC	Information, Education and Communication

IPV	Intimate Partner Violence
LMIC	Low- and Middle-Income Countries
M&E	Monitoring and Evaluation
MCH	Maternal and Child Health
MI	Motivational Interview
MNCH	Maternal, Neonatal and Child Health
MoE	Ministry of Education
MoE	Ministry of Education
MoH	Ministry of Health
MoH	Ministry of Health
MTCT	Mother-To-Child Transmission
MVA	Manual Vacuum Aspiration
NCD	Non-Communicable Diseases
NNS	National Nutrition Strategy
NPD	Neuro Psychiatric Disorder
PAC	Post Abortion Care
PHC	Primary Health Care
PHCU	Primary Health Care Unit
PMA	Performance Monitoring and Accountability
PMTCT	Prevention of Mother-To-Child Transmission
PNC	Postnatal Care
RHB	Regional Health Bureau
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RTA	Road Traffic Accident
SBA	Skilled Birth Attendance
SBCC	Social Behavior Change Communication
SDG	Sustainable Development Goal
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TOT	Training Of Trainer
TWG	Technical Working Group
UHC	Universal Health Coverage
UN-CRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Fund for Population Activities
UNICEF	United Nations Children’s Fund
USAID	United States Agency for International Development
WDA	Women Development Army
WHO	World Health Organization

Chapter 1: Introduction to the Training Program

Session 1.1 Introduction to the Training Manual

This training manual is divided into 14 chapters, the first chapter introduces trainees on the overall goal of the Adolescent Youth Health training program, rationale of the training, the course syllabus - course description, course duration, class size, participants and trainers selection, training-learning methodology and materials, how the course is evaluated, participatory learning method, and agenda of the training program with course duration. This is followed by a chapter that explains the prevailing health status of the adolescent and youth focusing on the demography and epidemiological disease patterns; and also discusses why investment on the health of the adolescent and youth is given due attention. The next chapter deals a very important matter that deals about the growth and development of the adolescent and youth. It is highly emphasized that trainees should have a deeper knowledge about it whereby they use it to effectively communicate with the adolescents, their parents and the community at large. The fourth chapter is one of the essential chapters of this manual why this training program envisioned; it is intended to improve the competency of the health-care providers communication and interaction while attending adolescent and youth. It will give the participants the skill how to motivate adolescent and youth not only in managing illnesses but help them adopt healthy life style.

The remaining chapters deal on adolescent sexual reproductive health; adolescent pregnancy and child marriage; care for adolescents and youth during pregnancy, childbirth and postnatal periods; STI/HIV focusing on the importance of prevention and early treatment for adolescent and youth STIs and also give direction on disclosure of HIV status in adolescent and adherence to treatment; the training manual has also given emphasis on adolescent and youth gender-based violence due to cultural harmful traditional practices like child marriage, and violence from intimate partner that exposes the adolescent and youth to unwanted pregnancy, STI, and psychological trauma. Non-communicable disease and modifiable associated risks have also received due attention in this manual with psychoactive substance use and associated common mental health problems in the adolescents and youth. Finally, the manual has brought into the attention of the trainees that the health –care services rendered at public and private facilities should be reoriented to be sensitive and responsive to the needs of the adolescents and youth.

Rationale of the Training

Adolescents and youth comprise one-third of the Ethiopia's population. This period, ages 10 – 24 years, is considered as a transition period from childhood to adulthood; the behaviors and lifestyles learned or adopted during this period will influence health both in the present and in the future. Well aware of, the Federal Ministry of Health has developed a National Adolescent and Youth Health (AYH) strategy and puts the strategic framework to addressing the full range

of adolescents and youth health and development issues in Ethiopia. Implementation of the strategy is expected to empower and engage adolescents and youth, their families and the community at large for better health, development and wellbeing of Ethiopian adolescents and youth. To materialize the strategy service standards, minimum service package and this training package are developed.

Adolescents and youth are different from adults:

Adolescents and youth (AY) are different from adults in many aspects, and this calls for special approaches to provide them quality AY health-care services. For instance, adolescent and youth have different needs because of their physical and psychological stages; they need different counseling approaches and more time as their cognitive abilities and skills are yet to be developed. The adolescent's brain is under development and it is at ages 23 – 25 years that it assumes a capacity similar to that of adults. This makes the adolescents more vulnerable for risk taking and unable to see the long-term consequences of their actions. As a result, they suffer immense conflicts between their own emerging values and cultural/ parental expectations; and need more information as they tend to be less informed. Adolescents and youth are moving towards independence; so they tend to experiment and test limits. They tend to practice risky behavior such as substance use and have many first time encounter/experience, as sexual activity. Thus, they could suffer from the consequences of their risk taking behaviors.

Adolescence and youth is a critical period for professional interventions: Since this is the time when important life-long health habits are established and carried into adulthood; Interventions during this period can help adolescents and youth make reasonable decisions; take responsibility for their actions; and prevent serious long-term consequences detrimental to their health and development. Thus, this special training allows providers to be more responsive to the needs of adolescents and youth by acknowledging their uniqueness from the rest of the population.

In summary, understanding Adolescents and youth population and their health needs are central to provide quality comprehensive health service. Providers need to be competent in three domains: the first two constituting the foundation of the adolescent health-care: 1) a basic concept in Adolescent development, and 2) policy and laws related to AY health and effective communication skill, and 3) managing any condition related to adolescent health.

Session 1.2 Course Syllabus

Training overview (Course Description): This course covers basic concepts on the growth and development changes during adolescence and youth; sexual and reproductive health issues; communicating adolescents for behavior changes; epidemiology of the common health problems such as STI/HIV, mental health disorders, injuries, GBV, nutrition as well as the AY health-care service provision standards. This course also introduces the principles of health-care service provision focusing on adolescent and youth friendly approach. This is a 4-day training which is prepared and delivered in 14 Chapters. (See Table 1.1)

Goal of the training:

The goal of this training is to orient and sensitize health-care managers and providers to the particular features of adolescent and youth that layout appropriate approaches to properly and adequately respond to selected priority health needs and problems of adolescents.

Course Learning Objectives and Competency:

At the end of the training, participants expected to bring about a change in competence-knowledge, attitude and practice in the area of AY health-care service provision:

- Have the necessary knowledge on adolescent development and characteristic features of adolescence
- Be more sensitive to the health needs of adolescent and youth
- Be capable to provide adolescent/youth-friendly health services
- Prepare personal action plan indicating the changes they will make at their work

Note: This training course is not intended to bring about changes in clinical skills in provision of adolescent health service provision.

Intended participants and Selection Criteria for Trainers:

This training course has been adapted and developed as part of the greater work to respond to health needs of the adolescents and youth comprehensively whereby health-care services providers and managers could effectively render Adolescent and Youth health information and services in their work.

Participants of this training may include physicians, health officers, nurses (Midwives, clinical, public health nurse, and psychiatry), counselors and social workers, HEWs, psychologists, and nutritionists. It is encouraged that all service providers and planners are re-oriented in line with the AY SP to make the existing AY health-care services more responsive to the health needs of the AY. So, there are no strict selection criteria, though those who are engaged with AY health-care service provision be given priority.

Trainers and number of participants: A minimum of two facilitators are required per Chapter as this training course has got several interactive exercises, group works, spot checks and case studies. Trainers should always meet and consult on how they are conducting the training, and assign works to each of them before they start the day or new chapter. Trainers with diverse experience and expertise will also help trainees gain the views of different health disciplines. A class size of 25 – 30 trainees is preferred in order to fully exercise a participatory facilitation.

Venue: This short-term orientation training program has to be conducted at any of the available National IST centers. In principle, this training should be organized at place where there is minimal or no sound/visual obstructions; and in a room where all participants and facilitators are accommodated comfortably

Methodology:

Teaching/Learning Methods and Materials:

In order to actively engage the participants and enable them have equal relationship with facilitators, the teaching and learning process will be participatory throughout the training course. In addition to mini lectures, this training will use an interactive learning method, 'Visualization in Participatory Programs' (VIPP). The method helps from introduction of participants to interactive teaching and learning process. There are varieties of VIPP: VIPP for introduction of participants, VIPP for need assessment, VIPP to elicit and discuss thoughts, VIPP to follow daily progress.

The method includes preparing a name plate in front of each participants, interviewing the person opposite to and present her/him in plenary, to present wishes and worries before and after the training sessions, spot checks, colored cards to share thoughts, buzz groups for brainstorming and discussion, ball throwing, mood board to gauge the daily satisfaction, parking lot to keep matters arising, role playing, case studies, module review and daily recap.

Course Evaluation:

As part of the teaching and learning process, and to understand how the participants are following the course, understand the three domain of adolescent youth health-care, and demonstrate a change in attitude to respond sensitively to adolescent & youth health-care needs, the following quantitative and qualitative means will be used:

- Pre-and-post tests
- Daily course evaluation by participants
- Mood meter (this is to check the level of satisfaction by participants on daily basis)
- Overall course evaluation

Session 1.3: Agenda of the training

Table 1.1 Training on “Adolescent and Youth Health” for Health-Care Service Providers

Schedule	Topics	
	Day 1	
08:30 - 08:45	Registration	
08:45 - 09:00	Welcome & objective of the workshop	
09:10 - 09:20	Opening Remark	
09:20 - 09:20	Participant introduction & expectation	
09:20 – 10:00	Pre knowledge assessment	
10:00- 10:30	Tea break	
11:00- 11:30	Chapter1: Introduction to the training <ul style="list-style-type: none"> • Rationale of the training program • Course Syllabus 	
11:30- 01:00	Chapter 2: Public Health Significance of Adolescent and Youth Health <ul style="list-style-type: none"> • Current Adolescent & Youth Health Status • Why invest in Adolescent & Youth Health 	
01:00-02:00	Lunch	
02:00 -04:00	Chapter3: Adolescent & Youth Growth and development <ul style="list-style-type: none"> • Stages and domains of adolescent of Adolescent development • Adolescent growth & development, sexuality and its implication • Brain development 	
04:00 -4:30	Tea break	
04:30 – 05:30	Daily Evaluation & Facilitators meeting	
	Day 2	
8:30 – 8:45	Day 1 Recap	
08:45- 10:45	Chapter 4: Communicating with A&Y and Motivational interview (MI) <ul style="list-style-type: none"> • Communicating with adolescent & youth • Motivational interview and its approach • Motivational skills and strategy 	
10:45- 11:00	Tea break	
11:00-1:00	Chapter 5: Adolescent Youth sexual and reproductive health <ul style="list-style-type: none"> • Key concepts in SRH • Sexuality education and effective communication • SRH indicators 	
1:00- 02:00	Lunch break	
2:00 – 4:00	Chapter 6: Adolescent Pregnancy <ul style="list-style-type: none"> • Prevention of Child Marriage • Prevention of Adolescent Pregnancy • Comprehensive Abortion Care 	
04:00-4:30	Tea break	
04:30 – 5:30	Continue with Chapter 6	
5:30 – 6:00	Daily evaluation and Facilitator’s meeting	

Day 3		
08:30- 8:45	Recap of Day 2	
08:45- 09:45	Chapter 7: Care for Adolescent during pregnancy, Child birth and Postnatal period <ul style="list-style-type: none"> • Care of adolescent during pregnancy, child birth and postnatal period 	
09:45 – 10:45	Chapter 9: Gender Based Violence in Adolescents and Youth	
10:45- 11:00	Tea break	
11:00- 12:30	Chapter 8: STI and HIV/AIDS <ul style="list-style-type: none"> • STI and its associated factors in A&Y • HIV/AIDS and its prevention approaches in Adolescents and Youth 	
12:30- 01:30	Lunch break	
01:30 – 02:00	Continue with Chapter 8	
02:00-03:30	Chapter 10: Non-communicable diseases in A & Y <ul style="list-style-type: none"> • Overview of NCDs and their risk factors in A & Y • Cervical Cancer prevention in A&Y • Injury in Adolescents and Youth 	
03:30 – 04:00	Tea break	
04:30 – 6:00	Chapter 11: Psychoactive substance use Mental Health Problems in AY <ul style="list-style-type: none"> • Mental health in Adolescents and Youth • Substance use in Adolescents and Youth 	
Day 4		
08:30-09:00	Recap Day 3	
09:00 – 11:00	Chapter 12: Adolescent Nutrition <ul style="list-style-type: none"> • Nutritional needs of Adolescents • Malnutrition in Adolescents and its consequences • Nutrition screening, assessment and intervention 	
11:00 – 11:30	Tea Break	
11:30 – 12:30	Chapter 13: Bioethics and autonomous decision making <ul style="list-style-type: none"> • Bioethics and its application in AY Health • Caring, respectful and compassionate services provision for adolescents and youth 	
12:30 – 1:30	Lunch	
01:30 – 02:30	Chapter 14: AY Responsive Health System & services <ul style="list-style-type: none"> • Health service and the needs of A & Y • Integrated management of common conditions 	
02:30 – 03:00	• Introduction to AYH supportive supervision tool	
03:00 -03:30	Development of plan of action	
03:30 – 04:00	Course evaluation and Post test	
4:00 – 4:30	Tea Break	
4:30-5:30	Closing	

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World Health Organization, Orientation Program on Adolescent Health for health care providers. Facilitators' Guide. Available at [ww.who.int/child-adolescent-health/documents/](http://www.who.int/child-adolescent-health/documents/)

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FDRE Ministry of Health, Training Manual for Adolescent and Youth Reproductive Health. Facilitators' Manual, 2008

FDRE Ministry of Health, Training Manual for Adolescent and Youth Reproductive Health. Participants Handout, 2008

VIPP- Visualization in Participatory Programmes :A manual for facilitators and trainers involved in participatory events. UNICEF, Bangladesh, 1993

Chapter 2: Public Health Significance of Adolescent & Youth Health

Session 2.1 Session outline and Learning Objectives

Duration: 90 min

Session outline

- Status of Adolescent and Youth health globally and in Ethiopia
- Epidemiology of selected Priority Health Problems of Adolescent and Youth
- Rationales in investing on Adolescent and Youth health

Learning objectives:

By the end of this chapter the participant's will be able to

- Describe the status of Adolescent and Youth health globally and in Ethiopia
- Describe the common health problems of Adolescent and Youth in Ethiopia
- Explain the rationales in investing on Adolescent and Youth health

Session 2.2: Overview of Adolescent and Youth Health

Adolescence is a transition stage of physical, cognitive and psychological development that generally occurs during the period from puberty to legal adulthood.

W.H.O defines Adolescence: 10 – 19 years; Young People: 10 – 24 years; and Youth: 15 – 24 years. The National AY Strategic Plan defines adolescent and youth: 10 – 24 years of age.

Adolescent and youth make significant proportion of the world population, one sixth of the world's and one third of Ethiopia's population, with unique needs related to their health and wellbeing; as they transition from childhood to adulthood. Improvement in child health interventions with better maternal health has resulted in Ethiopia marked reduction of under-five mortality meeting the MDG, impacting on the surviving children and changing the demography.

The priority health needs of adolescents and youth in general are not limited to sexual and reproductive health; but issues related to nutrition, substance use, non-communicable diseases such as mental health problems, injuries and violence are priority areas. However, evidences show that early sexual debut, risky sexual practices, child marriage, early child bearing, unintended pregnancy, unsafe abortion and its complications and STIs/HIV remain among the major health problems in the same population.

The life-cycle approach provides an important perspective for public health action. Events in one phase of life both affect and are affected by events in other phases of life. Effective interventions during adolescence protect public health investments in child survival and early child development. At the same time, adolescence offers an opportunity to rectify problems that have arisen during the first decade. Thus, what happens during the early years of life affects adolescents' health and development, and health and development during adolescence in turn affect health during the adult years and, ultimately, the health and development of the next generation.

Despite the significant improvement in Child Survival in the country, studies show that the mortality trends in the ages 10-19 years have not changed much. The three subsequent EDHS, (2000, 2005 and 2011), showed increase in the death rates of both females and males aged between 15 – 24 years. Compared to the adult counterparts, adolescents don't usually get the right information, the good overall care, and enough consultation time. In addition, clinicians who are treating adolescents often times don't explain the condition in simple way the adolescents understand, and cost is also a barrier.

Activity 2.1. Discuss the following points and share your responses with the group

1. What are the common health problems of AY observed in your health facility?
2. What are the challenges related to dealing with adolescent health?

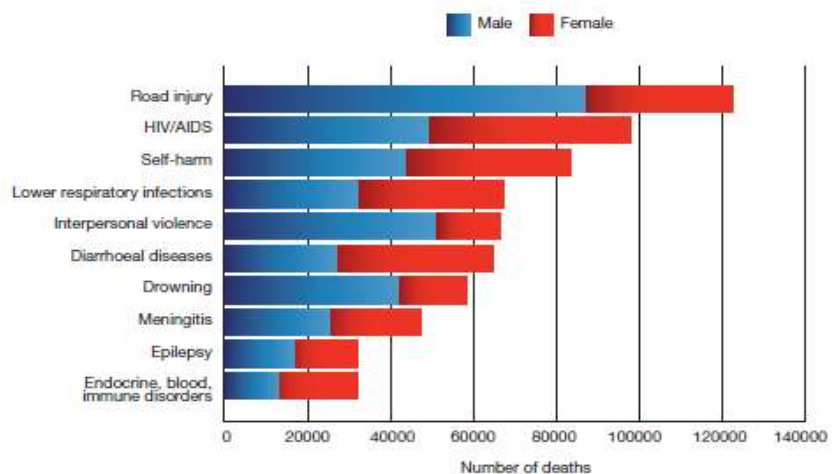
Session 2.3 Epidemiology of selected Priority Health problems of Adolescents and Youth

Globally, road-traffic injury is the most common cause of death among adolescent followed by HIV/AIDS and self-harm/suicide. The mortality rate varies by sex; as boys have higher rates mortality from unintentional injuries and violence compare to girls. In Ethiopia, reduction in mortality rate was registered among girls while a progressive increase in mortality rate was reported among boys. Road injury and violence are considered the common cause of death in this population as well.

Globally, the most common causes of morbidity among adolescents and youth are injuries/violence; sexual and reproductive health Problems; substance use; mental health problems; and non-communicable diseases. These health problems pose a great challenge among Ethiopian adolescents and youth as well. Each of these health problems are described briefly as follow:

Injuries: In Ethiopia, injuries due to road traffic accidents (RTA), physical fights and drowning account for 9% of the mortality caused by NCDs. Among adolescents and youth (defined as 15-29 years in the study), the prevalence of RTAs is 2.7% (3.2% male and 2% female) and that of non-RTAs is 2.4% (3% male and 1.6% female). The common non road traffic accidents are fall, burn, poisoning, cut, drowning, animal bites and violent injuries.

Gender-Based Violence: GBV is a common reality for many Ethiopian girls and young women. It increases the risk of adverse health outcomes such as unintended pregnancy, acquisition of HIV and other sexually transmitted infections (STIs); and mental health disorders. Young unmarried women commonly experience sexual or other forms of GBV. Despite its grave health consequences, GBV has been somehow traditionally accepted in our community. For instance, according to the EDHS 2011, 68% of married women accept that a husband is justified for beating his wife. Moreover, more than half of married adolescent women aged 15-19 do not know that there is law against domestic violence; which is consistent in all age groups.



Source: WHO, 2014 report

Adolescent Nutrition: Chronic malnutrition and iron deficiency anemia are the most common forms of malnutrition among Ethiopian adolescent girls. Thirty-six percent of non-pregnant adolescent girls aged 15-19 years are chronically malnourished (BMI <18.5) and 13% of the same population had anemia. Apart from the under-nutrition, 2.2% of the girls and 0.3% of the boys in this age group are overweight.

Substance Use: Harmful substance use (tobacco, alcohol and illicit substances) will increase the risk of cancers, cardiovascular diseases, and respiratory illnesses later in life. Substance use could co-occur with other health problem such as mental health problems. Use of such substance has shown increment in the last decade.

In Ethiopia, 4.4% of adolescents and youth smoke cigarettes or other tobacco products and 36.6% of 15-29 years adolescents and youth are using any form of alcohol; more male (42.6%) than females (29.5%) use alcohol. Khat is also one of the psycho-active substances commonly used in Ethiopia, other East African countries and Arabian Peninsula. The national prevalence of Khat consumption among adolescents and youth is 51%; more males (56.5%) than females (36.6%) consume it.

Mental Health: Mental health disorders account for a large proportion of the disease burden in young people in all societies. Most mental disorders begin during adolescence and youth, although they are often first detected later in life. Poor mental health is strongly related to other health and development concerns in young people.

In Ethiopia, mental health disorders are the leading non-communicable disorder in terms of burden. At a prevalence of 12-25%, childhood mental illnesses make the highest load of mental illnesses in the health sector. In the face of the lack of appropriate data, it is viable to deduce that mental illness and related conditions are among the main contributors for poor quality of life and productivity of adolescents and youth.

Sexual and Reproductive Health Problems: Existing evidences show that the major sexual and reproductive health problems of adolescents and youth in Ethiopia include early sexual debut, risky sexual practices, child marriage, early child bearing, unintended pregnancy, unsafe abortion and STIs including HIV.

- Early sexual debut and teenage pregnancies are common owing to the high rate of child marriages and the subsequent family and societal pressure on girls to prove their fertility. The median age at first sex for women is 16.4 years and 40% of girls marry before the age of 18 years and 20% before 15.
- High rate of unintended pregnancy indicates that there is low access and utilization of family planning services by young people. The current CPR, EDHS 2016, for adolescents

15-19 years and youth 20-24 years is 32% and 39% respectively while unmet need for FP for same age groups is 8.7% and 15.8% respectively.

- Lack of skilled care during pregnancy and delivery in this age group also poses significant health risk to the mothers and their children compared to older women in the reproductive age group. The coverage of ANC4+ for Ethiopian adolescent age below 20 years is 29%, and only 32.8% of adolescent deliveries are by skilled health personnel.
- Studies indicate that only 51% of school girls know about menstruation and its management, only one-third use sanitary napkins as menstrual absorbent and high proportion (>50%) avoid going to school during their menstruation period.
- Evidence indicates that there is increased risk of acquiring STIs and HIV among adolescents and youth due to the early initiation of sexual intercourse and higher-risk sexual behavior such as having sexual intercourse with multiple partners or somebody who is neither a spouse nor a cohabiting partner without use of condom. Use of alcohol and drugs is known to drive young people into higher-risk sexual behavior. Furthermore, transactional sexual relationship among young people has become an emerging contributing factor to STIs/HIV.
- The prevalence of HIV among adolescents and youth in Ethiopia particularly in the younger age group (15-19) is relatively lower (<1%) than other African countries. This is in contrast to the expected high prevalence of the disease thought to result from the high proportion of high risk sex in this age group. Prevalence is generally higher among females and increases by age: lowest (0.1%) for the 15-19 years, 0.6% for 20-24 years and 2.0% for 25-29 years.
- In Ethiopia, comprehensive knowledge of HIV/AIDS among youth is relatively low: 24% for girls and 35% for boys.

Non-Communicable Diseases (NCDs): Studies indicate that NCDs are an emerging epidemic in Ethiopia and other low- and middle-income countries because of the increasing urbanization and related changes in lifestyle and dietary habits. However, there is limited information on the prevalence of NCDs and their risk factors among adolescents and youth which are nationally representative.

Harmful Traditional Practices (HTPs): Female genital mutilation/cutting (FGM/C), child marriage, forceful abduction and domestic violence are the most widely practiced forms of HTPs that are classified as serious crimes by the Ethiopian Law. There are indications that attitudes towards FGM are changing and its prevalence is declining in Ethiopia. The prevalence of FGM/C in girls and women aged 15-49 has decreased from 79.9% in 2000 to 65% in 2016. Despite the law against it, child marriage remains prevalent in Ethiopia. In the 2005 EDHS, 34% and 66% of Ethiopian women aged 25 to 49 are married by the age of 15 and 18, respectively.

In the 2011 EDHS, the respective proportions decreased to 30% and 63% for women of the same age group.

Session 2.4: Why invest in adolescent and youth Health?

Ethiopia is the second most populous country in Africa. The population structure is predominantly young. A third of its population is in the age category between 10 – 24 years, young people. The huge investment made into the area of child survival has impacted in the demographic transition of the country, more children survived to adolescence. These adolescents, who have survived the menace of childhood, have to thrive and sustain to the benefits of themselves, their families, and the nation as a whole.

Moreover, effective interventions during adolescence protect public health investments that happened during childhood. The behavior and lifestyles learned or adapted during adolescence will influence health both in the present and future. This population either restricts, promotes or be neutral to the economic growth of the country. A right policy environment could use this young population to stimulate technological changes and innovation to bring a leap in the economy and to enjoy the demographic dividend. The benefits of adolescent and health development accrue not only to the adults that emerge from this process, but also to future generations.

There are important Demographic, Public Health, Economic, and Human Right justifications for addressing the health and wellbeing of adolescents and youth.

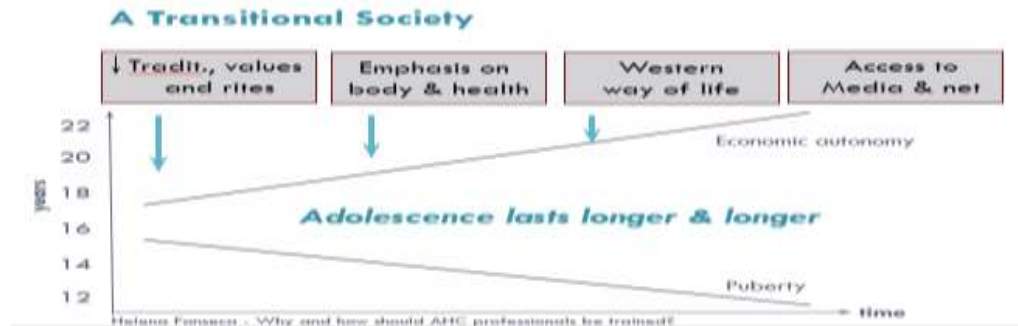
One in five individual in the world today is an adolescent, around 1.2 billion. This is a transition society, and it lasts longer and longer with puberty starting earlier while the economical autonomy happens later and later.

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

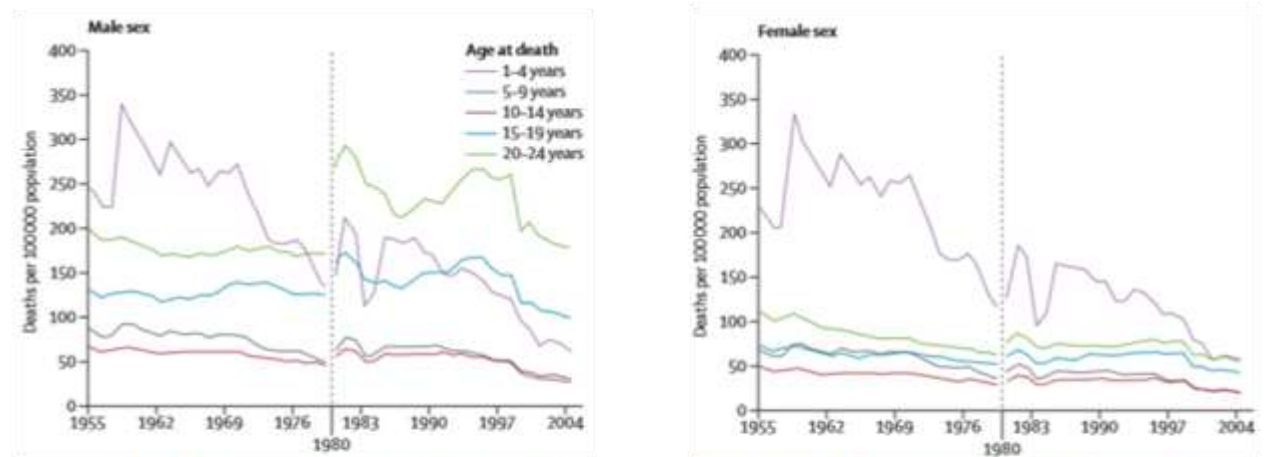
Box 1: Reasons for investing in Adolescent and youth health

- Demographic rationale
- Health benefit
- Economic benefit
- Human right benefit

It is estimated that every year about 1.4 million adolescents die – mostly from accidents, violence, pregnancy-related problems and illnesses that are either preventable or treatable. Many more develop behaviors that could destroy their chances for personal fulfillment and their ability to contribute to society.



Nearly two thirds of premature death and one third of the total disease burden in adults are associated with conditions or behaviors that began in adolescence. If specific and appropriate measures are taken during this period, it is possible to prevent significant proportion of adulthood morbidity and mortality. Thus, investing in adolescent health and development will reduce the morbidity and mortality in this age group, and It will maximize their opportunity to develop to their full potential and to contribute the best they can to society.



All-cause mortality per year from 1955 to 2004 by sex and age-group

50-year mortality trends in children and young people: a study of 50 low-income, middle-income, and high-income countries

Russell M Viner, Constan Giffey, Colin Mathers, Paul Burns, Anthony Costello, John Santoli, George C Patton

In this 50-year mortality trends in children and young people, mortality rate has steadily decreased for those aged between 1-4. However, the same has not happened for those aged 15-19 years with rates keeping more or less constant, while with those aged 20-24, the mortality rate has remained at the very top through the last decades and is 2-3 times higher than that of the 1-4 year-old.

Demographic change affects the economy through age structure and labor force participation. Labor is one of the important inputs in the production process, accounting for more than half of all output produced. (Hall and Jones 1999) Healthy adolescence and youth benefits the economy in two ways - healthy well-prepared adolescents and youth that are ready to join the productive workforce with less disease burden that is not demanding huge expenditure. When adolescents develop sub-optimally or die prematurely, this leads to wastage of earlier investments. Investing in prevention and promotion during adolescence also averts future health costs: smoking prevention averts health costs much later in life. The empowerment of girls and women is a crucial element in the economic growth of a country. Furthermore, the investment on gender aspect of adolescent health- adolescent pregnancy, child marriage, and other forms of GBV- can positively impact the productivity of the female cohort in the future that is entering the labor force.

Except few countries in the world, almost all countries ratified and endorsed the 'UN Convention on Child's Rights'. Ethiopia is one of the countries that have endorsed it. Promoting and safeguarding adolescent health should not only be regarded as an investment, but also as a basic human right. The UN Convention on the Rights of the Child (CRC), declares that young people have a right to life, development, and (in Article 24) "*The highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health*". The CRC also gives young people the right to preventive health care and requires specific protection for those living in exceptionally difficult conditions or with disabilities. This means that governments have the responsibility to ensure that health and other basic services essential for good health are provided.

Summary

- Adolescent and youth make significant proportion of the world population
- Rationales for investing in adolescent and youth health are 1. Demographic, 2. Public Health, 3. Economic and 4. Human rights
- Investing in adolescent and youth health should not be viewed only as investment, but also as a basic human right.
- Investing on Adolescent and youth health has positive health impact throughout their remaining life
- Currently adolescent and youth are not getting the expected services worldwide
- According to the life-cycle approach, events in one phase of life both affect and are affected by events in other phases of life

- Injuries/violence; sexual and reproductive health problems; substance use; mental health problems; and non-communicable diseases are the top 5 causes of morbidity and mortality
- Significant global and national efforts are undergoing to address this age groups
- As much as there are challenges, there are global and national opportunities which should be harnessed to improve health care for adolescents

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Chapter 3: Growth and Development during Adolescence and Youth

Session 3.1 Session Outline and Learning Objectives

DURATION: 180 Minutes

Session outline

- Stages and Domains of Adolescent Development
- Adolescent Development, Sexuality and its Implications
- Adolescent and Youth Brain Development

Learning Objective:

At the end of this chapter the participants will be able to:

- Describe biological, psychological and social components of adolescent development.
- Explain its potential impact on health behaviors and on the management of health issues.
- Recognize the major steps of brain reconstruction during adolescence
- Attitudinal changes towards adolescent health care from developmental perspective
- Ability to sensitively address the implications of adolescent developmental changes for parents, at health facilities and at schools
- Demonstrate knowledge of adolescent and youth brain development and its implication on their health

Session 3.2: Stages and Domains of Adolescent Development

The developmental transition from childhood to adulthood has the following steps: (1) completing puberty and somatic growth; (2) developing socially, emotionally, and cognitively, moving from concrete to abstract thinking; (3) establishing an independent identity and separating from the family; and (4) preparing for a career or vocation.

From a biologic perspective, the beginning of adolescence is marked by the onset of puberty. In the developed world the biologic age of menarche has declined over the past centuries from 16.6 years in 1840 to 12.5 years by 1980. Data on boys, though less reliable, suggest that they may be beginning maturation earlier as well.

Stages of adolescent development: In all countries adolescents go through the same stages of development for both males and females but the age ranges may vary.

Table 3.1: Stages and ages of adolescence in the developed world?

No	Stages of development	Age
1	Early adolescence	10-13
2	Middle adolescence	14-16
3	Late adolescence	>17

Domains of Adolescence Development: Adolescents go through various types of developmental changes (domains). These include physical, psychosocial and cognitive developments. Each stage of development has a group of characteristic features for each domains of development. We will now briefly examine these features using the tables below.

Table 3.2, Table 3.3, and Table 3.4 show the changes in the three domains throughout early, middle, and late adolescence respectively

Table 3.2. Physical, psychosocial and cognitive changes in early adolescence

Physical changes		
Girls	Boys	Both
<ul style="list-style-type: none"> • Growth spurts begins • Beginning of pubertal changes breasts/genitalia/pubic hair • Accrual of muscle mass peaks at menarche, thereafter the accumulation of fat predominates (breasts, thighs and hips) • Strength increases until menarche, there is no consistent evidence of a strength spurt in girls • Weight changes-body shape and size: Hips widen/Waist narrows 	<ul style="list-style-type: none"> • Development of the testes and scrotum is usually the first sign of puberty in boys • Pubic hair begins • Voice changes • Gynecomastia common 	<ul style="list-style-type: none"> • Appearance of Acne • Body odor change • Girls tend to lose less of their body fat than boys • An awkwardness as various body parts grow at different rates • Biologic changes in the brain causing dynamic emotional changes
Psychosocial changes (both sexes)		
<ul style="list-style-type: none"> • Begin to separate from parents and identify with peers • Confrontational with parents–Testing parental values • Interest in other gender for friendship • Curiosity about sexual matters begins • Travel in “packs” • Greater need for privacy 	<ul style="list-style-type: none"> • Preoccupation with self • Preoccupation with being like peers • Conformity • Same gender in clique • Still need “down-time” • Mood swings/Erratic behavior • Lack of impulse control 	
Cognitive changes (both sexes)		
<ul style="list-style-type: none"> • Retain concrete thinking • Begin to question authority and societal standards • Conformist morality of childhood 	<ul style="list-style-type: none"> • Learning by trial and error • Beginning abstraction • Imaginary audience, on stage all the time, others are thinking only about them 	

Table 3.3 Physical, psychosocial and cognitive changes in middle adolescence

Physical changes	
Girls	Boys
<ul style="list-style-type: none"> • Breast development • Nipples swell , breasts may feel tender and sensitive • Breasts fill out over three to four years. One breast may grow faster than the other • One or both breasts may secrete a small amount of milky fluid • Broadening hips leading to rounded feminine figure 	<ul style="list-style-type: none"> • Growth spurt in height usually occurs • Strength spurt about one year after peak height velocity • Increase in muscle mass occur later than increase in strength • Often the arms and legs lengthen before the trunk of the body, can cause awkwardness • Faster muscle growth in boys leads to greater strength • Penis growth • Development of pubic, facial and body hair. • Typically facial and body hair appear about two years after pubic hair
Psychosocial changes (both sexes)	
<ul style="list-style-type: none"> • Parental conflicts, peer involvement and risk taking behavior peak • Conformity with peer values—Strong emphasis on peer group • Feeling of omnipotence • Egocentric—Belief in own uniqueness • Self-centeredness and vanity 	<ul style="list-style-type: none"> • Increasing independence • Sexuality is a major preoccupation • Less idealistic vocational aspirations • Questioning “who is the real me?” • Behave differently with different people • Conflicting view of the self can be troubling—Ability to recognize that they have different roles with different people but don’t yet understand why and this can be troubling
Cognitive changes (both sexes)	
<ul style="list-style-type: none"> • Thinking tends to be less childlike, more abstract, introspective and analytic • Begin to realize they are sexual beings • Increased openness of feelings and sensitivity to the feelings of others 	<ul style="list-style-type: none"> • Can consider facts and make better decisions based on knowledge of the consequences of their choices • Sensitive to criticism • Continue to be influenced by peers

Table 3.4 Physical, psychosocial and cognitive changes in late adolescence

Physical changes	
Girls	Boys
<ul style="list-style-type: none"> • By 16 years most young women have completed puberty, the growth rate slows, there is pubic and body hair, a rounded and curved figure because of widened pelvis, hips and breasts • With a well-established menstrual cycle, a young woman at this point is physically able to produce offspring 	<ul style="list-style-type: none"> • By 16 to 18 years most males have completed puberty, their growth rate begins to slow, their shoulders have broadened, limbs and trunk are muscular and they have adult body and facial hair • Produce sperm and are physically able to produce offspring
Psychosocial changes (both sexes)	
<ul style="list-style-type: none"> • Integration of the diverse views of self • Less importance placed on peer group • May accept parental values or develop own 	<ul style="list-style-type: none"> • Less self-centered • Decreased impulsivity and increased ability to compromise and set limits • Refinement of moral and religious values • Realistic vocational goals
Cognitive changes (both sexes)	
<ul style="list-style-type: none"> • Conceptualize/verbalize thoughts • Full adult reasoning/identity • Ability for abstract thinking 	<ul style="list-style-type: none"> • Understanding consequences of behavioral choices • Increased thoughts about more global concepts such as justice, history, politics, patriotism and their emerging role in adult society

Summary points on adolescent growth and development:

- From a biologic perspective, the beginning of adolescence is marked by the onset of puberty
- Features and domains of adolescent development are universal
- Cultural influences on puberty include nutrition, the quality of health care and living conditions
- In girls, the first visible sign of puberty is the appearance of breast buds, between 8 and 12 years of age; menses typically begins 2-years later and the median age for menarche is also 12 years but normally range, 9-16 years of age.
- In boys, the first visible sign of puberty is testicular enlargement, beginning as early as 9 and half years and this is followed by penile growth. The left testis normally is lower than

the right; some degree of breast hypertrophy, typically bilateral, occurs in 40-65% of boys during middle adolescence.

- In the developed world the biologic age of menarche has declined over the past centuries
- Data on boys, though less reliable, suggest that they may be beginning maturation earlier as well
- Precocious puberty: The onset of secondary sexual characteristics before the age 8 years in girls and 9 years in boys
- Delayed puberty:
 - Boys: no testicular development by age 14 years
 - Girls: lack of thelarche (breast development) by age 13 years or no menarche by 15 years
- During puberty changes in melatonin secretion cause a sleep delay leading to later sleep onset and later waking times; adolescents need 9-9.5 hours of sleep/night
- The increase in risk-taking, sensation and reward-seeking behavior, especially in the presence of peers, is primarily linked to changes in patterns of dopaminergic activity that occur around the time of puberty.

Session 3.3: Adolescent Development, Sexuality and its Implications

Anxiety and interest in sex and sexual anatomy increases during early puberty. It is normal for young adolescents to compare themselves with others. In boys, ejaculation occurs for the first time; usually during masturbation and later as nocturnal emissions, and this may be a cause of anxiety for boys. Early adolescents sometimes masturbate together; however isolated incidents of mutual sexual exploration are not necessarily a sign of homosexuality. The prevalence of other forms of sexual behavior, other than masturbation, varies by culture but generally is less common in early adolescents.

Dating becomes a normative activity as middle adolescents assess their ability to attract others. The degree of sexual activity and its onset vary widely by race, ethnicity, and nation. In addition to sexual orientation, middle adolescents begin to sort out other important aspects of sexual identity, including beliefs about love, honesty, and propriety. Relationships at this age are often superficial and emphasize attractiveness and sexual experimentation rather than intimacy. Adolescents tend to follow several characteristic patterns of sexual behavior: abstinence, serial monogamy, or polyamory. Most adolescents have some knowledge of the risks of pregnancy, HIV, and other sexually transmitted infections, but knowledge does not consistently control behavior. Many sexually active adolescents use condoms consistently with or without other contraceptives; up to 70% of adolescents used some form of contraception or prophylaxis for sexually transmitted infections (STIs) at their first intercourse.

Implications of growth and developmental changes for health care workers and parents

The changes that are discussed above have implications on how we approach complaints or health problems of adolescents, interview adolescents, manage their problems and facilitate establishment of progressive relationship between adolescents and their parents.

Implications of changes in early adolescence:

Implications to parents:

- Parents may have concerns that they are hesitant to discuss issues with their adolescent children.
- Parents can be interviewed separately from the adolescent to avoid undermining the adolescent's trust.
- The health care provider needs to help parents to differentiate between the normal discomforts of the age and truly concerning behaviors.
- Bids for autonomy, such as avoiding family activities, demanding privacy, and increasing argumentativeness, are normal; but extreme withdrawal or antagonism may be dysfunctional.
- Parents must adapt disciplinary measures to the changing abilities of the adolescent, who can think through problems, assess consequences, and solve problems. Thus, the development of negotiation strategies is critical.
- Children and adolescents raised by parents who use negotiating as part of child rearing have more positive outcomes than those raised by parents who use more authoritarian or permissive styles.

Implications to a health care worker:

- When interviewing and examining an adolescent, health care providers should keep in mind that physical maturation correlates with sexual maturity, whereas psychosocial development correlates more closely with chronological age.
- Early adolescents typically need reassurance that the somatic changes they are experiencing are common and normal.
- Bewilderment and dysphoria (dissatisfaction with life) at the start of junior high school are normal; continued failure to adapt several weeks to months later suggests a more serious problem.
- Risk-taking is limited in early adolescence; escalation of risk-taking behaviors is problematic.

Implications of changes in middle adolescence

Implications to parents:

- Parental connectedness and close supervision or monitoring of the youth's activities and peer group can be protective against early onset of sexual activity and involvement in other risk-taking behaviors, and can foster positive youth development.
- Parents should also assume an active role in their adolescent's transition to adulthood to ensure that their child receives appropriate preventive health services.

Implications to a health care worker:

- Middle adolescence is a time when the opportunity to talk confidentially with a non-judgmental, informed adult can be particularly appreciated and helpful in the midst of significant psychologic and biologic change.
- Adolescents vary greatly in their rate of physical and social progress and in the resolution of central conflicts about autonomy and self-esteem.
- Questions about family and peer relationships can help locate a child along the developmental continuum and facilitate individualized counseling.
- Early- and late-maturing adolescents are at risk for psychological problems-anticipatory guidance with parents or guardians and appropriate referral to mental health professionals of these adolescents may be warranted.
- Regarding dating and sex, intention to have sex and whether close friends are sexually active are good indications that a youth may be initiating sexual activity shortly.

Implications of changes in late adolescence

Implications to parents:

- The crucial task of adolescence becomes the establishment of a stable sense of identity, including emotional and physical separation from the family of origin, initiation of intimacy, and realistic planning for economic independence.
- The relationship changes from one of parent-child to an adult-adult model.

Implications to a health care worker:

- When no barriers to access to social and health services exist, lack of progress toward adult autonomy may indicate a need for professional counseling.
- Adolescents who become parents may have the added difficulty of achieving appropriate developmental milestones prior to assuming adult responsibilities.

Session 3.4: Adolescent and Youth Brain Development

Reconstruction of brain during adolescence

Neurons and their axons are called the gray matter, which decreases during adolescence. Paraventricular central brain structures such as limbic systems are selectively stimulated by pubertal

hormones. Myelin, also called white matter, insulates the neurons and their axons, and builds stronger and faster connections between brain centers. During this period, the brain plasticity - the human creativity - is booming, but this capacity fades after the age of 25. Decrease of gray matter is age-related and occurs from 12 years on. Stimulation of paraventricular areas is dependent on puberty development, the pubertal hormones, and mediated by dopamine. The myelin insulation of axons in the prefrontal areas is the last to be completed and is not finished until about age 25. The pruning of gray matter in the brain works in a similar way as it is in horticulture where a redundant branches on fruit trees are cut away to make the fruit tree stronger and more productive. It helps the adolescent's cognitive function better and allowing for specific skills to develop better.

Recent advances in understanding the development of the adolescent brain show that the reward-seeking regions of the brain develop before the regions responsible for planning and emotional control. The stimulation of paraventricular areas (limbic system) stimulated by the pubertal hormones dopamine mediated begins typically around age 10 to 12 years and increases over the next several years. But, the prefrontal cortex which keeps a lid on impulsive actions doesn't approach full development until a decade later, leaving an imbalance during the interim years. Puberty is starting too early, boosting hormones when the prefrontal cortex even less mature (figure3.1)

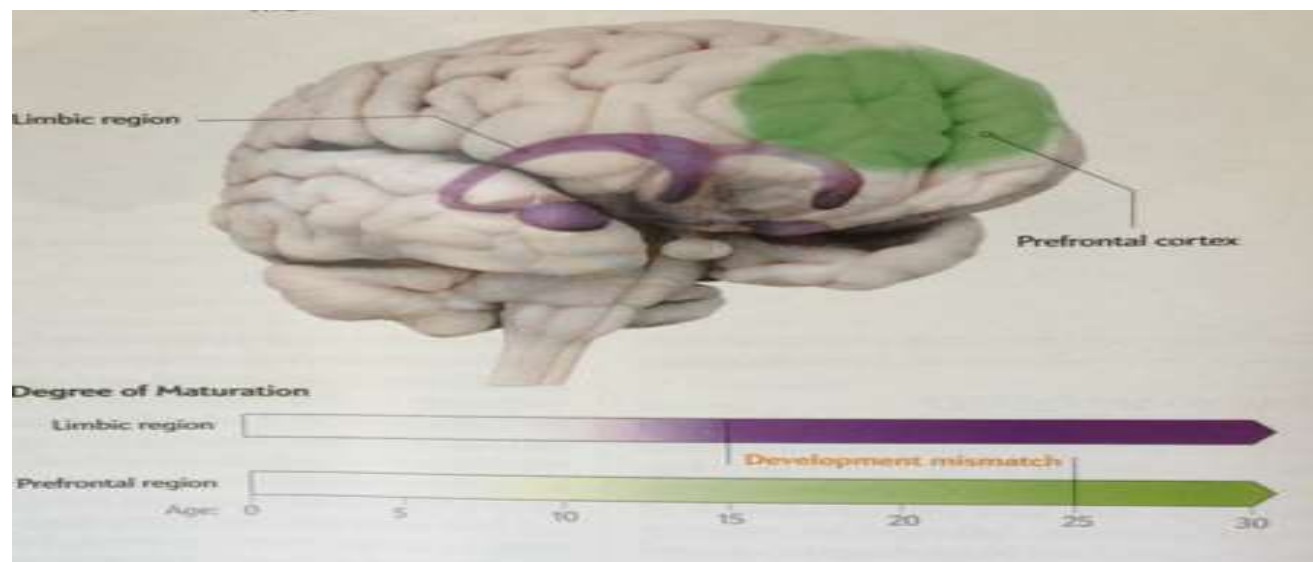


Figure 3.1 Developmental imbalances between limbic region and prefrontal cortex in relation of adolescent and youth and developmental stage.

Risk-taking, Exploring and Problem behaviour

Developments take place in regions of the brain (the limbic system) that are responsible for pleasure seeking, reward processing, emotional response, and sleep regulation. At the same time, changes take place at a somewhat slower rate in the pre-frontal cortex, the area responsible for decision-making, organization, impulse control, and planning for the future. Thus, during adolescence, biological maturity precedes psychosocial maturity and, to some extent, there is a disconnection between adolescents' physical capacities, their sensation seeking, and their capacity for self-control. This implies that the experimentation, exploration and risk-taking that take place during adolescence is more normative than pathological and that there is real potential to ameliorate negative developments that took place during the early years of life.

Figure 3.2 below illustrates the gap in control of the prefrontal area over the sensory intensity of the paraventricular area during mid-adolescence. Not until the mid-twenties is the control functioning fully.

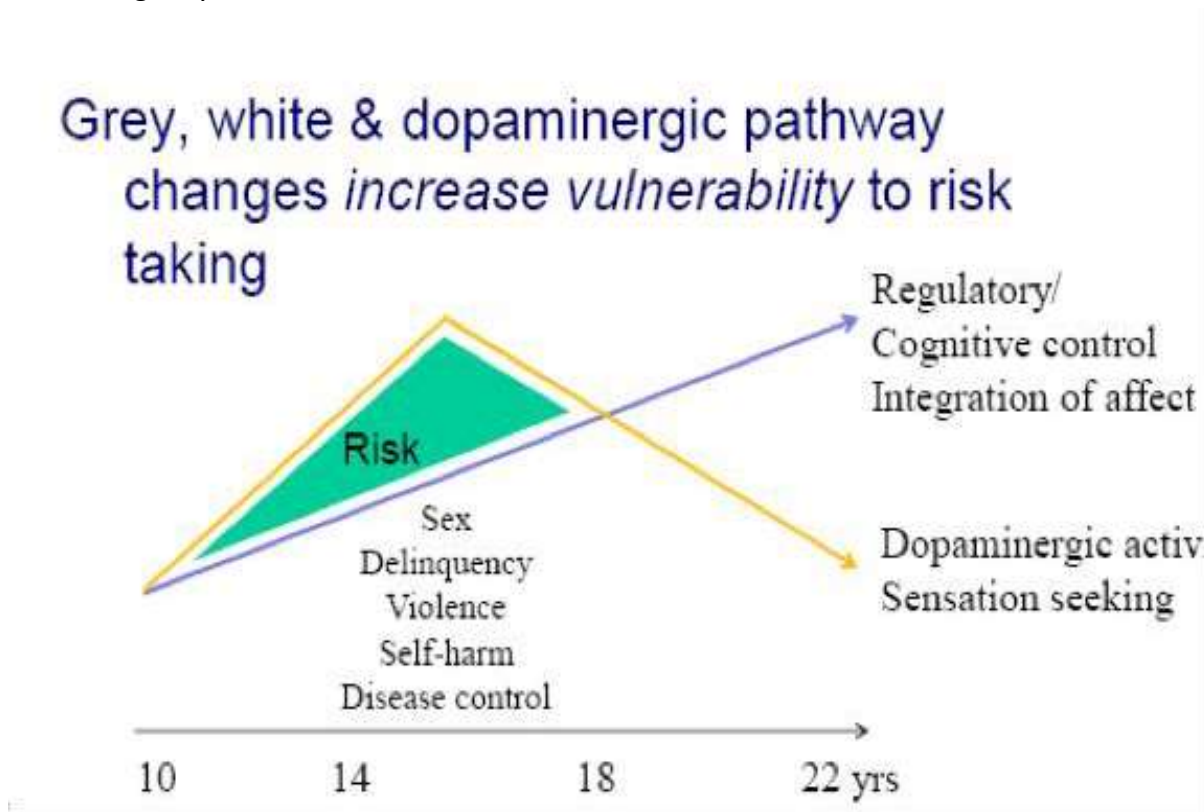


Figure 3.2. Mid-Adolescent risk taking due to mismatch of regulatory and sensation control

Cognitive developments start later and take longer in boys than girls, so boys' tendencies to act impulsively and to be uncritical in their thinking generally lasts longer than in girls. This is not to suggest that young adolescents, and particularly young adolescent boys, are incapable of decision-making or planning for their futures. In fact, some of the changes in social and

emotional processing that take place during adolescence may increase adolescents' ability to adjust to changing social contexts.

The prefrontal area gradually takes control. This means that young persons in their adolescence generally do not see the long-term consequences of their actions. They drop out of school from emotional reasons and would need a very strong reason for a specific educational goal to stay in school, or a strong emotional attachment to a parent to do so! Long-term goals motivating to adherence to treatment for chronic diseases are generally not useful, better to focus on short term aspects of well-being deriving on adequate adherence.

Figure 3.3 series illustrates the importance of white matter, myelin, to insulate and fortify main connections between brain centres. Also the nodes connecting the pathways are further developed by the myelin. Both these actions speed up the nerve transmission within the brain and serves to increase cognitive ability

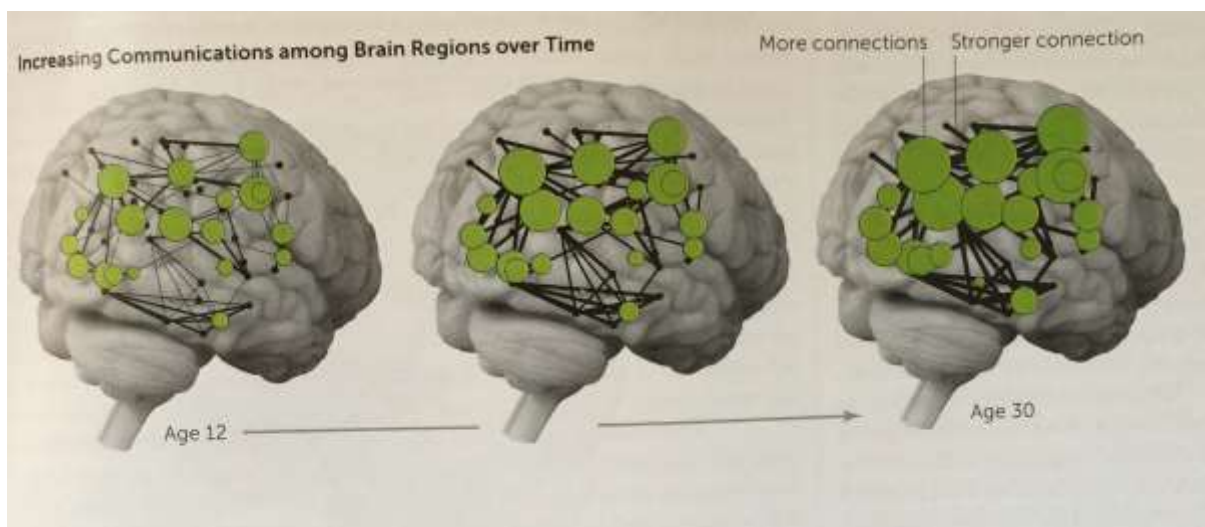


Figure3.3 Series of white matter, myelin, to insulate and fortify main connections between brain centres over time with developmental stages of young people

Only at age 23-25, adolescents now have the brain capacity that is similar to that of adults: adolescents find their assets and what they like, they demonstrate to themselves and others (parents) that they are growing up, and can do rebellious things, they test different life styles, they learn how to trust and nurture others outside family and it helps them identify their personality. A reciprocal pattern of brain function causes physical change (molding) of adolescent's brain. In the process, adolescents initiate actions or thoughts; they repeat the actions or thoughts. The experience of the actions or thoughts physically molds our brains to habitually repeat the actions or thoughts. The brain is plastic and can be molded. Parents have

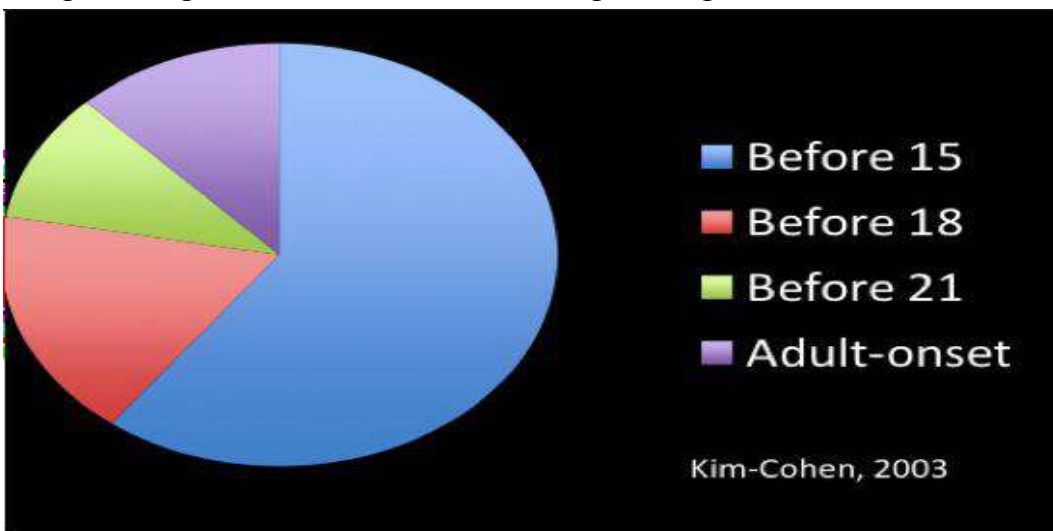
a powerful influence on teens. The brain learns by trial and error, particularly from the age of 18 on. Mistakes are supposed to be made by adolescents.

Risk taking and exploratory behaviour serves developmental needs as the young person learns something about him/herself, even if the act might be instantly dangerous. Problem behaviour is in itself harmful and becomes more so, because of its repetitive use. It does not fulfil a developmental need. Getting drunk once may be seen as an exploratory behaviour, but repetitive drunkenness is problem behaviour. However, problem behaviours should always be examined from the point of view, that this is a method that is the only one at that point which a young person can access for some strong need, such as anxiety modification, or as a way to survive in dire circumstances (prostitution).

Understanding the emergence of mental health problems in adolescence and youth:

Until the mid-twenties adolescents don't have the physical brain capacity to make fully mature decisions. The status and balance between the cognitive and emotional development impact the decision making outcomes of adolescents. During this period, as the cognitive development is not refined enough to allow realistic cost-benefit analysis, the decision adolescents often make is emotional flooded with passion and happens at heat of the moment. This makes them vulnerable for risky behaviours such as binge alcohol drinking, unsafe sex, substance and drug use, road traffic accidents, violence, etc.

The peak age of onset for many psychiatric disorders is during adolescence, a time of remarkable physical and behavioural changes. Adolescence is a time of dramatic change in brain, body and behaviour and time of peak emergence of: schizophrenia, depression, anxiety, substance abuse, eating disorder and etc. Figure3.4 below illustrates mental illnesses with age at diagnosis. Figure 3.4 Mental illnesses with age at diagnosis



Variety of mental diseases and disorders occur in adolescents and youth, and when brain is not up to same level. Adolescent brain is not up to same level when there is a slight mental retardation which has not yet been discovered, bipolar disease, neuropsychiatric disorder (NPD), schizophrenia, increasing demand in school, and external factors such as migration, divorce, dysfunctional family situation and death. For instance, depressive disorders are the number 1 DALY for young people.

Understanding Neuropsychiatric Problems (NPD)

The Neuropsychiatric disorder is the manifestation of several disorders that often affect adolescents challenges in cognitive and affect with challenging behavior for parenting and make the adolescents vulnerable as well. Below developmental profile of common NPD are discussed:

Typical developmental profile-ASD (Autism Spectrum Disorder)

- **In childhood:** a difficult child, labelled as "spoiled", screams a lot, difficulties falling asleep, tactile oversensitivity, clothes are always too tight, restricted food selection
- **School age:** difficulties meeting new people, teachers, changing rooms, gets overtired quickly, cannot manage to go by self to activities. Does not "read" people
- **In Adolescence:** becomes a loner, prefers staying home with own activities, does not seem to miss people, often bullied. Does not keep clean, becomes the odd person, sex with different partners without emotional involvement, turns to substances for kicks and as self-medication
- **As an adult:** stays with parents or becomes homeless
- If intelligent, may become the brilliant genius, if not, unemployed, even with a vocational training, never becoming a team worker

Typical developmental profile-ADHD (Attention Deficit Hyperactivity Disorder)

- **Childhood:** always on the go, creative, funny, leader on the playground, but tires easily
- **School age:** more problems with concentration, starts but does not finish projects in time, tries to hide school problems, uninterested in learning new things, difficulties doing homework without supervision
- **In adolescence:**
- Their hyperactivity now seems more like restlessness, appears much younger than their age, skips school more and more,
- cannot plan and does not understand consequences, does not realize dangerous situations, gets into risky situations, frequent unprotected sex, associates with older kids, experiments with drugs, initially as self-medication
- suffers from anxiety, tiredness, depression, becomes addicted,,
- **In adult life:**

- marries or has different partners , several children , do well with one child , cannot cope with more, gets into fights at job, , changes jobs
- Self-medicates with alcohol and amphetamine and gets better with that
- if intelligent, may be very creative and successful as an artist, in advertising, **self-employed** with the right secretary to control things

But ...

- Often no clear cut behavior as described above
- NPD can be classified as umbrella disorders, more of ADHD, less of ADS, or equally in the same person
- The intellectual functioning is very decisive; those with a high intelligence do well under the right circumstances. Those with low IQ become victims of substance use, homelessness, prostitution, involved in crime, abused and used
- Many of our outstanding artists, scientists, performers have aspects of NPD
 - ⇒ Now check if the scenarios fit any of the profiles described above (Sam= slight mental retardation, Cilla = ADHD, KAREN =ASD, BILL = DEPRESSION)

AND...

- These young persons had one thing in common - school dropout
- Three of them had another thing in common:
- Physical symptoms which could not be explained and were labeled as psychosomatic
- Consider NPD in these circumstances!

Chapter Summary

- Adolescents go through various types of developmental changes (domains). These include physical, psychosocial and cognitive developments. In all countries adolescents pass through the same stages (early, middle and late) of development for both males and females but the age ranges may vary.
- Understanding of the growth and developmental changes in adolescents is important on how we approach complaints or health problems of adolescents, interview adolescents, manage their problems and facilitate establishment of progressive relationship between adolescents and their parents.
- Until the mid-twenties young people do not have the physical brain capacity to make fully mature decisions
- The brain is plastic and can be remolded. Parents have a powerful influence on teens. Parents need to understand safe sex is not safe enough.
- Elements of Decision Making:
 - Cognitive Development – may not be refined enough to allow for realistic cost-benefit analysis
 - Emotional Development – Hot Emotions (strong undercurrents dependant on the situation) vs. Cold Emotions (rely on basic values and cognitive skills)

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Chapter 4: Communicating with Adolescents & Motivational Interview (MI)

Session 4.1: Session Outline and Learning Objectives

Duration: 180 Minutes

Session outline

- Communicating with Adolescent and Youth
- Elements of Successful and Effective Communication
- Adolescent Psycho-social Assessment Interview
- Motivational Interview
- Motivational Interview Skills and Strategies

Learning Objectives:

At the end of the session participants will be able to:

- Demonstrate effective communication and interaction with adolescents and youth
- Explain the concept of motivational interview and its approaches.
- Describe MI, its principles and approaches
- Demonstrate the ability to conduct motivational interview

Session 4.2: Communicating with Adolescents & youth

Adolescence is a period of rapid physical, psychological and social developmental changes, these changes affect the adolescent's health producing specific disease patterns, unusual presentations of symptoms, and most importantly cause unique communication and management challenges. This can make working with adolescents and youth difficult. In country like Ethiopia where a third of the population is adolescent and youth, the right communication skill for those who are working with them is very important and mandatory.

Health-care service providers require effective communication skill for the following basic reasons

1. Service provider's attitude which is disrespectful, judgmental and discriminatory
2. The difficulty of finding and interpreting the right presenting problem,
3. Skill to help adolescents in finding a path to a healthy lifestyle they are comfortable with
4. Inadequate knowledge with reference to adolescents and youth development

Responding to adolescent's uniqueness requires providers understanding of adolescent development to develop competencies in knowledge, skills and attitudes and in adopting a different communication style tailored to an adolescent's age and stage of development. Health-care providers are at front to own this communication skill so that the adolescents and youth get the quality of health-care information and services. Every graduate of a medical school or college should have core competencies in adolescent and youth health and development; however, the reality is different. Based on a global survey with primary care providers, 2013, a high proportion of providers either do not have any training at all, or learn on the job (33.5%, 6.7%) respectively.

Many health issues that particularly affect adolescents and youth are highly stigmatized within communities, it is important therefore that actions to improve the quality of care in the facility should be complemented by actions to improve community support for service use.

Adolescents and youth often find mainstream primary care services unfriendly/non-appealing because of perceived lack of respect, privacy and confidentiality, fear of stigma and discrimination, and imposition of the moral values of health-care providers.

If the adolescent and youth is accompanied by parents or other adults, the health care provider should explain to parents and the adolescent and youth at the beginning of the consultation that he/she will have time alone, that is confidential at the end of the consultation.

Providers need to be competent in three domains: the first two constituting the foundation of the adolescent health-care: 1) a basic concept in Adolescent development, 2) policy and laws related to AY health and effective communication skill, and 3) managing any condition related to adolescent health. In all of the adolescent health-care, attitude of the service providers and the community attitude towards adolescent health and health seeking behavior are the core at the service provision and uptake.

The competency of communicating with adolescent and youth clients mainly focus on

1. Information gathering strategies: history taking, physical examination, diagnostic aids
2. Successful involvement of parents/guardians where necessary
3. Helping adolescent and youth clients to make informed voluntary decision about their care and treatment

Health consultation with adolescents and youth should give **special attention** to the following major areas:

1. Communication style:
 - a. Use developmentally appropriate language
 - b. Build rapport, promote engagement and empowerment
 - c. Contextualize health-care to normalize confidential assessment of health related behaviors
 - d. Involves the adolescent in decision making
2. Policies and Procedures:
 - a. Ensure privacy and confidentiality
 - b. Promote adolescent assent and informed voluntary consent
 - c. Reduce financial burden of health care for the adolescents
 - d. Link to community services and agencies
3. Structure and consultation:
 - a. Integrate treatment of the presenting complaint with broader assessment
 - b. Provide time alone with the adolescent and youth that is confidential
 - c. Undertake psychosocial assessment
 - d. Assess capacity for autonomous decision making
4. Parent/guardian involvement in the process of care:
 - a. Support parents or guardian involvement as appropriate
 - b. Builds parent or guardian understanding of appropriate health consultation with adolescents

Exercise 4.1 Discuss

1. Challenges of interacting with adolescents and youth
2. Discuss the essential elements for successful and effective communication with adolescents

Session 4.3: Elements of successful and effective communication

A health-care provider who is interacting with adolescent and youth should possess, practice, and master the following features of effective communication:

1. Interest in adolescents and youth and liking them: health-care provider who is working with them should practically express his/her **interest and likings** in their problems to deal with and address.
2. Demonstrate knowledge of adolescent **growth and brain development**
3. Though adolescents & youth are the primary focus, **parents** should be considered as part of the problem as well as the solution.
4. Ensuring **confidentiality**: counseling or treating adolescent and youth with or without parental or guardians consent, informed voluntary consent
5. **Privacy**: adolescents & youth who are accompanied by parents, guardians, and friends should be given a chance to be alone by themselves to give them both visual and auditory privacy. This will help them to express their emotion, a confidence to speak their concern. The arrangement and setup of the interview room or place should reinforce the confidence in the adolescent & youth to talk freely, so it should be a separate room with door not curtain, a bit away from waiting room where discussion can't be overheard, coded records without names
6. Demonstrating concern and interest with what the adolescent and youth clients are telling - **Listening and displaying interest**. Let the adolescent & youth talk and treat their comments seriously. Be empathic, respectful and non-judgmental especially when discussing behaviors such as drug use, abortion, tobacco, khat, alcohol, STI, etc.
7. Discovering hidden agenda – often when adolescents & youth are accompanied by parents or guardians, negative past experience with service provider's and self expression skill of the adolescent & youth could have influence in **getting the true problems** of the adolescent & youth client other than the presenting problems.
8. Helping the adolescents & youth to understand health risks, motivate and support to give up risky behaviors and learn healthy life style.

The interview and examination of adolescent & youth should take into consideration the uniqueness of each adolescent & youth. The prevention and promotion services should include adolescent & youth development, parenting, diet and physical activity, healthy lifestyle, injury prevention, screen for eating disorder, sexual activity and STI, alcohol and drug use, tobacco use, abuse, school performance, depression, risk of suicide, etc.

In summary, in order to have a successful interview with adolescent and youth client, a health care-provider should be a good/active listener with respect and without being judgmental, giving the adolescent & youth privacy and ensure confidentiality, create an atmosphere to let

the adolescent & youth ask more question and empower to address health issue with final goal of enhancing self-esteem, and reinforcing protective factors.

Session 4.4 Adolescent Psychosocial Assessment-Interview

The traditional clinical interview in the busy clinics doesn't and can't help the adolescents to satisfy their needs for quality information and services related to adolescent and youth health. The clinical interview should enable the identification of both the protective factors and risk factors in the adolescent's & youth's life. The interview process should take into consideration the multidisciplinary nature of adolescent & youth health, as it is the product of interaction of bio-psychosocial and cultural factors. This makes the psychosocial assessment-interview a crucial means to collect information that will allow the health-care provider to be aware of adolescent's & youth's life context; it may be in itself a therapeutic tool as well.

The HEEADSSS PSYCHOSOCIAL INTERVIEW TOOL, in addition to providing an effective way of collecting the information that will allow the health-care provider to be aware of the adolescent's & youth's life context, it may be in itself a therapeutic tool. (See below) Adolescent & youth medical history taking and physical examination: vital sign check like BP and BMI followed by physical examination, should be followed with psychosocial (HEEADSSS) assessment.

The mnemonics **HEEADSSS** is to remind important information the health-care provider needs to obtain from adolescent & youth client or patient. The approach starts with nonthreatening, open-ended, non-judgmental questions and progress to more sensitive areas such as sexuality, feelings of depression, thoughts of suicide, and use of substance or drugs. The presenting complaint or reason for the visit should be addressed at some time during the visit even if other important issues are brought forward. Assure the adolescent & youth that all the questions are asked in an attempt to help the adolescent & youth improve its health.

Home

- Where, who lives there? How do the people in your family get along?
- Do you argue with your parents?
- Do you feel safe at home?

Education/Employment

- Do you feel safe at school?
- Performance at school (report card if possible)
- Do you have a job? How many hours per day/week?
- Have you ever failed or repeated a grade?
- Have you ever been suspended?

Activities

- What do you and your friends do for fun?
- What are your hobbies?
- Do you participate in sports?
- Have you ever been in trouble with the law?
- What would you like to do after you finish school?

Drugs/substance and dieting

- Do you or your friends often drink, use substance or smoke pot at parties?
- Do you ever drink or smoke pot alone?
- Have you ever been in a car driven by someone who was drunk or high?
- Have you ever tried any other drugs?
- Are you satisfied with your weight? Have you ever dieted, exercised or used drugs to change your weight?

Sexuality

- Do you have any concerns about your physical/sexual development?
- Are you dating? How long have you been together?
- Have you ever had sex? Are you sexually active now?
- What was your age when you first had sex?
- Have you used protection for sexually transmitted infection or birth control?
- Have you/your girl friend/partner ever been pregnant?
- Have you ever been forced to have sex/sexual violence?
- Did you ever have multiple sexual practice/partners?

Suicide (and depression)

- Do you feel down or depressed much of the time?
- For how long have you felt this way?
- Have you thought of hurting yourself?
- Have you ever tried to harm yourself?

Safety (violence and abuse)

- Have you ever seen or been the victim of violence?
- Have you ever been in trouble with the law?
- Do you have use of a bicycle/motorbike/car? Do you use safety measures like wear a seat belt etc?

Session 4.5: Motivational interview

Activity 4.1. (Brainstorming activity)

1. What is MI for you?
2. Why are you in the profession you are in?
3. How do you see yourself in your job/career?
4. Are you self-motivated? What motivates you in life?

Definition and approach

Motivational Interviewing (MI) is counseling technique used to motivate change. Originally created to help people struggling with alcohol abuse, it seeks to use tactics like collaboration and respect for autonomous thinking to guide clients toward finding ways to change their unhealthy behaviors.

The definition of MI has evolved and been refined since the original publications on its utility as an approach to behavior change. The most recent definition of Motivational Interviewing (2009) is: "...a collaborative, person-centered form of guiding to elicit and strengthen motivation for change". It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change, within an atmosphere of acceptance and compassion. This concept of Motivational Interviewing evolved from experiences with problem drinkers and now is applied to a wide range of concerns such as health-care improvement, high-risk sexual behaviors, diabetes management, and mental health problems.

MI recognizes and accepts the fact that clients who need to make changes in their lives approach counseling at different levels of readiness to change their behavior. If the counseling is mandated, they may never have thought of changing the behavior in question. Some may have thought about it but not taken steps to change it. Others, especially those voluntarily seeking counseling, may be actively trying to change their behavior and may have been doing so unsuccessfully for years. MI involves collaboration rather than confrontation, evocation rather than education, autonomy rather than authority, and exploration rather than explanation. Effective processes for positive change focus on goals that are small, important to the client, specific, realistic, and oriented in the present and/or future.

Change of any sort is usually somewhat stressful and uncomfortable. Whether or not someone attempts natural recovery or gets help, "something" must change. In other words, "something" must cause adolescents and youth to move away from unhealthy behavior to healthy behavior.

That "something" is the motivation to change. The difference between those who successfully make the needed changes, and those who do not, comes down to motivation. Since motivation is so critical to a healthy behavior, it is important for service providers and service seekers alike to understand the motivation for change. This includes understanding the degree of motivation; the type of motivation; as well as understanding various ways to increase motivation. Once sufficiently motivated, people can and do change. Let's now look at few points about the readiness to change.

Readiness to Change

Individuals differ in their readiness to change. This statement is not a revelation to most of you. Here are few basic concepts about readiness and change.

Ambivalence about change is normal. If changes were so obviously needed and so easily accomplished, they would've happened already, and clients wouldn't need our assistance. But because change is tough, people have mixed thoughts and feelings about it. Instead of viewing this uncertainty as a problem, it is viewed as part of the process and something that we work with the client to resolve.

Change is often nonlinear. Clients often do not move in straight lines from non-change to change. In some instances, there are initial steps, setbacks, and sometimes a return to old behaviors before change is accomplished. Often clients will have attempted to effect changes without our assistance, with success.

Readiness is not static. We will return to this concept repeatedly throughout the text. While clients may differ in their starting points, it's also become increasingly clear that this is something that we as practitioners can influence up or down. One can imagine many different paths Rick's response might take, based on what I did next in the opening example.

Attend to readiness in your practice. Some MI practitioners refer to readiness as a vital sign, just as blood pressure, temperature, and pulse are vital signs in health care setting. By attending to readiness levels, the practitioner can direct sessions more effectively. For example, when clients are high in their confidence about making a change but low in their perceived importance of making that change, then attention and energy can be directed to exploring the issue of importance. Most of us recognize that change is not an event that suddenly occurs. Rather, it is a process that gradually unfolds over time. As this process begins to unfold, a person's motivation starts to change as well.

Motivation for Change: The Stages of Change Model

The most popular framework for discussing motivation to change is the Stages of Change. This model is one of the most widely used and accepted models within the field of addiction treatment. In *Changing for Good* (1994), Prochaska and DiClemente describe the six stages of change:

Stage #1: Pre-Contemplation. People at this stage may be aware of the costs of their addiction. However, they do not see them as significant as compared to the benefits. Of course, others may view this situation differently. Characteristics of this stage are a lack of interest in change, and having no plan or intention to change. We might describe this person as unaware.

Stage#2: Contemplation. People in the contemplation stage have become aware of problems associated with their behavior. However, they are ambivalent about whether or not it is worthwhile to change. Characteristics of this stage are: exploring the potential to change; desiring change but lacking the confidence and commitment to change behavior; and having the intention to change at some unspecified time in the future. We might describe this person as aware and open to change.

Between stage 2 and 3: A decision is made. People conclude that the negatives of their behavior outweigh the positives. They choose to change their behavior. They make a commitment to change. This decision represents an event, not a process.

Stage #3: Preparation. At this stage people accept responsibility to change their behavior. They evaluate and select techniques for behavioral change. Characteristics of this stage include: developing a plan to make the needed changes; building confidence and commitment to change; and having the intention to change within one month. We might describe this person as willing to change and anticipating of the benefits of change.

Stage #4: Action. At this stage people engage in self-directed behavioral change efforts while gaining new insights and developing new skills. Although these change efforts are self-directed, outside help may be sought. This might include rehab or therapy. Characteristics of this stage include: consciously choosing new behavior; learning to overcome the tendencies toward unwanted behavior; and engaging in change actions for less than six months. We might describe this person as enthusiastically embracing change and gaining momentum.

Stage #5: Maintenance. People in the maintenance stage have mastered the ability to sustain new behavior with minimal effort. They have established new behavioral patterns and self-control. Characteristics of this stage include: remaining alert to high-risk situations; maintaining a focus on relapse prevention; and behavioral change that has been sustained six months. We

might describe this person as persevering and consolidating their change efforts. They are integrating change into the way they live their life.

Stage #6: Termination. At the termination stage, people have adopted a new self-image consistent with desired behavior and lifestyle. They do not react to temptation in any situation. Characteristics of this stage include: confidence; enjoying self-control; and appreciation of a healthier and happier life. The relapse prevention plan has evolved into the pursuit of a meaningful and healthy lifestyle. As such, relapse into the former way of life becomes almost unthinkable.

Note: Relapse to a prior stage can occur anywhere during this process. For example, someone in the action stage may move back to the contemplation or pre-contemplation stage.

Motivational Interviewing focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change. The method differs from more “coercive” or externally-driven methods for motivating change as it does not impose change (that may be inconsistent with the person's own values, beliefs or wishes); but rather supports change in a manner congruent with the person's own values and concerns.

MI works by activating patient own motivation for change and adherence to treatment. Let us look at what adherence is? Problems associated with it and how to tackle them?

Adherence

Health professionals are often very worried for those under their care who are not adhering; concerned for the risks they are taking and often feeling responsible for not being able to help. Why do some people struggle so much with adherence? A better question might be ‘why do so many people **not** struggle with adherence?’ After all, many healthy behaviors such as dental flossing or avoiding fatty foods are much less difficult to adhere to than the treatment regimen in many conditions and yet so many in the general population struggle with them.

Our starting point, then, is that adherence can be tricky. This doesn’t mean that we accept it if people don’t adhere without trying to intervene, but it does mean that if we are to stand a chance of influencing people so that they have better adherence we need to know what’s going on. So, what affects rates of adherence, and what can be done about different causes? We suggest a general framework below, but it is inevitably crude compared to the complexities of the individual-in reality, there is, of course, no substitute for talking to someone to find out their own individual circumstances.

Lack of knowledge, problems putting adherence information into practice, problems taking on board the importance of adherence and deliberately choosing not to adhere are major potential problems regarding adherence.

Activity 4.2. (Spot check)

1. In which stage of change most behavior change interventions target? Do you think all people are usually in those stages?
2. Look at the scenarios annexed (Annex 2) and identify at what stage of change the individuals are.

The Motivational Interviewing Approach

Motivational interviewing contains several important elements. These are: **MI spirit, MI principles, change talk, and OARS**. *Figure 1* provides one way of thinking about how these components fit together and combine to form MI.

The ‘spirit’ of MI

There are three components to the spirit of MI: **collaboration, evocation, and autonomy**.

Collaboration refers to the practitioner working in partnership with the client. Although the practitioner brings significant expertise to this relationship, a collaborative stance recognizes that clients are experts on themselves, their histories, their circumstances, and their prior efforts at change. So, the practitioner respects the client’s expertise, tries to understand the client’s aspirations and goals (as well as his or her own), and creates a positive environment within which change is possible. For example, the practitioner avoids prescriptive and proscriptive advice, even though he or she does offer concerns about certain client decisions.

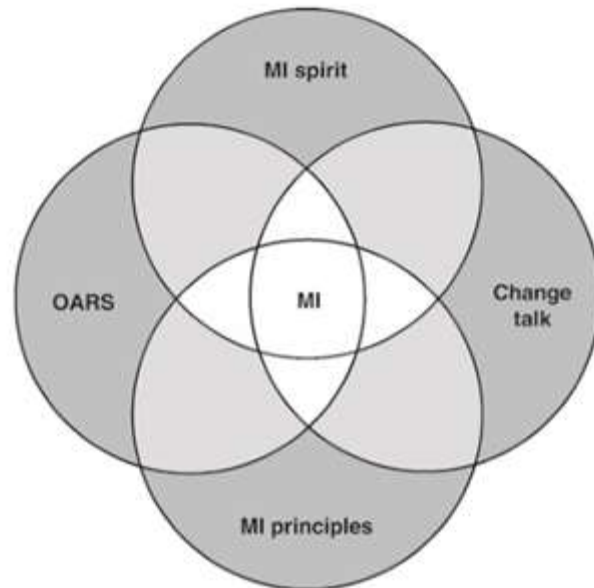


Figure 1. Elements of Motivational Interview Technique

Evocation: consistent with the comments just made, involves drawing out ideas and solutions from in clients. As experts on themselves, clients have experience with their challenges and the things that help and hinder them in attempting to change. As experts in our fields, we know something about clients with these issues generally, but we don't know what this specific client will need or want. Our goal is to evoke from clients their reasons and potential methods for change and to offer, as appropriate, ideas for clients' consideration. We also acknowledge that there are multiple ways to enact change and that motivation for change comes from within the client.

Autonomy in decision making is left to the client. We may have opinions and even compulsory actions we must take if clients engage in certain behaviors (e.g., continued drinking, abusive parenting), but within MI we recognize that clients are ultimately responsible for choosing their paths. This component of the MI spirit can be especially challenging for practitioners when clients choose paths that negatively affect others who may have few or no options (e.g., children). MI practitioners share this concern and at the same time recognize that they cannot force clients to change. Even within coerced circumstances where we control freedom and reinforces, clients must choose change. Thus, MI continually emphasizes the need to draw from clients their goals, values, and aspirations so that they-rather than we-argue for why change is required.

While there are as many variations in technique, the spirit of MI method, however, is more enduring and can be characterized in a few key points:

- Motivation to change is elicited from the client, and is not imposed from outside forces.
- It is the client's task, not the counselor's, to articulate and resolve his or her ambivalence.
- Direct persuasion is not an effective method for resolving ambivalence.
- The counseling style is generally quiet and elicits information from the client.
- The counselor is directive, in that they help the client to examine and resolve ambivalence.
- Readiness to change is not a trait of the client, but a fluctuating result of interpersonal interaction.
- The therapeutic relationship resembles a partnership or companionship. The style of the therapist using MI is nonjudgmental, non-confrontational, and non-adversarial.

The approach attempts to increase the client's awareness of the potential problems caused, consequences experienced, and risks faced as a result of the behavior in question. Therapists help clients envision a better future, and become increasingly motivated to achieve it. The MI approach seeks to help clients think differently about their behavior and ultimately to consider

what might be gained through change. It is critical to meet clients where they are, and to refrain from forcing clients toward change when they have not expressed a desire to do so.

Principle of motivational interviewing

Building on and bringing to life the elements of the MI “style”, there are different principles that guide the practice of MI. The therapist employing MI will hold true to these principles throughout treatment. These principles do not provide explicit strategies for how to do MI, but rather serve as a guiding framework for choosing techniques, strategies, and skills. The following are the basic principles of Motivational Interviewing.

Express Empathy: Empathy involves seeing the world through the client's eyes, thinking about things as the client thinks about them, feeling things as the client feels them, sharing in the client's experiences. This approach provides the basis for clients to be heard and understood, and in turn, clients are more likely to honestly share their experiences in depth.

Support Self-Efficacy: A client's belief that change is possible (self-efficacy) is needed to instill hope about making those difficult changes. Clients often have previously tried and been unable to achieve or maintain the desired change, creating doubt about their ability to succeed. In Motivational Interviewing, counselors support self-efficacy by focusing on previous successes and highlighting skills and strengths that the client already has.

Roll with Resistance: From an MI perspective, resistance in treatment occurs when then the client experiences a conflict between their view of the “problem” or the “solution” and that of the clinician or when the client experiences their freedom or autonomy being impinged upon. These experiences are often based in the client’s ambivalence about change. In MI, counselors avoid eliciting resistance by not confronting the client and when resistance occurs, they work to de-escalate and avoid a negative interaction, instead "rolling with it." Actions and statements that demonstrate resistance remain unchallenged especially early in the counseling relationship.

Develop Discrepancy: Motivation for change occurs when people perceive a mismatch between “where they are and where they want to be”, and a counselor practicing Motivational Interviewing works to develop this by helping clients examine the discrepancies between their current circumstances/behavior and their values and future goals. When clients recognize that their current behaviors place them in conflict with their values or interfere with accomplishment of self-identified goals, they are more likely to experience increased motivation to make important life changes. Yet gradually help clients to become aware of how current behaviors may lead them away from, rather than toward, their important goals.

More recently, Rollnick et al. (2008) expressed these principles using the acronym **RULE**:

- R**—Resist the righting reflex.
- U**—Understand your client’s motivation.
- L**—Listen to your client.
- E**—Empower your client.

Resist the righting reflex refers to the tendency of practitioners to try to actively fix problems in their clients’ lives and, by doing so, reducing the likelihood of client change. In **understand client’s motivation**, MI takes the position that motivation comes from within the client. That is, we do not motivate clients or install motivation in them; rather, we find the motivation that lies within and help them to recognize it. We direct them toward the discrepancies that already exist between what they want and how their behavior impacts these goals. **Listening to the client** may seem obvious, but in practice other imperatives often intrude on this foundational process. Clients come to us (sometimes unwillingly) for our expertise. Yet they remain responsible for bringing about any changes in their lives. To assist them with this process, we must create an atmosphere in which they can safely explore conflicts and face difficult realities. **Empowering the client** is the final principle. It is believed that outcomes are better when clients are engaged. Therefore, if change is to occur, our clients will need to actively engage in this process. It is important, therefore, that practitioners actively cultivate a stance of hope and communicate that hope to clients.

Change Talk

Change talk is defined as statements by the client revealing consideration of, motivation for, or commitment to change. In MI, the therapist listens for these expressions of importance, confidence, and readiness/commitment and seeks to guide the client to elaborate on these expressions of change talk as the pathway to change.

Research shows that the more someone talks about change, the more likely they are to change. Different types of change talk can be described using the mnemonic DARN-CATS:

Preparatory Change Talk

- **D**esire (I want to change)
- **A**bility (I can change)
- **R**eason (It’s important to change)
- **N**eed (I should change)

Implementing Change Talk

- **C**ommitment (I will make changes)
- **A**ctivation (I am ready, prepared, willing to change)
- **T**aking Steps (I am taking specific actions to change)

OARS (Open-ended question, Affirmations, Reflection and Summaries)

OARS is a brief way to remember the basic approach used in MI. Open-ended questions, Affirmations, Reflections, and Summaries are core strategies used to move the process forward by establishing a therapeutic alliance and eliciting discussion about change.

Open-ended questions are those that are not easily answered with a “yes/no” or short answer containing only a specific, limited piece of information. They invite elaboration and thinking more deeply about an issue. **Affirmations** are statements that recognize client strengths. They help build rapport and encourage clients to see themselves in a different, more positive light. **Reflections** or *reflective listening* is perhaps the most crucial skill in MI. It has two primary purposes. First is to bring to life the principle of Expressing Empathy. When the counselor utilizes careful listening and reflective responses, the client comes to feel that the counselor understands the issues from their perspective. Beyond this, strategic use of reflective listening is a core intervention toward guiding the client toward change, supporting the goal-directed aspect of MI. In this use of reflections, the therapist guides the client towards resolving ambivalence by a focus on the negative aspects of the status quo and the positives of making change. **Summaries** are a special type of reflection where the therapist recaps all or part of a counseling session. Summaries communicate interest and understanding, and call attention to important elements of the discussion. They may be used to shift attention or direction and prepare the client to “move on.”

Session 4.6: Motivational Interview skill and strategies

The practice of Motivational Interviewing involves the skillful use of certain techniques for bringing to life the “MI spirit”, demonstrating the MI principles, and guiding the process toward eliciting client change talk and commitment for change.

MI has four key overlapping processes. These are engaging, focusing, evoking, and planning. **Engaging** is the process of establishing a helpful connection and working relationship. **Focusing** is the process by which you develop and maintain a specific direction in the conversation about change. The process of **evoking** involves eliciting the client’s own motivations for change and lies at the heart of MI. The **planning** process encompasses both developing commitment to change and formulating a concrete plan of action.

For effective implementation of MI, five key communication skills are used throughout MI. These are asking open questions, affirming, reflecting, summarizing, and providing information and advice with permission.

Asking Open-ended questions

Open-ended questions create forward momentum used to help the client explore the reasons for and possibility of change. They are very useful for getting a conversation going. You probably use this lot, and they are great for opening up a conversation. They also prevent you from making the mistake of assuming you know what's going on for someone or how they feel. Some examples of open and closed questions are given below:

Affirmations

Affirmations can help clients feel that change is possible even when previous efforts have been unsuccessful. Affirmations often involve reframing behaviors or concerns as evidence of positive client qualities.

Several examples of affirming statements (Miller and Rollnick, 1991) follow:

- I appreciate how hard it must have been for you to decide to come here. You took a big step.
- I think it's great that you want to do something about this problem.
- That must have been very difficult for you.
- You're certainly a resourceful person to have been able to live with the problem this long and not fall apart.
- That's a good suggestion.
- It must be difficult for you to accept a day-to-day life so full of stress. I must say, if I were in your position, I would also find that difficult.

Reflections

Reflections or reflective listening have several levels of reflection ranging from simple to more complex. Different types of reflections are skillfully used as clients demonstrate different levels of readiness for change.

Practice the following example and develop your own on another case.

Clinician: *What else concerns you about your drinking?*

Client: *Well, I'm not sure I'm concerned about it, but I do wonder sometimes if I'm drinking too much.*

Clinician: *Too much for...?*

Client: *For my own good, I guess. I mean it's not like it's really serious, but sometimes when I wake up in the morning I feel really awful, and I can't think straight most of the morning.*

Clinician: *It messes up your thinking, your concentration.*

Client: *Yes, and sometimes I have trouble remembering things.*

Clinician: *And you wonder if that might be because you're drinking too much?*

Client: *Well, I know it is sometimes.*

Clinician: *You're pretty sure about that. But maybe there's more...*

Client: *Yeah, even when I'm not drinking, sometimes I mix things up, and I wonder about that.*

Clinician: *Wonder if...?*

Client: *If alcohol's pickling my brain, I guess.*

Clinician: *You think that can happen to people, maybe to you.*

Client: *Well, can't it? I've heard that alcohol kills brain cells.*

Clinician: *Um-hmm. I can see why that would worry you.*

Client: *But I don't think I'm an alcoholic or anything.*

Clinician: *You don't think you're that bad off, but you do wonder if maybe you're overdoing it and damaging yourself in the process.*

Client: *Yeah.*

Clinician: *Kind of a scary thought. What else worries you?*

Chapter Summary

- The rapid physical and psycho-social developmental changes during adolescence pose a different health problems pattern with unusual presenting symptoms, and most importantly cause communication and management challenges.
- Health-care providers are at the front to own an effective communication skill which is free from judgment, disrespect, and discrimination.
- Successful interaction with adolescent and youth includes reflective listening with respect, ensures privacy and confidentiality, encourage and prompt free talking, engages parents/guardians, and assist the adolescent and youth to pursue health life-style.
- Psychosocial assessment interview using HEEDSSS tool should always accompany the clinical history taking and physical examination of an adolescent
- Motivational Interviewing (MI) is defined as a collaborative, person-centered directive counseling method for addressing the common problem of ambivalence about behavior change
- Motivational Interviewing focuses on exploring and resolving ambivalence and centers on motivational processes within the individual that facilitate change
- Motivational Interviewing is grounded in a respectful stance with a focus on building rapport in the initial stages of the counseling relationship
- The practice of Motivational Interviewing involves the skillful use of certain techniques for bringing to life the “MI spirit”, demonstrating the MI principles, and guiding the process toward eliciting client change talk and commitment for change.

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Annex 1

Spot checks

1. Motivational interviewing include all of the following elements **except**
 - A. Collaborative
 - B. Evocative
 - C. **advice**
 - D. person centered
 2. Which of the following are the principles of Motivational Interviewing?
 - A. Empathy
 - B. Self-efficacy
 - C. A only
 - D. **A and B**
 3. List three strategies of motivational interviewing
-
-
-

Annex 2

Scenarios--1

Below are the scenarios for Stages of change activity adopted from FOOD FOR THE HUNGRY (2005). There are 9 scenarios here. Categorize the people in the scenarios in each stage of changes. Then tell why you chose to categorize the people in the scenarios as you did.

1. GG is 19 years old. He has been having sex for the past three years, and does not see any reason why he should stop. He says, "Yeah, I've heard all about getting HIV, but if I am going to get HIV, I probably already have it by now."
2. JJ is 18 years old, and has been having sex with men for money in order to feed her younger siblings since age 15. "I would like to ask each man to use a condom so I know I am at less risk for HIV" she says, "but I do not think I could do it. Plus, I fear he will always refuse, and maybe become angry with me and hurt me, or go to another woman and then I will lose money."
3. SS is 25 and newly married. "I have decided I must be faithful to my wife. She and our future children mean too much to me to risk their health."
4. KK is 24 years old, single, and has HIV. "I have just begun using a condom every time I have sex so that I will not infect my partners," he says. "I hope I will be able to remember to buy them."
5. AA is 18, and single. "It is such a relief to know that I will not have to worry about HIV. Since last month, when I made the decision to be abstinent until marriage, my heart feels light."
6. NN is 20 years old, and married for two years. "If I do not stop sleeping with other women," he says, "I am sure I will bring HIV home to my family. But what will my friends say? Will they think I am less of a man if I am only sleeping with my wife?"
7. TT is 16 years old. "I have thought about this a lot," she says. "I am ready to decide to be abstinent. I just need to know what I should tell my friends."
8. RR is 27, and married. "I don't want my family to experience the stigma of HIV, even if I am not always faithful to my wife. I have decided to use a condom every time I have sex with another woman."

9. HH is 24 years old. "Since I decided to be abstinent four months ago, I am happy with my decision," he says. "Sometimes it is hard to wait, but I will be married soon, and my wife and I will be safe from HIV."

Chapter5: Adolescent Sexual Reproductive Health (ASRH)

Session 5.1 Session Outline and Learning Objectives

DURATION: 120 Minutes

Session outline

- Definitions of Terms and Key Concepts in Sexual and Reproductive Health
- Sexuality Education and Effective Communication with Adolescent and Youth Health
- Indicators for Sexual and Reproductive Health in Adolescent and Youth

Learning Objectives:

By the end of this chapter participants will be to:

- Describe the effect of SRH issues in adolescent and youth health
- Able to communicate effectively about sexual health issues with Adolescents and Youth, by involving them in decisions regarding their sexual health
- Assess Adolescents and youth SRH risk/protective factors and SRH indicators
- Apply sexuality education based on its principles and local context
- Demonstrate a positive approach to sexuality rather than a problem and risk-oriented approach.

Session 5.2: Definition of Terms and Key concept in Sexual and Reproductive Health

Reproductive Health: WHO defines reproductive health as “...a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes.”

Sexual and reproductive health service has three components; these are: family planning, sexual health and maternal health (safe motherhood, prevention and management of unsafe abortion, safe abortion service, STI/HIV prevention and management). In addition, information provision and counseling on sexuality and reproductive health is important component of the service. This chapter will cover sexuality and the rest of the components will be addressed in subsequent modules.

Adolescent and Youth Sexual and Reproductive Health Rights: Adolescents and youth are entitled to this right just by being born human being. SRH rights means, they are entitled to accessible SRH information and services that help them decide freely and responsibly on issues related to SRH. Boxes below indicate ten Adolescents and Youth SRH rights:

7. The right to freely decide if and when to have children, and how many children to have
8. The right to freedom from discrimination and bias based on age, whether a boy or girl, or whether or not married
9. The right to be free from exploitation including physical, sexual and emotional abuse as well as harmful traditional practices
10. The right to be involved in the design, development, implementation, and evaluation of programs and services and all other sexual and reproductive health decisions that affect their life

1. The right to age appropriate reproductive health information and services
2. The right to be treated with care and respect by trained staff
3. The right to private and confidential services
4. The right to decide if and when to have sex
5. The right to freedom of sexual expression and to enjoy sex when ready
6. The right to be healthy and free from preventable disease, unplanned pregnancy, and unsafe abortion

Sexual health: Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as

well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sexuality: is a central aspect of being human throughout life; it encompasses sex, gender identities and roles; sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors.

Activity 5.2.

What are the major SRH problems of AY in your locality/region?

Discuss the problems, magnitude and causes and present to plenary.

Adolescence is the period during which sexual and reproductive health issues are added to the health concerns of an individual. It is the period during which sexual activity is initiated in a substantial proportion of individuals aged 10-19 years. More than 2.6 million Adolescents and youth aged 10 to 24 die each year in the world, mostly due to preventable causes including SRH problems.

- **Unwanted Pregnancy:** About 16 million girls aged 15 to 19 give birth every year; high proportions of pregnancies among 15-19 year-old women are untimely or unwanted. The unmet need for contraceptive in the same group in Ethiopia remains 30%.
- **Too-Early Childbearing:** Worldwide, more than 10% of all births are to adolescents and youth 15-19, and in the least developed countries, teen pregnancy (under 18 years) accounts for 17% of all births. In Ethiopia, teen pregnancy is 13% and around 40% of girls married before the age of 18 years.
- **Unsafe Abortion:** Most abortions among adolescents and youth are unsafe because they are performed illegally, under hazardous conditions, and/or by unskilled practitioners. In Ethiopia, the abortion rate is 28 per 1000 women out of which 52.2% is accounted by adolescent and youth.
- Young women, compared to older women, experience increased complications from pregnancy, childbirth, and unsafe abortion. Maternal mortality in this age category is much higher as a result of the aforementioned complications.
- Adolescents and Youth face increased health risks from sexual activity as HIV and other STIs. Each year, more than half of all new HIV infections occur in Adolescents and youth under age of 25, and more than two-thirds of all reported STI infections occur among this

group in developing countries. Unlike other African countries, in Ethiopia, the prevalence of HIV/AIDS in the 15-19 age group is lower (< 1%).

Sexual Relations and Expressions during Adolescents and Youth

Sexual relations during adolescence are not always consensual, the practice of contraception and condom use is often erratic, and unwanted/unplanned pregnancies and unsafe abortions are observed in many settings. Adolescents and youth must have the choice to consent to sexual activity and not to be forced or harmed in any way through sexual activities.

There are wide gender-based differences in sexual conduct and in the ability to negotiate sexual activity and contraceptive use. Demographic and Health Surveys (DHS) data indicate that the reported ages of sexual debut for adolescent and youth are generally decreasing. The earlier age of puberty, combined with the delayed age of marriage and the declining age of first sexual experience means that many more adolescents are having multiple sexual relations before marriage.

There are many ways of expressing sexual feelings that do not involve penetration: holding hands, hugging, kissing, body rubbing, masturbation and mutual masturbation. These are safe in terms of preventing pregnancy and infection from STIs and HIV. Health-care services providers often assume that all clients are heterosexual. Yet research shows that adolescent same-sex experimentation is probably more common than is believed, especially among boys.

Adolescent and Youth Sexual Health Risk/Protective Factors:

With some cultural/regional differences, there are several factors that have been identified as protective against early sexual initiation: a positive relationship with parents and teachers and spirituality are among the protective factors. On the other hand, engaging in risky behaviors (the cluster effect) and having friends who are sexually active are some of the risk factors.

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

Studies carried around the world, suggest that protective and risk factors can explain differences in adolescent sexual behavior even after accounting for variables such as age, sex, ethnic group and socio-economic status.

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

Key: + protective factor; - risk factor; ? not measured.
Source: Broadening the horizon: Balancing protection and risk for adolescents, WHO, 2002.

Figure 5.1: Protective and risk factors for Sexual initiation

Session 5.3: Sexuality Education and Effective Communication with Adolescents and Youth

Sexuality educations: “means learning about the cognitive, emotional, social and physical aspect of sexuality”. It aims to support and protect sexual development; which eventually equips and empowers adolescents and youth with the necessary information, skills and values to understand and enjoy their sexuality, have safe and fulfilling relationships take responsibility for their own and others sexual health and well-being.

There is full evidence that sexual education is effective, empowers adolescents and youths to make responsible decisions regarding sexuality and does not encourage them to increase sexual activity, contrary to what some people still think. Providing adolescents with age-appropriate and culturally acceptable sexual and reproductive health information **empowers them to make responsible decisions regarding sexuality**, thereby reducing the number of unintended /unplanned pregnancies and STI incidence.

Activity 5.3

Divide into three groups (depending on the size of the class) and discuss the barriers to adolescent and youth SRH education from

1. adolescent and youth,
2. community and
3. institutions perspectives

Characteristics of Sexuality Education: Sexuality education should not be limited to disease prevention, but include aspects such as physical, social and cultural; it should not be fear-based so that a positive attitude to sexual well-being is implied. Moreover, it requires careful choice of different methods which appeal to various types of learners and to different senses.

The following are the seven characteristics of sexual education:

- Adolescent and youth shouldn't be passive participant in sexuality education but take part in organizing, delivering and evaluating sexuality education eg. Peer educators
- Sexuality education should be delivered in an interactive way
- Sexuality education is delivered in a **continuous** way, since the development of sexuality is a lifelong process
- Continuity of sexuality education can be ensured by interacting with different partners in and out of schools
- Sexuality education does not take place in a vacuum, but is closely interconnected with the learner's environment and the specific experiences of target groups.
- Sexuality education establishes a close **cooperation with parents and community** in order to build a supportive environment
- Sexuality education is based on **gender responsiveness** to ensure that different gender needs and concerns are adequately addressed

WHO Matrix for sexuality Education

This matrix has been designed to show an overview about the topics which should be introduced to specific age groups. The matrix is structured according to different age groups and thematic categories. It is a framework from which the trainer or educator can pick topics from. Each theme is categorized to knowledge/information, skills and attitudes. Below is the proposed matrix for sexuality education for the three age groups roughly corresponding to early, middle, and late adolescence. For each topic the purpose is to provide the training of skills and attitudes beyond information.

- Adolescents and Youth should have the opportunity to explore and develop their own sexuality, without facing social repercussions.
- Adolescents and Youth usually tend to be generally less informed, though they have the right to be informed of the correct facts about sexual health,
- Adolescents and Youth seek information and clues about sexual life from a variety of sources – parents, siblings, peers, magazines, books, the mass media, etc. They receive a great deal of information from diverse sources, but not all of it is correct and complete. They lack information concerning the physical changes that occur during adolescence, their implications, and how to take care of themselves.

- Health-care provider can be a valuable source of accurate information and support to the adolescents they serve. Health care providers can present them with facts, respond to their questions, and provide reassurance. They can also work to make the services more sensitive and responsive to the needs of the adolescents and Youth they are serving.

Table 5.1 Sexuality Education Topics, age group: 10-12, 12-15, 15+

Topic	Knowledge/ Information	Skills	attitude
The human body & development			
Fertility and reproduction			
Sexuality			
Emotions			
Relationships and lifestyle			
Sexuality, Health and Wellbeing			
Sexuality and Rights			
Social and cultural determinants (values and norms)			

Menarche and Menstrual Hygiene

One of the defining events of puberty in girls is menarche. The mean age at menarche showed a substantial decline in most countries, and it is happening in the early stage of adolescence. The age at menarche and menstruation are strongly associated with girls' sexual debut though studies have shown that girls get married before they started experiencing menstruation particularly in rural Ethiopia.

Girls are not well informed about and not prepared for menstruation. There are misunderstandings of and myth and taboos associated with menstruation among boys and the society at large. Adolescent girls are ashamed of it or afraid of being discriminated. Studies have shown that girls are discriminated, insulted and isolated as result of menstruation, often associated with absenteeism from school. Girls in rural and poor urban communities are less likely to obtain and use sanitary pads; they use materials made at home, and often lack access to clean water and functional toilets at schools.

Adolescent health literacy must include menstruation and menstrual hygiene management, and girls should be well informed prior to reaching menarche.

Activity 5.4

Which personal values or attitudes are helpful to you when discussing about sexual health issue with Adolescents and Youth, and why?

Skills to achieve an effective communication

Boxes below show core skills to achieve with sexual education and the ingredients for achieving an effective communication effective with adolescents and SRH assessment approaches.

Core skills to achieve with sexual education

- Communication skills
- Negotiation skills
- Self-reflection
- Decision-making skills
- Problem-solving skills

Effective communication with adolescents

- Speak about sexual health in a comprehensive way with all adolescent and youth
- Use simple factual questions (for quality of intimate relationships, comfort with own body, belief etc.)
- Be PRECISE (eg: calendar for last sex to assess need for emergency contraception etc.)
- Encourage AY to speak about others (peers, family etc.)
- Assess cognitive capacities, observe non verbal cues

Sexual Education: what works?

- There is evidence that what works in sexual education is a combination of provision of information and building life skills.
 - Curriculum based provision of information
 - Building *life skills* (communication, decision-making)

SRH assessment (WHO Job Aid)

Be Explicit And Precise!

- Menstrual history and periods (pain, quantity, timing,....)
- Knowledge about sexuality and body
- Sexual activity (peers or self)
- Pregnancy and contraception
- STI's
- Broad definition of sexual health (body image, self esteem,.....)

Topic guide for individual interviews with Adolescents and Youth

Boxes below provide different topics needed to address while interviewing Adolescents and Youth individually. One must address issues related to sexual development, first sexual

experience and important aspects of individual sexual behavior during interviews with adolescents and youth. The assessment should also enquire about any protective practices against pregnancy and STI, measure the level of sexual risk taking and any experience with the sexual and reproductive health service.

Note: In order to conduct a developmentally adequate sexual and reproductive health assessment, it is important to follow the HEEADSSS (Home, Education/Employment, Activity/Eating, Drugs, Sexuality, Safety, and Suicide/Depression) structure in order to get a full psycho-social assessment of the adolescent and not to remain exclusively focused on the sexual and reproductive assessment.

Sexual development and first experiences

- To gain insight into the development of the Adolescent and Youth sexuality and factors shaping this development including parental attitudes, peer pressure and cultural norms
- Description of development of sexual intimacy including kissing, petting, heavy petting etc.
 - When do you recall first experiencing a sexual sensation? (sexual feelings /thoughts /dreams /desires /crushes)

First intercourse :

- Detailed description of first penetrative intercourse - what, where, why, when, who, how (context)

Sexual behavior:

- Partners and sexual activities through the years to the current time (sexual history)
 - Have you had more than one sexual partner?
 - Are you generally attracted to the same sex or the opposite sex or both?
 - Which forms of protection against pregnancy and STIs do you generally use?
- Sexual pressure (e.g. Affirm respect for sexual orientation of others, take responsibility for own behavior, sexual history (number of partners, quality of relationship, ...))

Protective practices

- Which forms of protection against pregnancy and STIs have you used?
- (Context) What, why, when and how was its use or non-use decided?

Sexual risk taking

- To what extent do you think about any risks involved with sex?
- Have you ever asked a partner to have a test? Why? Why not?
- Do you consider yourself to be at risk? Why? Why not?
- Have you ever paid someone for sex? Have you ever been paid for sex?

(e.g. Develop critical-thinking skills, avoid exploitative or manipulative relationships,....)

Use of services

- Awareness of services, Personal usage, Personal experience of the 1st, 2nd, etc. services visited
- How have you found out about the services? Family, friends, youth center, school etc
- Have you ever been to any services for help and advice about relationships, contraception, STIs, sex etc?
- Can you remember how old you were the first time you went there?
- Did you visit a sexual health service for the first time before or after you were sexually active? Why?
- What are your general feelings about the services you have accessed?

(e.g. Practice effective decision-making)

Activity 5.5

What could be the consequences of too early, unprotected sexual activity?

- Consequences for adolescents
- Consequences for babies born to adolescents
- Consequences for their families and communities

Outcomes of Sexual Education: there are two groups of outcomes for sexual education; the behavioral and biological.

Behavioral (self-report)

- Delay of age of first intercourse
- Reduction in number of partners
- Reduction in frequency of intercourse
- Increase in the use of condoms

Biological Parameters

- Reducing prevalence of STIs

- Reducing teenage pregnancy

Laws/Policies/Regulations

We need to be aware of the country's laws, policies and regulations on AYSRH and advocate for change when it applies; for instance: Prohibition of child marriage under age 18.

- The revised National Family Law
- National Health strategies including Adolescent and Youth H
- National strategies on AYH, on gender equality, violence
- Abortion Law etc...

Sexual Health Promotion: it is evident that sexual health promotion should target ALL teenagers (left box), use a variety of approaches and adapt to the teenager's developmental age and culture.

Adolescent and Youth SRH in a specific context

Young people most at-risk: Need interventions that provide information and services through *outreach facilities* (including: young sex workers, street Adolescents and Youth, disabled Adolescents and Youth, young injecting drug users or young men who have sex with men, etc..).

For teenagers

- from various societal and cultural backgrounds
- living in diverse contexts
- having a variety of capabilities and skills
- present diverse sexual behaviours
- exposed to diverse threats as regards to their sexual health

Sexual health promotion must

- use a variety of approaches
- Adapt to
 - Context/setting
 - Developmental age
 - Culture

Session 5.4: Indicators for Sexual and Reproductive Health

Indicators of Adolescent Sexual Health

- Intercourse 'ever had sex'
- Number of partners
- Condom use
- Use of modern contraception
- Teenage pregnancy and abortion
- HIV and other STIs: incidence and prevalence
- HPV vaccination coverage
- Access to reproductive health services
- Country laws, policies and regulations

Indicators sexual behaviour

- Age at first intercourse
- Types of intercourse
- Context of intercourse
 - (e.g. marital/non marital)
- Number of sexual partners
- parity and number of abortions???

Indicators on use of contraceptives /STI prevention

- Use of condoms (during last intercourse, at first intercourse ...)
- Use of medical contraceptive measures

Health outcomes /threats to health

- Adolescent pregnancy rate
- Teenage birth rate, incl. Maternal and neonatal death rate
- Induced abortion rate
- STI Rates (including HIV)

Utilization of Health Services

- Access to health care (e.g. numbers of youth friendly health services, utilization numbers)
- Vaccination rate for Hepatitis B, HPV...
- Voluntary counselling and testing for HIV

Sexual Health Education/Promotion

- Sexual health education
 - Number of Programmes in Schools, community/Youth Centers
 - Number of youth involved in programmes
 - Quality standards of programs

Chapter Summary

- Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.
- Sexual and reproductive health rights are basic human right Adolescent and Youth are entitled to, and service providers and planners should understand this right of the adolescent to access SRH information and services to have an informed decision.
- Adolescence is the period during which sexual activity is initiated in a substantial proportion of individuals.
- Significant number of Adolescents and youth aged 10 to 24 die each year in the world, mostly due to preventable causes including SRH problems.
- Sexual relations during adolescence are not always consensual, the practice of contraception and condom use is often erratic, and unwanted pregnancies and unsafe abortions are observed in many settings
- Positive relationship with parents and teachers and spirituality are important protective factors against SRH related problems to be promoted. Engaging in risky behaviors and having friends who are sexually active are some of the risk factors which needs to be addresses.
- Adolescents and Youth seek information and clues about sexual life from a variety of sources and they receive a great deal of information but not all of it is correct and complete.
- Proper use of indicators will help proper monitoring and evaluation of SRH interventions.

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Chapter 6: Prevention of Pregnancy in Adolescents & Youth

Session 6.1 Session Outline and Learning Objectives

Duration: 120 Minutes

Session outline
<ul style="list-style-type: none">• Child Marriage• Prevention of Pregnancy in Adolescent and Youth• Overview of Unsafe Abortion among Adolescent and Youth• Dealing with Unsafe Abortion

Learning Objectives:

At the end of the session participants will be able to:

- Analyze the extent of child marriage, its consequences and strategies to tackle it
- Describe the economic, psychosocial and health consequences of pregnancy in adolescence
- List strategies to end child marriage and its consequence
- Demonstrate the importance of prevention of untimely/unwanted pregnancies in adolescence and youth
- Recognize special considerations during provision of contraceptives for married and unmarried adolescents and youth

Session 6.2: Child Marriage

Child marriage

It is defined as marriage before the age of 18. Child marriage is a violation of children's human rights. Despite being prohibited by international law, it continues to rob millions of girls under 18 around the world of their childhood. Early marriage denies girls their right to make vital decisions about their sexual health and well-being. It forces them out of education and into a life of poor prospects, with increased risk of violence, abuse, ill health or early death.

Cohabitation – when a couple lives 'in union', as if married – raises the same human rights concerns as marriage. When a girl lives with a man and takes on the role of his caregiver, the assumption is often that she has become an adult, even if she has not yet reached the age of 18. Additional concerns due to the informality of the relationship – in terms of inheritance, citizenship and social recognition, for example – may make girls in informal unions vulnerable in different ways than girls who are married.

The scale of child marriage is huge: 15 million girls a year are married before the age of 18. Worldwide, more than 700 million women alive today were married before their 18th birthday. One in three girls in the developing world is married before the age of 18. If there is no reduction in the practice of child marriage, 1.2 billion women alive in 2050 will have married in childhood – that is equivalent to the entire population of India.

Child marriage among girls is most common in South Asia and sub-Saharan Africa, and the 10 countries with the highest rates are found in these two regions: Niger has the highest overall prevalence of child marriage in the world and Bangladesh with the highest rate of marriage involving girls under the age of 15 while Ethiopia stands third with Guinea and India for similar ages.

Ethiopian Revised Family Code proclamation No. 213/2000 under Chapter 1, Section 2 (Essential condition of Marriage), article 7 states that a man or woman shall attain the full age of 18 years to conclude marriage. Though child marriage is against the law and violates the human rights, it has been practiced in almost all regions of the country.

Nearly 28% of women have begun childbearing before they turn 20. Majority live in rural. Afar has the highest, 23.4% followed by Ethiopia Somali 18.7 and Oromia 17% respectively, and a steady decline to 8.3% in Amhara, and Addis Ababa has the lowest proportion under EDHS, 2016. Median age at first sex for women is at 16.4 years (PMA 2015). Girls who are wealthier, educated and living in urban set up experience their first sex relatively later and also married later. In Ethiopia, the age at first sex and marriage converge at approximated age. In this age

category (married and unmarried) the unmet need for family planning is near to 21%. The unmet need in the rural is twice as that of the urban setup.

Child marriage drives adolescent pregnancy

- There is high tendency for a child bride to get pregnant within the first year of her marriage-social pressure to prove fertility
- Adolescent birth rate are highest where child marriage is most common
- Child marriage encourages sexual debut at an earlier age when girls' bodies are still developing
- Child brides know little about their sexual and RH rights, including the right to access FP services
- Child brides lacks confidence to assert and negotiate safe sexual practices and use FP methods

Common contributing factors for child marriage

- Social norms and tradition – Family honor, younger wives are considered to be obedient, the younger the cleaner, the younger the fertile, marriage provides 'protection' from sexual violence
- Economic: cost of taking care of big size family; the older the girl, the higher the dowry
- Customary and religious laws that condone the practice
- Lack of alternative opportunities
- Inadequate law enforcement
- Discrimination against girls, inequalities between girls and boys

Health and other consequences of child marriage and pregnancy in Adolescence

- Denied of their childhood, socially isolated (from families and friends),
- Responsibility beyond their maturity...having many children to take care, mental health problems
- Inability to make informed decision about their sexual health and well-being
- Verbal abuse, domestic violence, and sexual violence – Mental health, STI/HIV, disability
- Low school enrollment, and higher drop out – unlikely to be in school and tend to have low levels of education
- Limited opportunities for career and vocational advancement
- Missed opportunities for entrepreneurship and economic empowerment
- Less likely to receive medical care during pregnancy
- Higher risk of having hypertension (eclampsia),obstructed labor, hemorrhage, infection
- More likely to die prematurely due to pregnancy and childbirth than girls 20-24 years

- Increased risk of post pregnancy-related complication. E.g., 65% of all cases of obstetric fistula occur in girls under the age of 18
- Increased risk of stillbirth, low birth weight, and neonatal death

Addressing child marriage and its consequences

- Multispectral engagement to enforce the law, age at marriage
 - Example: health facility board with other sectors
- Male engagement as a partner and program implementation
- Make quality FP services accessible and acceptable
- Social behavior change communication...wider awareness creation and education on family planning, religious leaders on child marriage.

Summary:

- Child marriage is violation of the Ethiopian Family Code and human right
- Early marriage drives untimely and unwanted pregnancies
- Pregnancy in adolescence is associated with higher risk of having hypertension (eclampsia), obstructed labor, hemorrhage, infection, still birth, low birth weight, obstetric fistula, neonatal death and maternal death
- Ending child marriage will help break intergenerational cycle of poverty by allowing girls and women to participate more fully in society.
- Empowered and educated girls are better to nourish and care for their children, leading to healthier, smaller families.
- Health facilities and offices with other sector offices should work to prevent child marriage and mitigate the consequences

Session 6.3: Prevention of Pregnancy in Adolescents

The need for contraception in Adolescence

Many individuals begin their sexual activity during their adolescent years. The 2011 EDHS reported that 62% of women age 25-49 had their first sexual intercourse before age 18. They do so often without adequate knowledge about sexuality, and without using modern contraceptives or protection against STIs including HIV. For example, few unmarried adolescents use contraception during their first sexual experience. Moreover, near to half of them experience a coerced sexual debut, and they also face sexual intimate partner violence. Only 5.3% of young women aged 15 to 24 reported using contraceptives. Sexually active young people are less likely to use contraception than adults even within marriage. The unmet need

for FP among married women under the age of 20 is about 21% as to EDHS 2016 while it is higher by 5% in those unmarried women of same age.

Unmarried adolescents and youth, who face additional barriers to obtaining contraceptives, are even less likely to use contraception than married adolescents and youth. Irrespective of the marital status, often time adolescents are at high risk of ending up in unwanted and untimely pregnancies; and STIs including HIV/AIDS as a result of unprotected sexual relations.

There are important reasons why adolescents in general – and unmarried adolescents in particular – often find it difficult to get contraceptives they need, including the following ones:

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

Provision of information and education on Sexuality and Contraception to Adolescents

Many adolescents and youth lack information about contraception. Furthermore, health-care providers are often unaware of the special needs of adolescents and contraceptive services are not geared to meeting the needs of adolescents and youth. In addition to the biomedical issues, it is important for health-care providers to be aware of the wider socio cultural issues that affect the adolescent's and youth's ability to obtain and use contraceptive services. Health care providers have key roles to play in order to address these issues and thus prevent the consequences of too-early and unprotected sexual activity among adolescents and youth.

SRH information and education result in postponed initiation of sexual intercourse and/or effective use of contraception. However, SRH education should be tailored to suit the needs of adolescents and youth who haven't begun sexual activity and those who are already sexually active.

Information provision alone doesn't lead to behavioral change; as such, adolescents and youth need to have access to and be comfortable to use the SRH services. Encouraging parents and school teachers to provide information and education on sexuality and contraceptives to the adolescents is important. In addition, informing them where to get services is crucial.

Provision of contraceptive services to adolescents

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

The AYH Strategic Plan (2016 – 20) stipulated high priority on ensuring that adolescents and youth in Ethiopia to have an informed choice for safe and high quality family planning/contraception services. The publication, *improving access to quality care in family planning: Medical eligibility criteria for contraceptive use*, provides recommendations of an expert scientific working group for appropriate contraceptive use in the presence of various medical conditions. It provides essential information for the provision of contraceptives safely to adolescents, while at the same time ensuring that they are not denied access to contraception based on unfounded “Contraindications”.

Dual protection provided by available contraceptive methods

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

Counseling for contraceptive method choices

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

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

- The effectiveness of the method
- Information on protection against STIs including HIV
- The common side-effects of the method
- The potential health risks and benefits of the method
- Information on return to fertility after discontinuing use of the method
- Where the method can be obtained and how much it costs.

After a method is chosen, it is also important to discuss correct use of the method and provide follow-up information such as signs and symptoms which would necessitate a return to the clinic. Proper education and counseling at the time of method selection can help adolescents address their specific problems and make well-informed, voluntary decisions. Further, expanding the number of method choices offered can lead to improved satisfaction, increased acceptance and higher contraceptive prevalence.

Special consideration

Married Adolescents:

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

Unmarried adolescents

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

they have the right to use contraception if they desire. For unmarried adolescents who do seek contraceptive services, it is important to discuss abstinence or non-penetrative sexual activity as options, even with those who have already had sexual intercourse. With support, individuals can delay sexual activity until they are older, and thus be better able to deal with its social, psychological and physical implications. This requires commitment, high motivation and self-control. Adolescents need support and encouragement to abstain from and/or delay the initiation or continuation of sexual intercourse.

For unmarried adolescents who want to have sexual intercourse, condoms – or condoms in combination with another method – are the best recommendation. For adolescents who are not in monogamous relationships, sexual activity may be sporadic and unplanned. In these circumstances, condoms are a good choice because they are widely available and can be used when needed. Adolescents, especially those in monogamous relationships, may also desire to use other, longer acting methods. Providers of contraceptives must support this decision. For these adolescents as well, the risk of STIs including HIV/AIDS must be discussed. Some of them may be at risk for STIs/HIV when they do not consider themselves to be, if their partner has other sexual partners. Adolescents who have been coerced into having sex In designing and providing services, it is crucial not to assume that clients are engaged in mutually consensual sexual relations. Adolescents who have been subjected to sexual coercion and abuse will require special care and support. Emergency contraception is part of a package of services that should be made available in such circumstances. Health-care providers need to be sensitive to these issues. They must also be well aware of how to access the health and social services that these adolescents may need.

Summary:

- In many parts of the world, adolescents are entering their reproductive years ill-prepared to protect and safeguard their sexual and reproductive health.
- For all adolescents, but especially for those who are sexually active outside the context of marriage, access to appropriate information and services – and the assurance of confidentiality – are particularly important
- To help ensure contraceptive use among sexually active adolescents, contraceptive information and services must be made readily available through variety of delivery points including community-based points and outreach services
- Health care providers who are providing FP/contraceptives should be well aware of the methods' *mode of action, efficacy/effectiveness, safety/side effects, and medical eligibility criteria and contraindications.*

- By providing quality services that respect adolescents rights and respond to their needs, reproductive health programs will contribute to the overall health and well-being of their adolescent clients and to their communities and societies

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Annex 1

Activity 1: Spot checks

Spot check 1: Which contraceptive methods should not be used by adolescents? Please mark all unsuitable methods:

1. Abstinence
2. Male condom
3. Female condom
4. Combined oral pill
5. Progestin-only pill
6. Progestin-only injectable
7. Combined injectable
8. Progestin-only implant
9. Intrauterine device (IUD)
10. Lactational Amenorrhea Method (LAM)
11. Standard Day Method (SDM)
12. Spermicide
13. Diaphragm
14. Fertility awareness based methods
15. Withdrawal
16. Sterilization

Spot check 2: Which contraceptive methods are protective against HIV/STI? Please write down two examples for each method

Protective

1. _____
2. _____

Non protective

1. _____
2. _____

Spot check 3: Which contraceptive methods do not require the cooperation of the male partners?

Please write down three examples

1. _____
2. _____
3. _____

Spot check 4:

The available combined oral contraceptive pills can be used as an emergency contraception after adjusting the dosage.

- True
- False

Spot check 5:

No contraindication exists for the provision of emergency contraceptive pills.

- True
- False

Annex 2:

Instruction: Please use this reference material with occasional cross-reference with the WHO Medical Eligibility Criteria for Contraceptive during the counseling of adolescent and youth for contraception/FP

Perfect use-correct and consistent use of a method; **Typical use**-assumes occasional non-use and/or incorrect use

Contraceptive methods and necessary information for counseling, informed consent/decision making

Contraceptive Counseling Cue Cards

Combined Oral Contraceptives (COCs)

What are they?

COCs are tablets containing the hormones estrogen and progestin. A woman takes one tablet daily to prevent pregnancy.

How effective are they?

Typically, among one hundred women using COCs for one year, eight become pregnant. If taken every day, COCs are highly effective. If taken irregularly, the risk of pregnancy is much higher.

How do COCs work?

COCs work by preventing the release of the egg from the ovary. Without an egg, a woman cannot become pregnant.

Advantages

- ◆ Safe
- ◆ Effective and easy to use

- ◆ Lighter, regular periods with less cramping
- ◆ Can become pregnant again after stopping the pill
- ◆ Don't interfere with sex
- ◆ Decrease risk of cancer of the female reproductive organs like developing ovarian cancer

Disadvantages

- ◆ Have some side effects
- ◆ Must be taken every day
- ◆ Don't protect against sexually transmitted diseases, such as HIV

Possible Side Effects

Most women experience no side effects. Occasionally, women may experience nausea, weight gain, breast tenderness, headaches, unexpected bleeding or spotting, depression, or dizziness.

Combined Oral Contraceptives (COCs)

Client Instructions

1. Show the client the pill packet and explain how to take the pills.
 - ◆ Take the first pill on the first day of period or on any of the next four days.
 - ◆ Take one pill every day, at the same time of day.
 - ◆ If the client has a 28-day packet, when she finishes one packet, she should take the first pill in the next packet on the next day. If the client has a 21-day packet, she should wait seven days, and then begin the next packet.

2. Explain to the client that if she forgets to take her pills, she may become pregnant. If she forgets to take her pills, she should do the following:
 - ◆ If she misses one pill, the client should take it as soon as she remembers. Take the next one at the regular time.
 - ◆ If she misses two pills, the client should take two pills as soon as she remembers. She should take two pills the next day at the regular time, and use a backup method for the next week. The client should finish the packet normally.
 - ◆ If she misses more than two pills, the client should throw away the packet, and start a new one, **and** use a back-up method for the next week.

3. Review possible side effects. Most women have no side effects. Occasionally, women may experience nausea, weight gain, breast tenderness, headaches, unexpected bleeding or spotting, depression, or dizziness.

4. Review the reasons why she should return to the care provider:
 - ◆ Chest pain or shortness of breath
 - ◆ Severe headaches (with blurred vision)
 - ◆ Swelling or severe pain in one leg
5. Tell the client to return anytime she has a problem and in time for re-supply.
6. Have the client repeat this information.

Condoms

What are they?

The condom is a thin sheath worn over the erect penis or put in to females' sexual organ when a couple is having sex.

How effective are they?

Condoms are effective if used consistently and correctly. If one hundred couples used condoms for one year, typically twelve to fifteen of the women might become pregnant.

How do condoms work?

The condom catches the man's sperm so that no sperm can enter the vagina.

Advantages

- ◆ Safe
- ◆ Doesn't require a prescription or medical examination
- ◆ Effective and easy to use
- ◆ Helps protect partners from sexually transmitted diseases

Disadvantages

- ◆ Interrupts the sex act
- ◆ May decrease sexual sensitivity in some men and women
- ◆ A new condom must be used each time the couple has sex
- ◆ A supply of condoms must be available before sex occurs

Possible Side Effects

Most men and women have no side effects. Occasionally a condom may break or slip off during intercourse. Some men or women may have an allergic reaction to Latex condoms

Client Instructions

1. Show the client the condom and explain how to use it.
 - ◆ Open the package carefully so the condom doesn't tear.
 - ◆ Don't unroll the condom before putting it on.
 - ◆ Place the unrolled condom on the tip of the hard penis.
 - ◆ Hold the tip of the condom with the thumb and forefinger.

- ◆ Unroll the condom until it covers the penis.
- ◆ Leave enough space at the tip of the condom for the semen.
- ◆ After ejaculation, hold the rim of the condom and pull the penis out of the vagina before it becomes soft.

2. Explain about the care of condoms.

- ◆ Don't apply oil-based lubricants (like baby oil, cooking oil, petroleum jelly/Vaseline, or cold cream) because they can destroy the condom. It is safe to use contraceptive foam or jelly, clean water, saliva, or water-based lubricants.
- ◆ Store condoms in a cool, dry place. Don't carry them near the body because heat can destroy them.
- ◆ Use each condom only once.

Don't use a condom if the package is broken or if the condom is dry or sticky or the color has changed.

- ◆ Take care to dispose of used condoms properly.

3. Review possible side effects.

4. Tell the client to return to the clinic:

- ◆ Any time there is a problem.
- ◆ In time for resupply.
- ◆ If either partner is unhappy with the method.
- ◆ If either partner thinks she or he may have been exposed to an STI.

5. Have the client repeat the instructions.

DMPA: The Injectable Contraceptive

What is it?

DMPA is an injection containing the hormone progestin. The injection is given every three months.

How effective is it?

DMPA is highly effective if the injections are given every three months. If one hundred women use DMPA regularly for one year, typically only one of them might become pregnant.

How does DMPA work?

DMPA works by preventing the release of the egg from the ovary. Without an egg, a woman cannot become pregnant.

Advantages

- ◆ Safe and effective
- ◆ Lasts for three months

- ◆ Periods become very light and often disappear after a year of use
- ◆ Completely reversible, can become pregnant again after stopping DMPA, although there might be a delay of several months
- ◆ Can be used while breastfeeding
- ◆ Doesn't interfere with sex
- ◆ May improve anemia

Disadvantages

- ◆ Menstrual pattern will probably change
- ◆ Increased appetite may cause weight gain
- ◆ Typically a four-month delay in getting pregnant after stopping DMPA
- ◆ Doesn't protect against sexually transmitted diseases

Possible Side Effects

Most women initially experience irregular spotting or prolonged light to moderate bleeding. Later, bleeding is likely to be lighter, less frequent, or stop altogether. Some women also experience weight gain or headaches.

Client Instructions

1. Show the client the vial of DMPA.
2. Explain the use of DMPA.
 - ◆ DMPA is given by injection every three months. The client should never be more than two weeks late for her repeat injection. If the client knows that she may not be able to come at the appointed time, she may come up to four weeks early.
 - ◆ The injection will take effect immediately if it is given between day one and day seven of her menstrual cycle.
 - ◆ If the injection is given after day seven of her cycle, a back-up method should be used for 24 hours.
3. Review possible side effects. Most women initially experience irregular spotting or prolonged light to moderate bleeding. Later bleeding is likely to be lighter, less frequent, or stop altogether. Some women also experience weight gain or headaches.
4. Review the reasons why she should return to the care provider:
 - ◆ Heavy vaginal bleeding
 - ◆ Excessive weight gain
 - ◆ Headaches

5. Tell the client to return anytime she has a problem and in time for her next injection.
6. Have the client repeat this information.

Emergency Contraception Pills (ECPs)

What are they?

ECPs are a hormonal method of contraception that can be used to prevent pregnancy following an act of unprotected sexual intercourse. Progestin-only (levonorgestrel-only) pills or combined oral contraceptives (combined pills) are used for ECPs.

How effective are they?

Progesterone-only pills can prevent pregnancy in 52 – 94% when taken with 72 hours after unprotected sex. ECPs are more effective when used early, rather than late, in the 120-hour period after unprotected sex.

How do ECPs work?

ECPs are thought to prevent ovulation and fertilization. They are not effective once the process of implantation of a fertilized ovum has begun. ECPs will not cause abortion.

Advantages

- ◆ Safe and readily available
- ◆ Reduces risk of unwanted pregnancy and need for abortions
- ◆ Appropriate for use after unprotected intercourse (including rape or contraceptive failure)
- ◆ Can be used by young adults, who are less likely to prepare for a first sexual encounter
- ◆ Provides a bridge to the practice of regular contraception
- ◆ Drug exposure and side effects are of short duration

Disadvantages

- ◆ Doesn't protect against transmission of STIs and HIV
- ◆ Doesn't provide ongoing protection against pregnancy
- ◆ Must be used within 120 hours of unprotected intercourse
- ◆ May change the time of the woman's next period
- ◆ Inappropriate for regular use (high cumulative pregnancy rate)

Possible Side Effects

Side effects may include nausea, vomiting, abdominal pain, spotting, breast tenderness, headaches, dizziness, and fatigue.

Emergency Contraception Pills (ECPs)

Client Instructions

1. Show the client the pills and explain how to use them.
 - ◆ Swallow the first dose as soon as possible and optimally within 120 hours after having unprotected sex.
 - ◆ Swallow the second dose 12 hours after the first dose.
 - ◆ If client vomits within one hour of taking a dose, she should repeat the dose as soon as possible. If the vomiting occurs after the first dose, client will still need to take a second dose 12 hours later. (Provider can give client extra pills.)

Instruct the client **not to take any extra emergency contraceptive pills unless vomiting occurs**. More pills will **not** decrease the risk of pregnancy further.

2. Review possible side effects. ECPs often cause temporary side effects such as nausea and vomiting. Sometimes they can cause headaches, dizziness, cramping, or breast tenderness. These side effects generally do not last more than 24 hours.
3. Review what to expect after using ECPs. Women will not see any immediate signs showing whether the ECPs worked. The menstrual period should come on time (or a few days early or late). Tell the client that if her period is more than a week later than expected, or if she has any cause for concern, that she should return.
4. Instruct the client to return when she has her period if she wishes to use a contraceptive method to prevent future pregnancies.
5. Have the client repeat this information and give her a copy of the written instructions.

Intrauterine Device (IUD)

(Information is for the TCU 380A IUD)

What Is It?

An IUD is a small plastic and copper device that is inserted into the uterus to prevent pregnancy.

How effective is it?

If one hundred women use IUDs for a year, typically one will become pregnant.

How does the IUD work?

The IUD works by preventing sperm from joining with the egg.

Advantages

- ◆ Safe
- ◆ Effective and long-acting (10 years)
- ◆ Easy to remove if the client wants to become pregnant
- ◆ Doesn't interfere with sex
- ◆ Doesn't interfere with breastfeeding

Disadvantages

- ◆ Client may feel slight pain during the first few days after IUD insertion
- ◆ Heavier and/or longer periods, which normally decrease during the first and second years
- ◆ Doesn't protect against STIs
- ◆ Not suitable for women with multiple sexual partners or whose partner has other sexual partners

Possible Side Effects

Side effects of the IUD may include cramping and some pain during and immediately after insertion, heavier and longer menstrual flow for the first few months, increased vaginal discharge, and possible infection.

Intrauterine Device (IUD)

(Information is for the TCU 380A IUD)

Client Instructions

1. Show the client the IUD and explain how it is inserted.
2. Explain to the client how to check for the strings.
3. Review possible side effects. Side effects of IUD use may include: cramping and some pain during and immediately after insertion, heavier and longer menstrual flow for the first few months, increased vaginal discharge, and possible infection. Heavier and longer bleeding is normal and expected, especially in the first few months. Bleeding usually decreases during the first and second years of IUD use.
4. Explain the warning signs of potential complications:
 - ◆ Abnormal bleeding
 - ◆ Abnormal discharge
 - ◆ Pain (abdominal or pain with intercourse)
 - ◆ Fever
 - ◆ Strings missing, shorter, or longer
5. Tell the client to return any time she has a problem. Remind her that the IUD can stay in for up to 10 years.
6. Have the client repeat this information.

Lactational Amenorrhea Method (LAM)

What is it?

The Lactational Amenorrhea Method (LAM) is a temporary family planning method based on the natural infertility resulting from exclusive breastfeeding. ("Lactational" means related to breastfeeding and "Amenorrhea" means not having menstrual bleeding.)

How effective is it?

Effective as commonly used—2 pregnancies per 100 women in the first 6 months after childbirth.

How does LAM work?

Exclusive breastfeeding causes changes in the woman's hormones that prevent ovulation resulting in no menstruation.

Advantages

- ◆ Is effective in preventing pregnancy for up to 6 months.
- ◆ Encourages the best breastfeeding patterns which have health benefits for the mother and baby. Can be used immediately after childbirth.
- ◆ No need to do anything at the time of sexual intercourse.
- ◆ No direct cost for family planning or for feeding the baby.
- ◆ No supplies or procedures needed to prevent pregnancy.

Disadvantages

- ◆ Short term; can only be used for up to 6 months after delivery.
- ◆ Frequent breastfeeding may be difficult for some mothers.
- ◆ Does not provide protection against STIs/HIV.
- ◆ If the mother has HIV there is some chance that breast milk will pass HIV to the baby.

Possible Side Effects

There are no side effects associated with LAM.

Client Instructions

1. Ask yourself these 3 important questions:

- ◆ Have your menses returned?
- ◆ Are you giving the baby water, liquids, or other food besides breast milk or allowing long periods without breastfeeding, either day or night?
- ◆ Is your baby more than 6 months old?

If the answer to **all** of these questions is no then you can use LAM. Your chance of pregnancy is 1% to 2%.

If the answer to **any** of the questions is yes, you are at risk of getting pregnant. To prevent another pregnancy, you should use another method of family planning and continue breastfeeding.

For LAM to be effective, you should do the following:

- ◆ Breastfeed exclusively for six months.
- ◆ Breastfeed on demand, day and night (8-12 breastfeeds during a 24-hour period with at least 1 feeding during the night.)
- ◆ Continue breastfeeding even if the mother or the infant becomes ill.

3. You must stop using LAM as your form of contraception if:

- ◆ Your baby reaches 6 months of age **or**
- ◆ You are having menstrual bleeding **or**
- ◆ You begin giving the baby supplemental foods.

4. As soon as any one of the conditions mentioned above changes, you must switch to another method of family planning in order to prevent pregnancy and continue breastfeeding for the health of your baby.

Progestin Only Oral Contraceptives (POPs)

What are they?

POPs are tablets containing only a very small amount of one hormone, a progestin. A woman takes one tablet daily to prevent pregnancy. POPs are the best oral contraceptive for breastfeeding women.

How effective are they?

POPs are very effective for breastfeeding women, about 1 pregnancy per 100 women in the first year. As commonly used, they are less effective for non-breastfeeding women.

How do POPs work?

POPs work by thickening the cervical mucus, making it difficult for sperm to pass through and by preventing the release of the egg from the ovary in about half of menstrual cycles.

Advantages

- ◆ Safe
- ◆ Can be used by nursing mothers starting 6 weeks after childbirth
- ◆ No estrogen side effects
- ◆ Can become pregnant again after stopping the pill
- ◆ Doesn't interfere with sex
- ◆ May help prevent benign breast disease, endometrial and ovarian cancer, and pelvic inflammatory disease

Disadvantages

- ◆ For women not breastfeeding, menstrual periods may change
- ◆ Must be taken at the same time every day
- ◆ Doesn't protect against sexually transmitted diseases, such as HIV

Possible Side Effects

- Amenorrhea or irregular bleeding or spotting for women who are not breastfeeding
- Less common side effects include headache and breast tenderness.

Progestin Only Oral Contraceptives (POPs)

Client Instructions

1. Show the client the pill packet and explain how to take the pills.
 - ◆ Take the first pill on the first day of period or on any of the next four days
 - ◆ Take one pill every day, at the same time of day
 - ◆ Take the pills non-stop, from one packet to another
 - ◆ **Do not miss a day**
2. Explain what the client should do if she misses taking one POP:

- ◆ Take it as soon as she remembers
 - ◆ Continue taking the next pill at the usual time
 - ◆ Use a back up method for the next 7 days
 - ◆ Then continue taking the pills as usual
3. Explain what the client should do if she misses 2 or more POPs:
 - ◆ Take 2 pills as soon as she remembers
 - ◆ Take 2 pills on the next day
 - ◆ Use a backup method for the next 7 days
 - ◆ Then continue taking the pills as usual
 4. Review possible side effects. Women not breastfeeding may have a change in menstrual periods. Most breastfeeding women have no side effects. Occasionally, women may experience breast tenderness, or headaches.
 5. Review the reasons why she should return to the care provider:
 - ◆ If she thinks she might be pregnant
 - ◆ If she has abdominal pain, tenderness, or fainting
 6. Tell the client to return anytime she has any worries or problems and in time for re-supply.
 7. Have the client repeat this information.

Session 6.4 Overview of Unsafe Abortion among Adolescents and Youth

Definition of Abortion:

Abortion is the termination of pregnancy before fetal viability, which is conventionally taken to be less than 28 weeks from the last normal menstrual period. If the LNMP is not known, a birth weight of less than 1000gm is considered as an abortion (National Abortion Guide). Based on its causes, abortion can be categorized as spontaneous abortion or miscarriage that happens on its own or induced that happens deliberately caused by medical procedure. Induced abortion can be either safe or unsafe. The World Health Organization (WHO) defines unsafe abortion as a procedure for terminating a pregnancy performed by persons lacking the necessary skills or in an environment not in conformity with minimal medical standards, or both.

Abortion Care

Types of abortion care

Abortion care can be either post abortion care (PAC) or Women-centered abortion care.

Post Abortion Care (PAC): is a comprehensive service to treat women that present to a health care facility after abortion has occurred spontaneously or after attempted termination. It has five essential elements. These are:

- **Emergency treatment** of incomplete abortions and its complications

- **Counseling** where women are provided with accurate and complete information on RH issues including FP, VCT, gender-based violence and other concerns and queries.
- **Family Planning** services based on free and informed choice as well as method- mix.
- **Linkage** of the above services with other RH services including STIs management, information on breast feeding, child nutrition and immunization, screening of reproductive tract cancers, etc.
- **Community-service provider partnership** involving the local community and actors like Health Development Army (HDA), in addition to the formal health personnel to address recognition of symptoms and signs of pregnancy complications, resource mobilization, social and economic issues at the community level.

Women-centered abortion care is a comprehensive approach to providing abortion services that takes into account the various factors that influence a woman’s individual mental and physical health needs as well as her ability to access services and her personal circumstances and her ability to access services. Women-centered abortion care includes a range of medical and related health services that support women exercising their sexual and reproductive rights.

Women-centered abortion services have three key elements.

- **Choice** that includes the right to determine if and when to become pregnant, to continue or terminate a pregnancy, the right and opportunity to select between options, and having complete and accurate information.
- **Access**, includes having termination of pregnancy service by trained competent providers with up-to-date clinical technologies, easy-to-reach services that are affordable and non-discriminatory.
- **Quality** service, address respectful, confidential services tailored to the woman’s needs using accepted standards with appropriate referral procedures.

Women-centered abortion services include provision of safe abortion care, which is a comprehensive termination of pregnancy that is offered to clients as permitted by the law. Several methods of termination of pregnancy are available now. Which method is best for individual client depends on the duration of pregnancy, the general health status of the client, availability of method, distance from referral center, knowledge and skill of the provider, and level of care.

Nature and magnitude of unsafe abortion among adolescent and youth

Abortion is more than a medical issue, or an ethical issue, or a legal issue. It is, above all, a human issue, involving women and men as individuals, as couples, and as members of societies. The WHO estimates that about 210 million women become pregnant each year worldwide and about 25% of all pregnancies end in an induced abortion. Moreover, about 22

million pregnancies are terminated unsafely and are major causes of mortality and morbidity. The vast majority of unsafe abortions take place in developing countries, and as can be expected, in countries in which abortion is restricted by law. Some 80,000 women are estimated to die every year as a result of unsafe abortion. Many more women survive the experience only to suffer throughout the rest of their lives from chronic health problems, and in many cases infertility. As a result, unsafe abortion accounts for up to 13% of all maternal deaths.

In many parts of the world, more adolescent girls than adult women will resort to abortion as a way of solving an unwanted pregnancy. Estimates show that the total number of abortions among adolescents in developing countries ranges from 2 million to 4.4 million annually. In many developing countries, hospital records of women treated for complications of abortion suggest that between 38% and 68% are less than 20 years old. Evidences also show that about 32-93% of the births among unmarried adolescents and 61% of married adolescents are unwanted or mistimed.

Ethiopia has become one of the countries that have shown significant reduction in maternal mortality in relation to unsafe abortion. Before the revision of abortion law in 2006, the contribution of unsafe abortion to maternal mortality was estimated at 32% as opposed to the current estimate of 6-9% per documented evidences. In 2008, an estimated 382,500 induced abortions were performed in Ethiopia, for an annual rate of 23 abortions per 1,000 women aged 15-49.

As indicated in the most recent national study (Tamara et al, 2014), the proportion of adolescents and youth among post abortion clients in Ethiopia is increasing significantly. The proportion of under-18 adolescents among post abortion clients increased from 3% in 2008 to 6% in 2014 and among 18-24 years from 35% to 43 %. Similarly, the proportion of unmarried women among post abortion clients doubled from 14% in 2008 to 28% in 2014. This clearly indicates that giving special emphasis to unmarried adolescent and youth is very crucial if we have to reduce the magnitude and consequences of unsafe abortion.

Why adolescents and youth seek abortion?

The choice to have an abortion is not an easy one. Adolescents often state a number of reasons for resorting to abortion. The following are the common reasons.

- **Education:** Pregnant girls, who fear expulsion from school or the interruption of their studies may believe that they have no choice; but, to terminate their pregnancy.

- **Economic factors:** Since adolescents and youth have fewer economic resources to care for a child, it is not surprising to find economic pressures influencing their decision to seek an abortion.
- **Social condemnation:** In societies, like Ethiopia, where a pregnancy before marriage is considered immoral, adolescent and youth girls choose termination of pregnancy to avoid bringing shame and condemnation on themselves and their families.
- **Having no stable relationship:** This reason is encountered more commonly among adolescents than in adults.
- **Contraceptive failure:** Contraceptive use among adolescents and youth is often low. Where they are used, this is often done so inconsistently and incorrectly because of insufficient knowledge. Besides, because of misconception related to infertility after using LARC, short-acting and less effective methods tend to be used.
- **Coerced sex (including rape and incest):** Cross-cultural data point to the fact that a larger percentage of rape and sex abuse incidents are perpetrated against adolescents than among adults. These lead to the occurrence of unwanted pregnancies and lead the adolescents to seek abortion.

Factors contributing to unsafe abortion in adolescents and youth

There are different factors that determine the magnitude and severity of unsafe abortion; these include,

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

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

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

methods for abortion, such as inserting objects into the cervix, placing herbal preparations into the vagina, or taking various preparations from modern and traditional systems of medicine – orally or through injection.

Varying forms of legal barriers to the provision of abortion services exist in many countries. Even in countries where these laws are relatively liberal, various requirements that have been created make it harder for adolescents to have access to safe abortion. For example, in some countries the consent of the husband, parent or guardian is needed for the abortion if the woman is below a certain age. Generally speaking, abortion-related mortality is highest in countries where abortion is legally restricted and reproductive health service provisions are not widely available. Globally, unsafe abortion contributes to 13% of maternal deaths, and 6 -9% in Ethiopia (32% in 2000, UNICEF). It must be noted that even where laws and policies are not restrictive, societal views and the real or perceived – attitudes of health-care workers act as obstacles to access.

The way in which service-delivery is organized affects the extent to which adolescents have access to sexual and reproductive health information and services, including safe abortion when needed. A study in 2008 in Ethiopia reported, 45% of all facilities visited reported that they provide safe abortion services: 86% of hospitals and 38% of health centers. In the case of removal of retained products for incomplete abortion, 24 of 93 facilities did not have the equipment (either MVA or curettes) or the skilled staff.

The magnitude and severity of problems related to unsafe abortion among adolescents vary from country to country, and within communities in the same country. Factors that positively influence magnitude and severity of unsafe abortion among adolescents and youth include the extent to which:

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

The consequences of unsafe abortion among adolescents

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

Medical consequences

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

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

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

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

Psychological consequences

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

Social and economic consequences

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

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

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

Session 6.5 Dealing with Unsafe Abortion

Legal provisions for safe abortion services in Ethiopia

Health workers involved in the abortion care services, particularly for adolescents, should be well aware of legal provisions for safe abortion services in the country. Knowledge of the law and its interpretation is essential so that providers not only know what is expected of them but can also inform and educate women and community at large.

Until 2005, the Ethiopian penal code permitted abortion only to save the pregnant woman's life or to preserve her health from grave danger, and required diagnosis and certification by a medical practitioner, as well as confirmation by an obstetrician/gynecologist.

Article 551 of the 2005 revised penal code of the Federal Democratic Republic of Ethiopia allows termination of pregnancy under the following condition. Article 551:

1. Termination of pregnancy by a recognized medical institution within the period permitted by the profession is not punishable where:
 - a. The pregnancy is a result of rape or incest; or
 - b. The continuation of the pregnancy endangers the life of the mother or the child or the health of the mother or where the birth of the child is a risk to the life or health of the mother; or
 - c. The fetus has an incurable and serious deformity; or
 - d. The pregnant woman, owing to a physical or mental deficiency she suffers from or

- e. Being minority is physically and mentally unfit to bring up the child.
2. In case of grave and imminent danger which can be averted by an immediate intervention, an act of terminating pregnancy in accordance with the provision of Article 75 of this code is not punishable.

The details of the law and its interpretation can be obtained from the 2014 revised Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia.

Diagnosing unsafe abortion among adolescents and youth

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

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

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

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

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

Managing unsafe abortion among adolescents and youth

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

The management of the patient will depend on the history and the findings of the examination.

It should be based on the following principles:

- **Emergency resuscitation may** be necessary as many adolescents present in shock. In primary level facilities, health-care workers will need to be prepared to make referrals and arrange for transport to a referral facility with effective treatment.
- **Evacuation of the uterus** is necessary to remove all the products of conception. For inevitable or incomplete abortion, uterine evacuation is necessary. The technique chosen will depend on the length of gestation, stage of the abortion, uterine size and availability of skilled staff and supplies. If there are signs of infection, abdominal injury, cervical or uterine perforation, evacuation should be carried out only after broad-spectrum antibiotics effective against gram-negative, gram-positive and anaerobic organisms, as well as Chlamydia, have been started.

In the first trimester, vacuum aspiration is the surgical procedure of choice. In the second trimester, the risk of complications is higher. Because delay is so characteristic of adolescent abortion patients, many second trimester abortions are carried out in this age group. Early second trimester (12-14 weeks) procedures can be done by vacuum aspiration using larger cannulae. Curettage is also sometimes required. The treatment of incomplete abortion in the late second trimester (more than 14 weeks), by dilation and evacuation/curettage or by uterotonics, should be done by experienced health-care workers. In addition, intravenous fluids and oxytocics, blood transfusion and facilities to perform abdominal surgery must be available as a back-up.

- **Management and prevention of complications** such as infection and injury. It is unfortunately true that complications are more frequent and more severe in environments where self-induced or otherwise unsafe abortions are common and where reproductive health services in general are lacking.
- **Arrangements for post-abortion care** must be put in place because adolescents are more easily “lost to follow-up” than are adults. Establishing a good rapport with the adolescent patient will facilitate follow-up. In any case, patients must be given information on danger signs to look out for, such as fever and chills, nausea and vomiting, abdominal pain and

backache, tenderness to pressure in the abdomen, heavy bleeding and foul-smelling vaginal discharge. They must also be provided with information on sexuality and contraception for well-informed decision-making.

In general, **comprehensive abortion care** includes the following components

- Emergency treatment of incomplete abortion and potentially life threatening complications
 - Initial assessment to confirm the presence of abortion complications.
 - Medical evaluation(brief history, limited physical and pelvic examinations)
 - Prompt referral and transfer if the woman requires treatment beyond the capability of the facility where she is seen.
 - Stabilization of emergency conditions and treatment of any complications
 - Uterine evacuation to remove retained products of conception
- Post abortion family planning counselling and services
 - Informing, educating and counseling about family planning (“ Favorable time”)
 - Opportunity for approaching groups that normally routinely do not use services.
 - Initiating family planning immediately (Ovulation returns rapidly)
- Links between post abortion emergency services and the reproductive health care system.
 - Identify the reproductive health services that each woman may need
 - Offer as wide a range of services as possible
 - E.g. Treatment of STIs, cervical cancer screening

Preventing unsafe abortion among adolescents

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

Improve access to reproductive health information and services

The need to improve adolescents’ access to reproductive health information and services has been discussed in module-5 “*Adolescent sexual and reproductive health.*” Specifically, there is an urgent need to expand the availability of a wide range of contraceptive methods to enable sexually active adolescents to choose the method that best suits their needs. The contribution that emergency contraception could make in preventing unsafe abortion needs to be clearly articulated. Adolescents need to know that this method is available, and where it could be obtained when needed. Information on ways and means of improving the accessibility and acceptability of health services is provided in Chapter-14 “*Adolescent-Responsive health*”

services.” Further information on contraception is attached as an annex under session two, ‘Prevention of Pregnancy *in adolescents.*”

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

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

Provider competency and responsibilities

Providers should have the knowledge of the law and guideline related to abortion care so that services can be delivered with reference to it and level of responsibility

Health care providers should acquire basic knowledge and skills. They are responsible for the provision of comprehensive abortion care services and authorized to perform abortion procedures on women whose medical condition warrant the immediate termination of pregnancy. They also need to be trained in post abortion counseling. In this way, they can help adolescents deal with the many health and social issues that arise.

Providers should have respect and empathy, respect privacy and confidentiality with total adherence to the voluntary and informed consent process. It is important to help them examine their attitudes and beliefs, in order to prevent these factors from hindering the provision of care. So, value clarification should be done to distinguish between their values and clients rights to safe reproductive health services.

Involve communities in protecting and safe-guarding adolescents

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

Summary

- Unsafe abortion is common among adolescents and youth in many countries, including Ethiopia.
- Unsafe abortion implies interference of pregnancy without the necessary knowledge and skills or in conditions that are not conducive to good health. It can be within or outside the law.
- Adolescents obtain abortions for a broad range of reasons related to social, economic and cultural reasons.
- Adolescents undergoing unsafe abortions tend to be single pregnant for the first time and tend to obtain their abortions later in their pregnancies than adult women.
 - They are more likely to have resorted to illegal providers to have used dangerous methods for inducing abortion, later present with more entrenched complications.
 - They tend to face more barriers than adults in accessing and using the health services they need, and they are less likely to come for post treatment follow up.
 - The management of unsafe abortion should include post abortion counseling, addressing contraception in addition to other issues.

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Annex 3: Spot checks

Take a minute to think and respond to the following questions.

1. Some people say that if safe abortion services are made available and accessible to adolescents, it will encourage promiscuity. Do you agree with this?
 - a. No, absolutely not agree
 - b. Not sure
 - c. Yes, absolutely agree
2. How confident do you feel about working with adolescents on the issue of abortion?
 - a. Not very confident
 - b. OK
 - c. Very confident
3. A school girl presents with complication due to unsafe abortion. Which of these best describes how you feel about her situation?
 - a. I feel angry with her
 - b. I feel angry with the boy or man who is responsible
 - c. I feel angry with the politicians for the restrictions on safe abortion
 - d. I feel we have failed because she resorted to unsafe abortion
 - e. I feel sadness that she didn't use safe abortion
 - f. I feel pity for the life that has been aborted
 - g. I feel angry with the person who did the abortion
4. As health care providers, what should we focus on to prevent unsafe abortion among adolescents?
 - Train modern and traditional health care providers in abortion care
 - Support efforts to change the law to expand access to safe abortion
 - Improve confidentiality for adolescents seeking abortion
 - Improve access to safe abortion for adolescents
 - Improve provision of contraception to all adolescents
 - Encourage the authorities to stop untrained people carrying out abortions
 - Emphasize abstinence from sex before marriage
 - Encourage adolescents to go through with their pregnancies

Chapter 7: Care for Adolescents during Pregnancy, Childbirth, and Postnatal Periods

Session 7.1: Session outline and Learning Objectives

Duration: 90 Minutes

Session outline

- Overview of Pregnancy during Adolescent and Youth
- Care during Pregnancy for Adolescents and Youth
- Management of Labor and Delivery
- Post Partum Care

Learning Objectives:

At the end of the training on this chapter, you will be able to:

- Identify the factors that make the adolescents vulnerable for early pregnancy and consequences associated
- Describe associated risks and consequences with pregnancy in adolescence
- Explain the different cares pregnant adolescent requires during pregnancy, childbirth, and postnatal periods

Session 7.2: Overview of Pregnancy during Adolescence

For those adolescents who do give birth, every effort is required to make motherhood safe. The statistics show that this is not currently the case. Pregnancy-related complications are the main cause of deaths for 15-19-year old girls worldwide. In some developing countries, maternal mortality among adolescent girls under 18 years is 2-5 times higher than in those aged 18-25 years. In Ethiopia, Pregnancy and childbirth among adolescents is a common phenomenon, Adolescent pregnancy accounts 13% of pregnancies as to 2016 EDHS.

Children who are born to adolescent mothers usually experience higher risk of deaths during their first five years of life. A comparative study of Demographic and Health Surveys data from 20 countries showed that the risk of death by age five was 28% higher for children born to adolescent mothers than those born to women aged 20-29 years.

Factors influencing adolescent pregnancy and childbirth

- The decline age of menarche: the age of menarche is declining from 14 to 12 years and the age at first sexual intercourse shows a decrease in many countries.
- Early initiation of sex: sexual activity among unmarried adolescents is increasing
- Early marriage and pressure to have children upon marriage: married adolescents face immediate pressured to prove their fertility
- Sexual coercion: young girls may be coerced into having sex and pregnancies can result from such assault.
- Education: adolescents and youth who stay on in schools for longer period marry and have children late
- Socio-economic factors: economic hardships expose young girls to sexual exploitation and prostitution and can lead to early pregnancy
- Risky behaviors: Use of alcohol and other substances can lead to unprotected sex and unwanted pregnancies
- Lack of access to sexual and reproductive health information and services

Risks associated with pregnancy and childbirth in adolescence

Pregnancy and childbirth in adolescence carry a greater risk to the health of both mother and baby, than in adult women. This is attributable to both biology and the social environment. A young maternal age, when combined with low social status and inadequate access to health care, contribute to the observed high maternal mortality in adolescents. Babies born to

adolescent mothers also have a higher risk of being of low birth weight, and of higher rates of morbidity and mortality. Pregnancy complications more common in adolescents than adults

These risks are summarized as follow:

Socio-economic complications

- Social and economic costs: early end to education and reduced earning opportunities

Antenatal complications

- pregnancy-induced hypertension
- anemia
- Higher severity malaria
- STI/HIV

Complications during labor and delivery

- preterm birth
- obstructed labor

Post partum complications

- anemia
- preeclampsia
- postpartum depression
- Fistula

Risks to the fetus/newborn

- Low birth weight
- higher perinatal and neonatal mortality
- Inadequate breast feeding and child care

Complications during pregnancy

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

Anemia: Results from global review of adolescent pregnancy show an increased risk of anemia in adolescents from developing countries, compared with women over 20 years of age. Anemia in pregnancy is often caused by nutritional deficiencies, especially of iron and folic acid, and by malaria and intestinal parasites. Vitamin A deficiency and HIV infection may also play a role in its causation.

STIs/HIV: mother-to child transmission of HIV in adolescents. Sexually active adolescents are at an increased risk of contracting STIs, including HIV infection, owing to their biological and

social vulnerability. There is also the increased risk of mother-to child transmission of HIV in adolescents, because the HIV infection is more likely to be recent, and therefore associated with higher viral loads. The presence of other STIs (syphilis, gonorrhoea and Chlamydia) with local inflammation may increase viral shedding, thereby increasing the risk of transmission during labour.

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

Complications during Labor and delivery

Pre-term birth: Compared to women over twenty years of age, adolescents are at increased risk for pre-term delivery. A likely cause of this is the immaturity of the genital organs of young women. However, social factors such as poverty, behavioral factors such as psycho-active substance abuse, and lack of optimal antenatal care also have a negative influence on pregnancy outcome.

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

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

Postpartum Complications

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

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

Risks to the fetus and newborn

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

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

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

Why are these complications worse in adolescents than in adults?

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

1. **Biological:** young adolescents are not mature enough for the strain imposed on them by pregnancy. Firstly, in physical terms, their pelvic bones are not fully mature, and as a result, cephalo-pelvic disproportion could potentially occur. Secondly, young adolescents may continue to grow during pregnancy. What this means is that there is a potential for competition between the mother and the foetus for the nutrients required for growth and development. If the adolescent's growth and development have been hindered by under-nutrition during childhood, she would then be entering pregnancy with nutritional deficiencies as well as impaired growth and development, further increasing the risk of negative outcomes. Thirdly, young adolescents may also not be psychologically prepared for motherhood. This could result in mental health problems such as depression.
2. **Psycho-social reason:** Compared to older women, adolescents are less empowered to make decisions about matters affecting their health. If married, the husband is likely to be older, and the principal family wage-earner. The husband's mother is likely to have a greater say in decision-making in matters concerning the household than his young wife. If single, the shame of the pre-marital pregnancy may leave her voiceless and even as a family outcast. In such circumstances, the adolescent is unlikely to get the psychological and practical support that she needs.

3. **Late enrollment of ANC:** Adolescents are more likely to enroll later and to make fewer health-facility visits for antenatal care. Clearly, socio-economic factors have a major influence on antenatal care utilization. The stigma associated with premarital pregnancy is another critical factor contributing to this. In many places, unmarried adolescents hide their pregnancies for as long as they can. On the other hand, married adolescents may not even know of the value of antenatal care, and even if they do, may be unable to obtain it. What this means is that adolescents are deprived of a service that has been shown to contribute to positive pregnancy outcomes.
4. **Lacks Autonomous Decision making:** In many places, adolescents deliver at home. They come to - or are brought to - hospital only as a last resort, often with serious complications. The factors that contribute to this include:
 - Social and cultural norms may dictate that they deliver at home;
 - They may be afraid of delivering at health facility;
 - They may have heard discouraging stories about mistreatment by health facility staff
 - They may be unable to pay for health care costs and the cost of transport to get there.

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

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

Care for Adolescents during Pregnancy, Childbirth and the Postnatal Period

The main goal of the continuum of care in adolescent pregnancy is to ensure healthy and enjoyable pregnancy with safe childbirth and quality postnatal care for both mother and newborn.

There is much that can be done to reduce the occurrence of problems, and to improve the health of the mother and the (unborn) baby. This includes:

- Early diagnosis of pregnancy and effective antenatal care,
- Effective care during labour and delivery
- Effective postpartum care.

Session 7.3 Care during Pregnancy

Early diagnosis of pregnancy

Early diagnosis of pregnancy is an important first step in drawing the adolescent into antenatal care. Timely diagnosis of pregnancy in adolescents by health-care providers is often challenged by unreliable menstrual history, vague symptoms, fear and reluctance to disclose, inconsistent diagnostic supplies at facilities, busy schedule due to patient load, and inadequate skills to communicate with adolescents.

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

- **Antenatal care**

The goal of ANC in adolescent pregnancy is to identify and timely enroll pregnant adolescents into the program, prepare them for birth and parenthood as well as prevent, detect, alleviate and manage any health problems during pregnancy.

Repeated contacts with the health-care system provide a useful opportunity for the detection and treatment of problems that commonly affect pregnant adolescents such as hypertension disorder, anemia, malaria, syphilis/HIV, iodine deficiency, and etc. So, diagnosis of such complications and the right measures is one of the objectives of ANC. Pregnancy-induced hypertension can easily be detected. Uncomplicated hypertension can be managed on an outpatient basis. In case of complications (such as pre-eclampsia, eclampsia), referral to a hospital is indicated. Anaemia and malaria too can be detected and treated during routine antenatal care. Antenatal visits also provide a valuable opportunity to screen for STIs such as syphilis and to provide the required treatment, when needed.

Antenatal care should go much further than the detection and treatment of problems. It provides a valuable opportunity for the provision of information and counseling support that adolescents need. Currently, it recommends a minimum of four antenatal visits for all pregnant

women. This is especially important in the case of adolescents – specially unmarried ones – because of their greater need for support.

Counseling during pregnancy

As indicated above, health-care providers should seek to understand the situation that their adolescent clients are in and to provide them with the relevant information and counseling support that meet their needs (listed below). ANC is more than a technical screening procedure. The pregnant woman needs social contacts with the caregiver, and she needs reassurance and answers to many questions and fears. The trust may also be important for the point of delivery and the outcome of labor. The counseling sessions should give an opportunity for the pregnant adolescent to discuss their worries, concerns. They do usually question again and again, and the providers should be patient, frank and supportive.

- The life situation of the adolescent including her marital status and socio-economic situation, and the support available to her from her husband/partner, family members, friends and others;
- The options available to her in terms of the pregnancy and the support that she needs;
- Her access to health services for routine antenatal care and in case of emergency;
- Her plans for the delivery;
- How to recognize signs of labor or danger
- Advice on delivery at health facilities (or at a minimum, delivery by a trained provider);
- Her plans for the care of the baby;
- Her plans for continuing with her education or work after the delivery.

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

An HIV-positive adolescent/youth pregnant woman needs extra post-test counseling and support. She needs counseling to understand the benefits of taking ART; adherence

preparation and initiation of ART needs to be **rapid** to ensure maximum benefit from ART to prevent MTCT. She also needs support to disclose her HIV status to her partner, and to encourage her partner get tested.

Session 7.4 Management of labor and delivery

The cardinal rule for birthing care for adolescents or youth is **NEVER LEAVE HER ALONE**. Support, comfort, and explanations of what is happening or going to happen will break the cycle of *fear* that produces *tension* and thereby increases the intensity of *pain*. Support also increases the likelihood that the adolescent or youth will cooperate when you need her to do so. Friends, the adolescent's or youth's partner, family members, or anyone the adolescent or youth identifies can and should be encouraged to be involved in providing physical care and emotional support. Empathic support during labor from care providers is a key for successful childbirth – shorten labor, less pain and pain medication, fewer APGAR score <7 and fewer operation delivery.

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

As a general rule, if the labor is a potentially high-risk one, it is advisable to encourage hospital delivery. In some places, “waiting mothers” shelters have been established to help ensure that women who are likely to require institutional delivery do not find themselves stranded at home because transportation is not available/affordable.

Besides observing and monitoring, supporting the woman and her partner (or companion) is very important, especially in adolescents. Studies have shown that continuous empathetic support during labor, provided by a nurse or midwife results in many benefits both to the mother and the baby.

Special provider characteristics for managing adolescents/youth during birth

- The provider's demeanor to support adolescents or youth during the birthing process requires patience, understanding, explanations, compassion, and caring. Adapt to the adolescent's or youth's individual needs in order to support her coping efforts.
- Create an atmosphere of inclusion with family and/or identified support person(s).

- When preparing to perform examinations and procedures, explain to the adolescent or youth and her support person what you will be doing and why; perform maneuvers slowly and gently.
- Use firm but caring speech to get the adolescent's or youth's attention. Shouting is never acceptable

Session 7.5 Postpartum care

The period of six weeks following birth is a period of dramatic change and tremendous adjustment that affects the young mother physically and emotionally. This is a very crucial period to give a second chance for the adolescent mother to plan her future. For those who are not married: child care plan, use of contraceptive/FP methods, going back to school, or earning livelihood are big issues to deal with. Married adolescent should be supported with child care, family planning and socio economic planning. In general the first 48 hours should be given due attention as it is critical for the mother and newborn, hence proper visit and care from health workers is a must.

The demands of mothering are high, and the adolescent or youth mother will need support from those closest to her not to feel overwhelmed and tempted to give up. It is a critical time for learning and guidance, yet it must be given in a way that does not make the young mother feel incompetent. Help and guide her to carry out tasks as she is able within the limits of safety; praise her efforts; and offer corrections as “tips” for doing something.

As the adolescent or youth mother tries to cope with the demands of infant care (e.g. sleep deprivation, physical discomfort), the psychological shift into a role of greater responsibility, and rapidly altering hormone levels, dramatic mood swings characteristic of *postpartum blues* may occur. Postpartum blues usually occur around the third to fifth day after birth and range from mild (feeling “down,” teary, unexplained sadness, easily upset) to more profound with frequent bouts of crying for unexplainable reasons. It is normal for all women to experience a sense of loss after birth, but it may be more acute for the adolescent or youth.

Some causes of postpartum blues are:

- Loss of physical attachment to the baby; empty space where the baby was.
- Loss of attention, no longer “center-stage.”
- Adjustment to yet another self-image.
- Loss of freedom to pursue adolescent interests with peers.
- Heightened sense of insecurity and lack of self-confidence with resultant over-sensitivity to comments.

The primary goal of health staff is to help the adolescent or youth mother successfully take on the role and responsibilities of mothering. Adolescents or youth need close monitoring to keep them focused on the wide range and seemingly endless tasks involved in caring for a baby.

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

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

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

Breastfeeding: breastfeeding is a particular challenge for adolescents and youth. They often consider breastfeeding to be too confining of their movements and too demanding of their time. Help maintain a realistic perspective that supports the adolescent or youth mother in making a decision that she is comfortable with and can successfully carry out. Help her achieve her identity and minimize role confusion as she negotiates between her personal development needs and her role as a mother. A young adolescent – especially one who is single – would require extra support in achieving breastfeeding successfully.

Between 5-20% of infants born to HIV-positive mothers may acquire HIV through breastfeeding depending on a range of factors. Every HIV-infected mother should receive counseling, which includes information about the risks and benefits of different infant feeding options, and specific guidance in selecting the option most suitable for her situation. The final decision should be the woman's, and she should be supported in her choice. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV-infected mothers is recommended. Otherwise, exclusive breastfeeding is recommended during the first 6 months of life, and should be discontinued when an alternative form of feeding becomes feasible.

Summary:

- Factors such as early marriage, , service availability and affordability, and risky sexual behavior contribute to pregnancy in adolescence
- Pregnancies in adolescents are accompanied by higher deaths and complications compared to adults
- Babies born to adolescents have higher chances of low birth weight and deaths
- During the continuum of care, health care providers should be cognizant of the mentioned relatively high morbidity and mortality associated with adolescent pregnancy and prepared to deal with it properly and promptly
- Service providers (during ANC, Delivery & PNC) should be courteous, patient, caring and compassionate

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Annex 1:

Case Study

1. A doctor, a midwife in-charge and two nurses are conducting a ward round in the maternity ward of a government hospital. There are around 25 patients in the ward. About a third of them are adolescents. The teams arrive at the bedside of a 14-year old girl who has been admitted with severe anemia (complicating her pregnancy). Her haemoglobin is 7gm%. As they reach the bed the nurse in-charge, starts berating the girl loudly. "You had no business to have sex before getting married, and no business getting pregnant. You play around and we all have to work to take care of you." The girl starts weeping silently; her mother hangs her head in shame. The doctor is clearly embarrassed by this outburst; he gently tries to intervene.....

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

3. A teacher at a school comes in to the casualty unit of a district hospital with a 16-year old school-girl (who is in school uniform). The teacher says that the girl has been complaining of severe lower abdominal pains, and wonders whether she has menstrual cramps. On examination, the midwife on duty confirms a full-term pregnancy. The girl has concealed her pregnancy from her family and from teachers at school by binding her abdomen tightly.
The girl is in labour. Her cervix is 4cms dilated. After sending the girl to the labor ward, the midwife sends her to the doctor on call, to help explain matters to the teacher.

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

Chapter 8: Sexually Transmitted Infections & HIV-AIDS among Adolescent and Youth

Session 8.1 Session Outline and Learning Objectives

Duration: 120 Minutes

Session outline

- Basics on Sexually Transmitted Infections in Adolescent and Youth
- STIs Management in Adolescents and Youth
- Basic Facts on HIV/AIDS among Adolescent and Youth
- Combination Prevention Intervention for HIV/AIDS in Adolescent and Youth

Learning Objectives

By the end of the session participants will be able to

- Demonstrate an understanding on epidemiology, causes, modes of transmissions, prevention, treatment and care of STI/HIV and AIDS
- Describe basic facts on HIV among adolescents and youth
- Ability to make appropriate decisions in the provision of or referral for different STIs, PEP, ART, PMTCT, etc. services
- Demonstrate willingness to effectively assist clients to address the consequences of STI/HIV and AIDS

Session 8.2: Basics on Sexually Transmitted Infections in Adolescents and Youth

STIs in adolescents and youth: Sexually transmitted infections (STIs) refer to infections transmitted from one person to another primarily through unprotected sexual intercourse. Other modes of transmission include: mother-to-child, blood transfusions, or other contacts such as with blood or blood products or skin to skin. Sexually transmitted infections (STIs) are among the most common causes of illness in the world and have far reaching health, social and economic consequences. STIs have public health importance because of their communicability, magnitude, potential complications and their interaction with HIV/AIDS. They affect the health and social well-being of women, adolescent and youth disproportionately by producing significant impact on their reproductive potential.

The 2011 EDHS has shown that the prevalence of HIV among adolescents and youth in Ethiopia is lower than 1%. There is significant disparities exist between young females and males: 0.1% among 15-19-year-old (0.2% among females and 0% among males), 0.6% among 20-24-year-old (0.9% among females and 0.2 % among males).The overall prevalence of HIV was higher among respondents with other STIs or STI symptoms. Exposure to STIs during adolescence is a known risk factor for development of cervical cancer as well as infertility later in life. The four most prevalent STIs are Chlamydial infection, gonorrhea, syphilis and Trichomoniasis. These STIs can be prevented and cured provided that adequate antibiotics are available and standardized treatment protocols are followed.

Factors contributing to STIs among adolescents and youth:

Explorative nature of Adolescent and youth: Adolescents and youth have higher risks of exposure to STIs. Although to explore and experiment are normal parts of adolescent and youth development, they often make them vulnerable and expose them to a variety of health risks. As young people experiment sexually, it is possible for them to indulge in risky sexual practices and increases their chances of contracting and spreading STIs.

Multiple casual sexual partners: In many parts of Ethiopia marriage often occurs during adolescence and sexual relations are more likely to be with a regular partner. Even though having a regular partner decreases the risk of exposure to STIs, it is possible to have infected even in this scenario in case of polygamy and infidelity when a spouse experience extramarital sexual affairs. On the other hand, adolescents and youth engage in premarital sex and/or have multiple sexual partners that put them at greater risk of acquiring STIs than those who are in stable relationships.

Unplanned and unprepared sexual acts: Sexual relations during adolescence are often unplanned and sporadic, and results of pressure, coercion or force. There is an increased practice of higher-risk sexual behavior such as having sexual intercourse with multiple partners and/or somebody who is neither a spouse nor a cohabiting partner without condom. Adolescents start sexual activity typically before they have:

- Adequate information about STIs and how to avoid contracting STIs
- Experience and skills to protect themselves
- Access to SRH services and supplies such as condoms

Drug/substance/alcohol use and abuse: Substance abuse or experimentation with drugs and alcohol is common among adolescents and youth. This often leads to irresponsible decisions, including having unprotected sex. Adolescents or youth may feel peer pressure to have sex before they are emotionally prepared to be sexually active.

Biologic factors: Young girls are more vulnerable than young men and adults because of biological, social, cultural and economic factors. Hormonally-driven protective mechanisms are not yet fully developed in adolescent girls. Inadequate mucosal defense mechanism and immature lining of the cervix result in a poor barrier against infection. Moreover, the thin lining and relatively low acidity in the vagina makes it more susceptible to infection.

Sexual violence/Intimate Partner Sexual Violence: Sexual violence and exploitation, lack of formal education, inability to negotiate with partners about sexual decisions, and lack of access to reproductive health services work together to put young women at especially high risk. Poverty and financial pressures force young women/girls to sell sex for favors or cash. Young men often feel that they have to prove their sexual powers.

Consequences of STIs among Adolescents and Youth:

Generally, the long term consequences of STIs are more serious among women. Women and girls are less likely to experience symptoms; so many STIs go undiagnosed until a serious health problem develops.

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

- Adolescents or youths who contract syphilis may develop heart and brain damage if the syphilis is left untreated (Tertiary Syphilis). The presence of STIs also increases the risk of HIV infection.

- STIs can be transmitted from an adolescent mother to her infant during pregnancy, delivery and postnatal period in case of HIV. Infants of mothers with STIs may have infants with lower birth weights, premature birth, and have increased risk of other infections, and their offspring might suffer from blindness- ophthalmia neonatorum.

Session 8.3: STI management in Adolescents and Youth

Factors that Influence Diagnosis & Effective Management of STIS in Adolescents and Youth

Adolescent and youth often lack information about the services that are available. Even if they have this information, they are often reluctant to seek help for diagnosis and treatment because of embarrassment, fear of negative reactions from health-care workers, cost of services, and because they do not want to be seen by people they may know.

STIs may be asymptomatic, especially in young women. Adolescents and youth may not be aware that they have STIs. 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 and youth who are not fully knowledgeable about their bodies.

Often times, adolescents and youth with STIs seek help from their friends or revert to self treatment by buying medicines from drug vendors. This is likely to result in improper and inadequate treatment of 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.

As indicated above, adolescents and youth 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 STI.

Adolescents and youth often have difficulty in complying with treatment because it may be lengthy (e.g. in the case of Chlamydia) or painful (e.g. in the case of venereal warts), and sometimes they may need to hide their medication from their friends or people around them to keep their status unrevealed. It is therefore important for health-care providers to ascertain if the adolescent/youth has tried any medication for the STI, before coming for help.

Approaches to STI Management and Comprehensive care package for AY with STI

There are generally three diagnostic approaches to the management of STIs

Etiologic: A diagnosis is based on the results of laboratory tests that can identify the specific organism causing the infection. Thus, it is possible to treat only for one infection given the results of laboratory tests are returned quickly.

Clinical: Provider makes a diagnosis (or educated guess) about which organism is causing infection based on the patient's history, signs and symptoms.

Syndromic: The patient is diagnosed and treated based on groups of symptoms or syndromes, rather than for specific STIs. All possible STIs that can cause those symptoms are treated at the same time.

Advantages of Syndromic Approach: WHO recommends the use of the *Syndromic approach* to the management of STIs. This approach is especially appropriate where human resources and laboratory facilities are not available for etiological diagnosis to be made in resource-poor settings. Costs relating to and the inherent delays associated with laboratory testing are avoided in the Syndromic approach.

Benefits of the Syndromic approach include:

- Standardized clinical management
- No laboratory diagnosis is required

Comprehensive care includes diagnosis, treatment, counseling, contact tracing and follow up (See Box 1).

Box 1: Comprehensive care

- Effective medical treatment
- Education on risk reduction
- Counseling including testing for HIV antibodies
- Contact tracing and management
- Promotion and provision of condoms
- Ensure follow up management
- Legal and emotional support

The syndromic approach can be used for STI assessment in adolescents and youth because the presentation of symptoms is similar irrespective of age. However, health-care providers must be aware of the factors discussed earlier, which could hinder prompt and correct diagnosis and effective management of STI in adolescents and youth.

Disadvantages of Syndromic Approach: Though syndromic management of STIs is the preferred approach in resource-poor countries, a number of limitations hinder its wide acceptability. However, the limitations of the other approaches mean that some patients with atypical clinical features, false negative results or with mixed infections will be inadequately managed. Such patients may have to return for further investigation, suffer prolonged morbidity and then be re-treated at further cost. Consequently, in the long term, the cost per patient cured by the concomitant syndromic approach may be cheaper.

- The syndromic approach for vaginal discharge is poorly predictive of the presence of cervical chlamydia and/or gonococcal infection.
- As the syndromic approach is based on self-reported symptoms, it does not detect or treat patients with asymptomatic infections. Detection of asymptomatic infections remains one of the problems in STI control.
- The approach has not been easily acceptable to doctors who regard it as unscientific inferior medicine and feel threatened by any restriction on their freedom to prescribe.
- No single procedure is appropriate for every setting. Procedures need to be evaluated for validity, feasibility, cost and acceptability to facilitate their effective use. The approach should not obviate the need for referral and full clinical investigation when required. Other problems with syndromic case management relate to its implementation. Funds are often not available in resource-poor countries for initial and refresher training of health care workers.

Practical Considerations for Management of STIs in adolescents and youth

It is crucial to maintain confidentiality of AY clients, show them respect and stay non-

BOX 2: Practical Considerations when managing STIs among adolescents and youth

- **Establishing good rapport**
- **Carrying out history taking and physical examination in a sensitive manner**
- **Arriving at the right diagnosis: risk assessment**
- **Communicating the diagnosis and its implications, discussing treatment options and providing treatment**
- **Linkage with HIV counseling and testing**
- **Follow up visits**
- **Promotion of safer sex**
- **Prevention of recurrence/risk reduction counseling**
- **Notifying and managing partners**

judgmental. Health-care providers should acknowledge the rights of AY to health information, counseling and services, and focus on their well-being.

There are some issues that health-care providers need to be aware of and do differently, when they are dealing with adolescent and youth clients (BOX 2). Following them faithfully will enable health-care providers to deal with their adolescent and youth clients more effectively and with greater sensitivity.

It is important for AY to understand the diagnosis and its implications. They will also need to know services available to them at the health facility, and what

exactly they should – and should *not* do – to ensure that they can take the full course of treatment and are cured of the problem. An important issue is ensuring treatment compliance. The factors that may hinder compliance in adolescents have been discussed earlier. The health-care provider needs to raise this issue and to tailor the treatment regimen (as and when possible) to make it easier for adolescents to complete their treatment.

Health-care providers should use the opportunity presented by the adolescent's and youth presence at the health facility to determine his/her need for other services that could be provided by the health facility (e.g. contraceptive services).

Cases study 8.3.1

A 22-year old man presents at a rural health centre with a urethral discharge. He tells the health provider that he has been suffering from this, on and off, for a year. He knows that this is an STI, but does not seem very concerned about it. He says that he has had similar episodes in the past after visits to prostitutes in the nearby town. He is rather open about this and says that all his friends do the same. On enquiry, the health provider learns that the young man is married and has a wife who is 18 years old. The health provider explains that it would be important for both partners to be treated. The young man shakes his head, saying that it would be out of the question....

Q. If you were the doctor, how would you deal with this situation?

A 10-year old girl is brought to a health center by her mother because she has noticed that her daughter has genital sores. No meaningful history could be obtained from the mother or from the child on how and when the sores started. The girl was examined behind a screen while her mother sat in the same room. Examination revealed that the child had florid vulval condylomata strongly suggestive of syphilis. The nurse in charge, a mature and experienced woman, took the child into another room and probed the matter gently. After several minutes of gentle but persistent probing, the girl told the nurse that her uncle had been "playing" with her, and had warned her that if she told anyone he would kill her.

Q. If you were the doctor, how would you deal with this situation?

Session 8.4: Basic Facts on HIV/AIDS among Adolescents and Youth

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS, which is a lifelong infection. A *positive HIV test* does not mean a person is ill with AIDS; it means that he/she is infected with the virus (HIV) and that HIV antibodies are detectable in that person's blood. AIDS stands for Acquired Immune Deficiency Syndrome, "acquired" referring to the fact that the virus was caught; "immune deficiency" means that the person's immune system is weakened against infectious and non-infectious diseases. The word "syndrome" describes a group of symptoms indicating a particular disorder. The syndrome in AIDS is a set of infections or illnesses that occur because HIV has damaged the immune system. AIDS is result of progression of HIV

infection. Not everyone who is infected with HIV has AIDS. Anyone infected with HIV, although appearing healthy, can still transmit the virus to another person.

Modes of Transmission of HIV/AIDS: HIV is found in many body fluids but transmissions take place through blood, seminal fluid, vaginal and cervical secretions and breast milk. The main modes of transmission are:

- Unprotected sexual intercourse with infected people: Accounts 80-90%
- Mother to child accounts
 - During pregnancy through the placenta (before birth) 5-10%
 - During labor and delivery (at the time of delivery 10-15%
 - At time of breast-feeding (mainly through breast milk) 5-20%
- Through contact with infected blood or body fluid, tissue or organ

Factors Influencing the Risk of HIV Infection: Many factors contribute to the spread of the epidemic. Below are a few of the most dominant factors that have driven the epidemic

A. Behavioral factors:

- Level of awareness
- Multiple casual sexual contact
- Alcohol and drug use
- Condom use
- Health seeking behavior – treatment of STI, HIV testing

B. Socio-economic & cultural factors:

- Stigma and denial
- Poverty and mobility
- Cultural practice (HTP)
- Gender inequality
- Conflict
- Peer pressure

C. Biological factors:

- Exposure to blood, genital secretion and semen
- genital ulcers, trauma during sexual contact
- Circumcision in men
- Sex during menstruation, increasing a woman's risk
- Presence of an ulcerative or non-ulcerative STIs
- Infectiousness of host
- High viral load
- Breastfeeding by a HIV-positive mother

- Susceptibility of recipient
- Inflammation or disruption of genital or rectal mucous

Vulnerability to HIV: Vulnerability is a measure of an individual's or community's inability to control their risk of HIV infection. Vulnerability recognizes that they may not have a choice as to whether they engage in behavior that puts them at risk of acquiring HIV. Vulnerability increases the likelihood of negative health outcomes. There are social and contextual risk factors that make many young people vulnerable to HIV infection. These include: gender norms, relations between different age groups, race and other social and cultural norms and value systems, location and economic status. For most young people, the important messages that will protect them from the risk of HIV are: delaying sexual debut, reducing the number of sexual partners, and using condoms correctly and consistently.

Course of HIV in Young People: Young people differ from adults in the natural history of HIV infection and can differ from each other depending on their infection history (infection around birth or adolescent infection through unprotected sex or injecting drug use). In young people who were infected around birth and have survived into adolescence, HIV disease may have a rapid progression or a slow progression. In rapid progression, they are likely to have begun ART in childhood.

- **HIV acquired prior to puberty:** Young people who were infected before entering puberty can present with slow skeletal growth, delayed pubertal maturation, and irregular menstrual periods in girls. This is due to the effect HIV has on metabolic and endocrine functions. This delay in growth and sexual maturation may also have an impact on the psychosocial development of the individual.
- **HIV acquired after puberty has begun:** For young people infected after puberty, the infection can remain asymptomatic for a longer period of time than for adults. There appears to be an inverse correlation between age of infection and length of asymptomatic period (i.e. the younger the age at infection (after puberty), the longer the virus remains asymptomatic).

Impacts of HIV Infection on Physical Development: If HIV disease is fairly advanced, an adolescent may experience delays in physical development, including the physical changes of puberty. ALHIV may be shorter than their peers, either because of stunting early in life or slowed growth throughout childhood and adolescence. This may lead to a negative sense of self-image and affect how other people view the adolescent. Note that as we have already discussed in the growth and development module, self-image is a critical issue for adolescents.

Impacts of HIV Infection on Cognitive Development: Perinatally infected ALHIV will often have developmental delays and learning problems if untreated early in life. This can result in school

failure and dropping out. This in turn increases risks of adolescents to be taken advantage off (sexual and emotional abuse). It also exposed them for mental disorders like depression, anxiety disorder and hyperactivity.

Impacts of HIV Infection on Psychological and Social Development: Adolescents living with HIV are more prone for emotional difficulties. A Zambian study has showed that this is four times common in ALHIV. Illnesses may prevent ALHIV from going to school regularly, making friends, learning sports and hobbies. On the other hand, managing a chronic disease can have an impact on ALHIV's mental health. A common scenario is many ALHIV are not living with one or either of birth parents exposing them for more social and familial burdens.

Other challenges related to HIV/AIDS in adolescent and youth: Challenges related to HIV/AIDS on adolescents and youth is not limited to the above ones. A few others are provided below.

- Limited knowledge about HIV transmission and prevention
- Limited access to health information and care
- Lack of adolescents-friendly health services
- Issues related to disclosure of their own status and to others
- Single family or may be the head of house hold, have to look after younger siblings because of death or illness of parents
- Stigma and discrimination
- Challenges at national level
 - There is an expected growing number of ALHIV
 - However, no appropriate data on ALHIV
 - The environment is not supportive for care and support to ALHIV
 - The health system
 - The school

Effects of stigma and discrimination in adolescents and youth

- Keep ALHIV from accessing care, treatment, counseling, and community support services
- Cause a great deal of anxiety, stress, and/or depression
- Make adolescents feel isolated and as if they do not fit in with peers
- Make it difficult for ALHIV to succeed in school
- Result in poor adherence to medications
- Discourage adolescent and youth pregnant women from taking ARVs or accessing other PMTCT services

There is no single magic bullet for HIV prevention. Combination HIV prevention is likely to be most effective when different points in the “transmission cycle” are impeded. Combination prevention is using a mix of the following methods.

- Behavioral
- Biomedical
- Structural

Behavioral interventions

- Efforts geared to increased comprehensive knowledge on HIV/AIDS, delay of onset of initiation of sexual intercourse, reduce the number of sexual partners, etc.

Biomedical interventions

- Ensure adolescents and youth have access to: HCT, PMTCT, STIs management services, male and female condoms, PEP, VMMC, ART.

Structural interventions

- Address the critical social, legal, political, and environmental enablers that contribute to the spread of HIV

Special consideration in HIV Testing & counseling

- Do not discount the potential for HIV in young people
- Take Advantage of your first meeting with a young person
- Promote beneficial disclosure
- Take the opportunity given by a negative HIV test
- Promote future counseling of client together with their sexual partner

Approach to Care and treatment of ALHIV: to be effective, adolescent services must:

- Be integrated as one-stop shopping
- Be age and developmentally appropriate
- Be responsive to the needs of both perinatally infected adolescents and those infected later in childhood or adolescence
- Be empowering; encourage adolescents to take responsibility for their own health care, treatment, and for living positively
- Emphasize both care and treatment; and retention in care
- Complete assessment of care
 - Screening and management of opportunistic infection
 - Pregnancy status , family planning and contraception
 - Support for disclosure and partner notification
 - Risk reduction, counseling and combination HIV prevention
 - Screening for and managing mental health problems and substance use
- Provision of ART

- Adherence and psychosocial counseling and support
- Nutritional assessment and counseling
- Screening for STIs
- Prevention of cervical cancer
- Management of pain and symptoms: “ Done at first visit and at each follow-up visit as needed”

Psychosocial interventions

- Psychotherapy, Play therapy, Family therapy, Group therapy and support group

Case study 8.5.1

A 14 years old boy with HIV is living with his younger brother, father and step mother. His step mother came complaining that he tries to bite his younger brother and also tried to rape her. He usually doesn't want to go to school and mostly spends his time on Facebook. How do you think this case can be managed?

Disclosure of HIV status to children and adolescents: It is a process that involves ongoing discussions about the disease as the child matures cognitively, emotionally and sexually. Disclosure is a step by step process which should start earlier from childhood. HIV is also potentially life-threatening condition. Disclosure is beneficial and there dangers of non-disclosure and/or deception.

Disclosure of child's HIV status

Adherence support to A&YLHIV: Adherence refers to patients' ability to stick to or be devoted to HIV care/ART. It ranges from taking medications in the correct amount, at the correct time, and in the way they are prescribed to following a care plan, attending scheduled clinic appointments, picking up medicines on time, etc. Care givers need to identify factors which affect adherence such as: health service factors, individual client factors and community and cultural factors

Advantages of adherence for A&YLHIV: Adherence is a key to sustained HIV suppression, reduced risk of drug resistance, improved overall health, quality of life, and survival as well as decreased risk of HIV transmission.

Disadvantages of non-adherence: Poor adherence is the major cause of therapeutic failure. Loss of virologic control may lead to emergence of drug resistance and loss of future treatment options.

Peer support group: is a group of people who come together:

- to share a common situation describe basic facts on HIV among Adolescents and Youth
- help each other to improve and better manage their situation discuss prevention of HIV in adolescents
- share challenges and discuss solutions

Members support each other to implement decisions made to meet their psychological, social, physical and medical needs. Caregivers may benefit from groups, have a chance to share and talk. ALHIV may want to form their own support groups to discuss some of the special challenges that they face.

The group is coordinated by trained health provider in an ART providing health facility such as a physician, HO or Nurse who are working in pediatric or adult ART. The coordinator or ART provider directly involved with care and treatment of children may facilitate group sessions. Ethiopia has adopted a curriculum to guide the process of the peer support program based on experiences from other countries.

PMTCT in Adolescents and Youth Living with HIV: Global data shows that HIV is a leading cause of death among adolescents while older adolescent girls (15-19 years) account for 64% of new HIV infections among all adolescents. Eighty percent of adolescents living with HIV are found in SSA. On the other hand, global population projections demonstrate that there will be an enormous growth in the number of adolescents in the subsequent decades. Such youth bulge will be predominantly observed in HIV high burden regions including SSA. The increment in number coupled with the fact that >50% of births among older adolescent girls occur in SSA would mean that PMTCT programs in this region will be threatened by the double burden of HIV and pregnancy.

On the contrary, there has been emerging data from national PMTCT impact evaluations and other operations research studies that suggest pregnant adolescents have lower uptake of PMTCT services and poorer maternal and infant HIV outcomes although it is unclear whether these findings are consistent across multiple countries/cultural contexts in sub-Saharan Africa. The following are among the current recommendations to enhance improve PMTCT services for A&YLHIV:

- Preventing early defaulters among Pregnant Women.
 - Enough preparation of clients prior to start of treatment
 - Decentralization of health services
 - Counseling: more time and better
 - Provide more and more diverse types of information to community and to women:
 - Community engagement is crucial

- Address stigma as a source of LTFU
- Reduce patient waiting times, improve relations between patients & providers
- Support the formation of family support groups within facilities for psychosocial support
- Targeted interventions to mother who are most likely to be LTFU
- Detect and manage early defaulters
- Reduce the LTFU at the transition points for pregnant and postpartum women?
 - From ANC to postpartum care
 - Communication to clients regarding transition must start as early as possible: strengthen messaging at ANC and delivery/post delivery
 - Link postpartum care with immunization package
 - From MCH to Adult ART/chronic disease clinic
 - Establish standardize procedures to ease transition to post perinatal care
 - Counseling started earlier to prepare the woman
 - Patient escorting
 - Scaling up of ART to cover all sites providing PMTCT **OR** possibility for small clinics to distribute ARVs also after 2 y postpartum
 - Linkages to the networks of people/women living with HIV

Summary:

- STIs among adolescent and youth are an important public health problem requiring good clinical management
- Adolescent and youth run special risk of exposure to STIs; it must be stressed that adolescent girl are especially vulnerable
- There are three diagnostic approaches to STI management: etiologic, clinical, and syndromic. Effective treatment includes contact tracing and treatment.
- Important issues in A&Y HIV/AIDS include psychosocial support, adherence and disclosure
- There is a need to prevent defaulter earlier during pregnancy
- Disclosure of HIV status in adolescence should consider the cognitive, emotional and sexual maturity of the child. Timely disclosure is always beneficial

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Chapter 9: Gender Based Violence (GBV)

Session 9.1 Session Outline and Learning Objectives

DURATION: 60 Minutes

Session outline

- Definition and Epidemiology of Gender Based Violence
- Health System Response to GBV

Learning objectives:

By the end of this chapter participants will be able to:

- Explain the concepts of gender based violence, magnitude, it's causes and consequence in Adolescent & Youth
- Recognize survivors of gender based violence and their health needs
- Identify the role of the health system in the prevention and management of GBV
- Demonstrate readiness to provide health care services for survivors of gender based violence free of judgment

Session 9.2: Definitions and Epidemiology Gender Based violence

Gender refers to roles, responsibilities, opportunities, privileges, limitations and expectations related to boys/men and girls/women in a society often influenced by culture, religion, tradition, history and societal norms.

Violence: according to the *World report on violence and health*, *violence is defined* as, “the intentional use of physical force or power, threatened or actual, against another person or against a group or community, that either results in or has a high likelihood of resulting in injury death, psychological harm, and deprivation”.

Youth violence is defined as violence that occurs among individuals aged 10–29 years who are unrelated and who may or may not know each other, and generally takes place outside of the home.

Gender Based Violence:

It is violence that is perpetrated against an individual based on their socially prescribed gender roles, expectations and norms. While GBV largely affects women and girls because of their socially subordinate status in relation to men and boys it is acknowledged that men and boys are also victims of violence because of their gender roles and expectations linked to ideas of masculinity. GBV infringes on victims/survivors human rights and reinforces the inequities between men and women often leaving life-long physical and emotional scars and sometimes resulting in death.

Gender-based violence (GBV) is a significant well-recognized threat to public health and human rights globally. The UN General Assembly Declaration on the Elimination of Violence Against Women defines GBV, or violence against women, broadly to include any act that results in or is likely to result in physical, sexual, or psychological harm or suffering, whether occurring in private or public life.

GBV is a manifestation of the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men and it is one of the crucial social mechanisms by which women/girls are forced into a subordinate position compared with men/boys.

Violence against women/girls includes:

Violence occurring **at home** (in the family), including battering, sexual abuse of female children in the household, dowry-related violence, marital rape, female genital mutilation and other

traditional practices harmful to women and girls, sexual intimate partner violence, non-spousal violence and violence related to exploitation.

Violence is occurring within the **general community**, including child marriage, abduction, rape, sexual abuse, sexual harassment and forced sexual debut, trafficking in women/girls and forced prostitution. It is also occurring at **workplace, school, and cyberspace** taking the form of bullying, stalking, harassment, forced sexual debut, intimidation.

At the individual level, adolescents are considered uniquely impacted by GBV. Their young age and relative inexperience with relationships can heighten their risk for physical and sexual IPV. Those involved with or married to older men or married at a very young age can face IPV and other dimensions of limited relationship power. Abuse during adolescence imparts risk for subsequent health concerns, including depression, suicidal ideation, chronic inflammation, and can set young women on a trajectory for subsequent abuse. Youth are also at high risk for sexual assault. The sexual initiation marking the transition into adulthood is often characterized by violence and coercion.

Burden of GBV:

According to a WHO-supported review, nearly 30% of cohabiting 15-19 year adolescent women experience violence by their partners with a regional range of 10%-30% in high income to 43% in low income countries. IPV is also common for school adolescents in romantic relationships with 10% prevalence rates for either sex in developing countries.

Evidence suggests that GBV is common in Ethiopia. In the 2005 EDHS, 81% of married women agreed that a husband can be justified in beating his wife with slight decrease in the EDHS 2011 (68%). Young unmarried women also commonly experience rape or other form of GBV. The Ethiopian Criminal Code of 2005 addresses human rights issues, women's and children's rights in particular including the criminalization and punishment of any act of GBV. Using various media, concerned government institutions and development partners have been educating the community about these laws, particularly the laws that criminalize GBV. However, knowledge of law against domestic violence among adolescents and youth is poor. In the 2011 EDHS, 53% of married adolescent women aged 15-19 do not know that there is such a law; and the lack of knowledge is similar across all age groups.

Value Clarification:

Values are sets of principles and rules that help and guide in decision making and orient oneself within a governing system. The following statements are reflection of the gender construction

of a society based on what they value. Based on your experience and understanding identify them as gender or sex:

1. Most building-site workers in Ethiopia are men since women can't engage in such tasks
2. Women often take responsibility for household chores because this is naturally their role
3. Men are naturally responsible to protect and care for the family
4. Boys are naturally active in public while girls remain shy since both are biologically meant to be so
5. Wife battering is normal, in fact it helps to discipline wife
6. Conflict and losing control is normal part of any relationship and it should not be a big deal
7. Girls/women should take responsibility for the violence they suffered
8. Women should tolerate violence to keep the family together
9. Forcing female partner into sex can't be considered rape
10. Most GBV is perpetrated by strangers

GBV encompasses a broad range of harmful acts: GBV can be psychological, sexual, emotional, or economic violence. It involves not only direct force, but also threats, intimidation and coercion. Violence does not have to be direct to be effective. The threat of violence can have a devastating impact on people's lives and the choices and decisions they make.

- **Physical violence**, e.g.: slapping, hitting, pushing, choking, shaking, spitting, restraining, use of weapons. May or may not cause injuries
- **Sexual violence**, e.g. rape, other forms of sexual assault, forced marriage, forced abortion, forced sterilization, female genital mutilation (FGM), trafficking, incest
- **Psychological violence**, e.g. Verbal abuse, intimidation/threats, emotional violence, constant criticism, humiliation, stress

Adolescent girls are at risk for child marriage, Incest, Sexual violence, trafficking and intimate partner violence. Forced and coerced sexual initiation is linked with contraceptive nonuse, condom nonuse, unintended pregnancy, and STIs, suggestive of a sexual trajectory of disempowerment stemming from trauma and lack of control at initiation. Violence, limited control, and sexual coercion and force continue to affect women as they transition into early adulthood, through many of the same pathways. This could lead to low birth-weight for newborns, higher pre-natal, neonatal, and infant mortality, morbidity and pregnancy-related complications. What makes this group peculiar is: they know little about services, lack of financial resources to access services and hesitant to seek services due to lack of confidentiality. In addition, they may not recognize the behavior of perpetrators as violent and they are afraid of not being believed or taken seriously thus they are less likely to report the incidence.

Causes of GBV

GBV is caused by a **combination of factors** that increase the risk of a man/boys committing violence and the risk of a woman/girls experiencing violence. The ecological framework is used to understand the multiple causes of GBV and their interrelationship. (See figure 9.1)

The **individual level** factors are more of biological and personal factors such as: Young age (early marriage), Pregnancy, low level of education, Past experiences of violence, and attitudes of violence as acceptable behavior.

The **relationship factors** focus on women/girls relationship with family and their peers. The following are some of relationship related factors:

- Men with multiple partners
- Disparities in education status between partners
- Family blaming the girls instead of the man for sexual violence

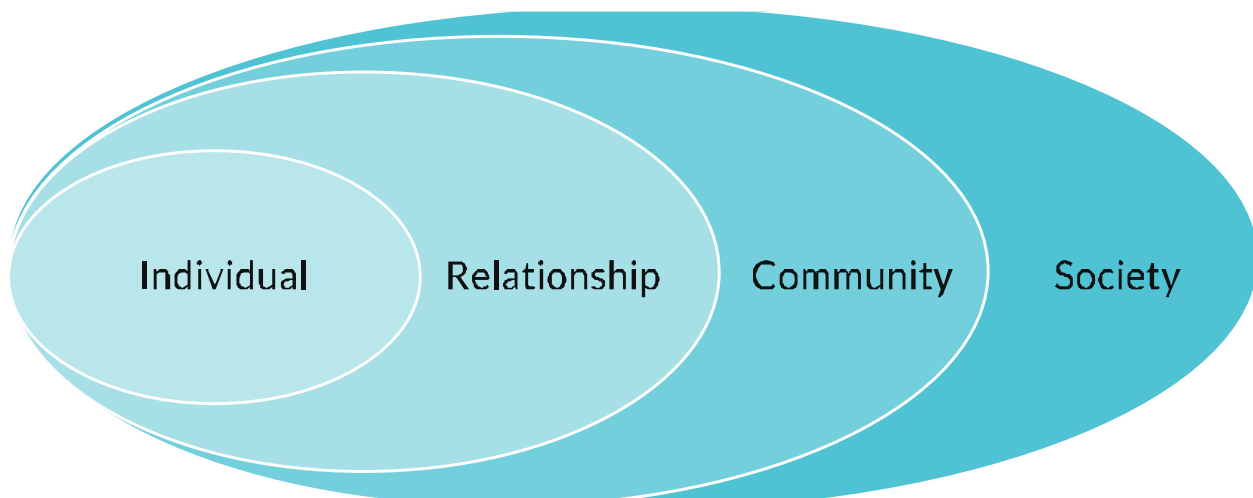


Figure 9.1 – Ecological frame, causes of GBV. Source Heise, 1988

The **community level factors** consider the Social relationships in school, workplace, and neighborhood. Societies with community sanctions against violence have the lowest levels of GBV in general.

The **societal level factors** considers: those cultural and social norms that shape gender roles. Higher GBV is reported specifically intimate partner violence is reported when men have economic and decision-making powers in the household. Ideology of male sexual entitlement also considers one of the societal level factors.

Myths about GBV:

The myths and stereotypical attitudes about GBV are harmful because they blame the survivor and not the perpetrator. It shapes society and the health sector's perceptions and responses which may prevent health care providers from identifying GBV and providing care. Health care providers need to distinguish between myths and facts and maintain a professional and impartial attitude. Some examples of myths about GBV:

- Battering is not a crime. Men have the right to control their wife's behaviour and to discipline them.
- Some women deserve the violence they experience.
- Battered women/girls allow abuse to happen to them. They can leave if they really wanted to.
- Conflicts and losing control are a normal part of any relationship.
- Domestic violence is a private family matter and therefore the state or service providers have no right to intervene.

Consequences of GBV:

The consequences of GBV are fast and can have severe negative health consequences for those who experience it. This can include the immediate physical consequences of a violent act but can also include long-term mental health consequences. These consequences depend on the type and severity of the incidence but can include but are not limited to: unintended pregnancies, HIV and other sexually transmitted infections, and even death.

The most significant social outcome of GBV is the stigma and the blame the victim must endure, especially after sexual violence. Survivors often feel extreme shame, and this shame may prevent them from disclosing their abuse to others or seeking the help they need, resulting in more psychological and emotional suffering, and often influences the behaviour of those who should be helping. The survivor may also be forced to endure other forms of violence because of the sexual violence – for example a young girl forced to go through secret society initiation because she is no longer a virgin.

Activity 9.2 Refer to Annex 1 and respond to the following questions

- What factors made the woman vulnerable to violence from her partner?
- What factors made the man violent?
- What were the consequences of violence for FF?
- How does violence affect MM and his children?
- How does the violence experienced by FF affect the community?
- What kind of relationship did Fatmata have with her neighbours?
- What did it mean for the contribution and participation of FF and her children in community life?
- What impact did it have on community resources such as health services social welfare services or the police?

Session 9.3: Health system response to GBV

The health sector is often the first point of contact for survivors of GBV and is a key entry point into the referral pathway to other sectors. For example, one study examining emergency department utilization by women who were ultimately killed by an intimate partner found that 44% of the women had sought help in an emergency department within the two years prior to their death which signifies the need for the health sector to be sensitive to GBV.

GBV survivors have different needs, depending on their individual situation, the severity of the violence experienced, and the consequences. However, regardless of the type or setting of the violence experienced, health care providers should consider the following standards and principles:

- Services are based on a gendered understanding of violence against women and focus on the human rights and safety of the victims.
- Services are based on an integrated approach, which takes into account the relationship between victims, perpetrators, children and their wider social environment.
- Services aim at avoiding secondary victimization.
- Services aim at the empowerment and economic independence of women victims of violence.
- Services allow, where appropriate, for a range of protection and support services to be located on the same premises.
- Services address the specific needs of vulnerable persons, including child victims, and services are made available to them.

Health care providers should have the skills to identify GBV survivors and do proper medical examination and provide medical care. This process should always be documented. In every contact with GBV survivors, risk assessment and safety planning should also be part of the management with possible referral to other services needed. Moreover, the health sector, in collaboration with other sectors, can contribute significantly to preventing and responding to GBV at various stages of the cycle of violence:

Primary prevention: refers to efforts to prevent violence from occurring in the first place. Examples of primary prevention activities include increasing community awareness of VAWG risk factors, healthy conflict resolution, challenging harmful gender norms, etc.

Secondary prevention: focuses on early identification of survivors (via screenings in emergency departments and reproductive, maternal and child services, for example), responding to their physical, mental, and reproductive health care needs, and referral to appropriate services.

Tertiary prevention: serves to mitigate the negative impacts of violence that has already occurred. Examples include long-term counseling, HIV post-exposure prophylaxis, and emergency contraception for rape victims.

Multi-sectoral Response to GBV

Though survivors of GBV often go to health facilities seeking first hand help, this does not limit the response to GBV to a sector. It must be a multi-sectoral response addressing the social, psychological, economy, and legal aspects associated with GBV.

Referral to social, economic and legal support: given that women/girls experiencing physical violence will likely seek health services at some point, health care providers are favorably positioned to refer survivors to other services to address their immediate needs and prevent future incidents of violence from occurring.

Ethical conduct in GBV Management

Any intervention that aims to prevent or address GBV should include precautions above and beyond routine risk assessment to guarantee no harm is caused. This includes following ethical guidelines related to: respect for persons, non-maleficence (minimizing harm), beneficence (maximizing benefits), and justice to protect the safety of both service providers and the survivors.

The three main principles that guide the conduct of those working to prevent and respond to acts of violence against women are:

- **Respect:** for the wishes, rights, and dignity of the survivor and be guided by the best interests of the child
- **Confidentiality:** at all times, except when the survivor or the service provider faces imminent risk to her or his well-being, safety, and security
- **Safety and security:** ensure the physical safety of the survivor and those who help her

The sensitive nature of collecting information about GBV demands additional precautions above and beyond routine risk assessments to guarantee no harm is caused. Interventions should:

- **Assess whether the intervention may increase GBV:** Examine pre-existing gender vulnerabilities such as gender discrimination, gender-based exclusion, unequal gender norms, or institutional weakness. Assess how the interaction of these factors, in combination with the intervention, may contribute to increased VAWG. Identify and add elements to prevent or mitigate this risk.

- **Minimize harm to women and girls:** A woman may suffer physical harm and other forms of violence if a partner finds out that she has been talking to others about her relationship with him. Because many violent partners control the actions of their girlfriends or wives, even the act of speaking to another person without his permission may trigger a beating. As such, asking women about violence should be confidential, and should take place in complete privacy, with the exception of children under the age of two. Informed consent for any data collection, even as part of a case file, should be offered and if anonymity can be guaranteed, it should also be provided. The project staff must be trained on how to preserve the safety of women while interviewing/collecting data on this topic.
- **Prevent re-victimization of GBV:** Promote use of the Gesell Dome system by justice system personnel for obtaining testimonies of survivors of violence to avoid the re-victimization of women through a) telling their story in front of an audience and b) repeating their statement various times. If this mechanism is not available, record survivor statements.
- **Consider the implications of mandatory reporting of suspected GBV cases:** Certain countries have laws that require professionals (including health care providers) to report cases of suspected abuse to authorities or social service agencies. Such laws are challenging because they can conflict with key ethical principles: respect for confidentiality, the need to protect vulnerable populations, and respect for autonomy. In the case of adult women, there is consensus that the principles of autonomy and confidentiality should prevail.
- **Minimize harm to staff working with survivors:** Given the high prevalence of GBV globally, it is likely that a substantial proportion of service providers will have experienced it themselves at some point. Even for those service providers or project staff who have not experienced GBV, hearing about experiences of violence can induce vicarious trauma. Ensure there is a supportive venue, ideally another trained professional (such as a psychologist) for staff to debrief and share their concerns.
- **Provide referrals for care and support for survivors:** at a minimum, professionals working with adolescents in a situation of violence have an ethical obligation to provide them with information or services. Where specific violence-related services are available, develop a detailed directory professionals can use to make referrals, and consider developing a small pamphlet with listed resources that can be given to adolescents.

Chapter Summary:

- Gender-based violence is violence that is perpetrated against an individual based on their socially prescribed gender roles, expectations and norms
- A good proportion of adolescent in marital union as well as in relationship face gender based violence. Forced sexual debut and sexual intimate partner violence are common in adolescents and youth. It is fairly prevalent both in developed and developing countries.
- GBV is caused by a **combination of factors** that increase the risk of a man/boys committing violence and the risk of a woman/girls experiencing violence. The violences take different forms: physical, sexual, and psychological, and are happening at home, within the community, workplace, at schools, and in the cyberspace.
- GBV is a basic human right violation.
- The consequences of GBV can include the immediate physical consequences of a violent act but can also include long-term mental health problems and also death.
- The health sector is the first point of contact for survivors of GBV and is a key entry point into the referral pathway to other sectors. Consequently, the health sector, in collaboration with other sectors, can contribute significantly to preventing and responding to GBV at various stages of the cycle of violence.
- Handling of GBV victims require empathy and strictly follow ethical guidelines for both the victim as well as the service provider.
- Responses are expected to be both prevention and supporting survivors which requires policy and program level attention.

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Annex 1: The story of FF and MM

“FF lived with her husband, MM, and her three children in a small house near the market. When they got married, MM paid a high bride price to her family and, from the beginning, expected FF to work hard to make up for it. He would often tell her that he had paid a good price for her so she better work and be a good wife, or else he would send her back and demand the money back from her family.

FF worked from early in the morning until late in the evening selling vegetables in the market. When she got home, she would be tired, but she had to cook dinner, fetch water, wash clothes, and look after her young children as well.

MM would take the money that FF earned at the market and would go out in the evening. He would not come home until late, and often, he would be drunk and start shouting at FF. He would beat her in front of the children. Sometimes he would make her sleep outside to punish her if the food was cold or not cooked to his liking and to show the neighbours that he was the boss in his house. Many of their neighbours were afraid of MM and ignored FF. FF was too ashamed to talk with her friends or neighbours about MM. Although they would often see her with bruises on her face, they just kept quiet.”

Chapter 10: Non-Communicable Diseases (NCD)

Session 10.1 Session Outline and Learning Objectives:

Duration: 75 Minutes

Session outline

- Global Overview of NCDs and the context in Ethiopia
- Prevention of Cervical Cancer in Ethiopia
- Injury during Adolescence and Youth

Learning objectives:

By the end of this chapter participants will be able to:

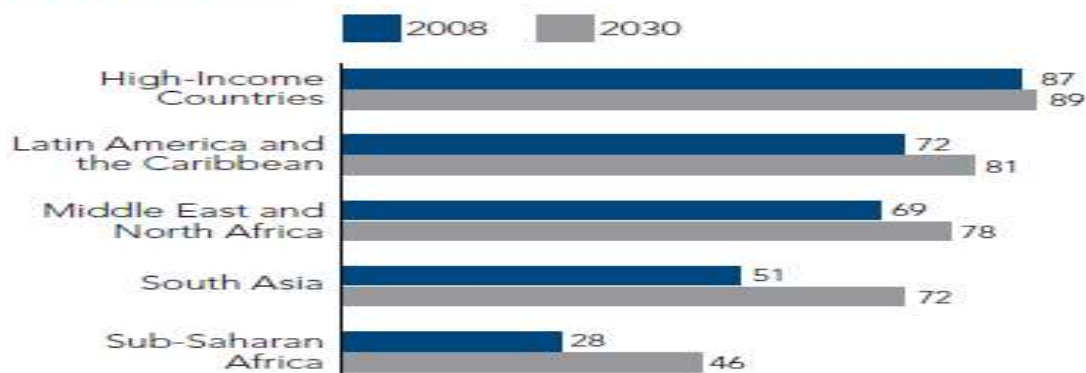
- Demonstrate understanding about NCD and their risk factors and prevention approach
- Discuss the common risk factors and methods of prevention of cervical cancer during adolescence and Youth
- Define injury in the context of adolescence and youth,
- Describe the current status of injury among adolescence and youth population
- Identify common risk factors , consequences of injury and approaches towards injury prevention
- Demonstrate readiness to promote healthy behaviors among adolescents and youth

Session 10.2: Global Overview of Non-Communicable Diseases and the Context in Ethiopia

Non-communicable Diseases affect large numbers of people under the age of 60 and pose a huge toll on health, the economy, and human potential. The prevalence of NCDs is related to unhealthy behaviors and practices typically initiated in adolescence. Given that a third of Ethiopian population is between the ages of 10 and 24, these unhealthy behaviors among young people will have a direct effect on their risk of developing NCDs later in life. Building a healthier future depends on effective interventions during this critical window of opportunity. NCDs are especially important for young people, now and in the future. Two thirds of premature deaths in adults are associated with childhood conditions and behaviors, and behavior associated with NCD modifiable risk factors is common in young people: WHO estimates over 150 million young people smoke; 81% adolescents don't get enough physical activity; 11.7% of adolescents partake in heavy episodic drinking and 41 million children under 5 years old are overweight or obese.

Cardio-vascular diseases (CVDs), diabetes, cancer, chronic respiratory diseases and mental health problems are the major non-communicable diseases (NCDs) worldwide. Globally, they account for 60% of all deaths and 80% of these deaths occur in low and middle income countries. Approximately 42% of all NCD deaths globally occur before the age of 70 years; 48% of NCD deaths in low- and middle income countries and 28% in high-income countries were in individuals under the age of 70 years.

Percent of Total Deaths Attributed to NCDs by Region



Source: Irina A. Nikolic, Anderson E. Stanciole, and Mikhail Zaydman, "Chronic Emergency: Why NCDs Matter," World Bank Health, Nutrition and Population Discussion Paper (2011).

In Ethiopia, NCDs are recognized as emerging public health problems and accounted for 30% of deaths in 2014. In a study conducted among working adults in Addis Ababa, the prevalence of diabetes mellitus was 6.5% and the prevalence of hypertension was 19.1% with higher

proportion among males (22%). Not only the NCDs but their risk factors are also fairly prevalent. An estimated 3.3% of adults use some form of tobacco, while the prevalence among very young adolescents (aged 13–15 years old) is estimated to be much higher rate of 7.9%; these figures also vary between regional states. Also, an estimated 9% of males and 25% of females, and 11% of rural and 20% of urban populations have insufficient levels of physical activity.

In addition to the above mentioned NCDs, mental health problems and injuries have gained greater emphasis recently especially, in the Adolescent and Youth population; as these two contribute significantly to morbidity and mortality in the same population.

Risk factors of NCDs

The four major NCDs share common modifiable risk factors: the behavioral risk factors consist of tobacco use, physical inactivity, unhealthy diet, and harmful use of alcohol. The metabolic/physiological risk factors include, raised blood pressure, overweight/obesity, high blood glucose level and hyperlipidemia. These biological risk factors are actually the result of those behavioral risk factors. In terms of attributable deaths, tobacco is the leading behavioral risk factor which accounts for 6 million deaths every year globally while, elevated blood pressure contributed to 18% of global deaths. In addition to the four common risk factors, NCDs also have other risk factors that include infectious causes such as Hepatitis B & C, Human Papilloma Virus, HIV, Helicobacter pylori, Schistosomiasis, and the Liver Fluke. Infectious causes of non-communicable diseases are more highly prevalent in developing countries.

Global Initiative in the Prevention and Control of Non-communicable Diseases

The World health assembly has taken different actions to support the national initiatives in combating the non-communicable diseases. These efforts included: (1)the adoption of comprehensive global monitoring framework with 25 indicators and nine voluntary global targets for 2025; and (2)endorsing the Global action plan for the prevention and control of NCDs 2013–2020 (Global NCD Action Plan 2013–2020).

The Global action plan has six objectives aimed at strengthening national capacity, multi-sectoral action and boosting international cooperation to reduce exposure to risk factors, strengthen health systems, and monitor progress in attaining the global NCD targets. Ethiopia has also indorsed the targets and develops its own national strategy

The following are the global targets for NCD from 2013 to 2020:

- Global target 1: A 25% relative reduction in overall mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases

- Global target 2: At least 10% relative reduction in the harmful use of alcohol as appropriate, within the national context
- Global target 3: A 10% relative reduction in the prevalence of insufficient physical activity
- Global target 4: A 30% relative reduction in the mean population intake of salt /sodium
- Global target 5: A 30% relative reduction in prevalence of current tobacco use in persons aged 15+ years
- Global target 6: A 25% relative reduction in the prevalence of raised blood pressure, or contain the prevalence of raised blood pressure, according to national circumstances
- Global target 7: Halt the rise in diabetes and obesity
- Global target 8: At least 50% of eligible people receive drug therapy and counselling (including glycaemia control) to prevent heart attacks and strokes
- Global target 9: An 80% availability of the affordable basic technologies and essential medicines, including generics, required to treat major NCDs in both public and private facilities

Why focus on NCDs during Adolescence and Youth

Prevention of the occurrence of NCDs through interventions which target the shared modifiable risk factor is the way to go about it. Although the level of NCDs among adolescent and youth is low compared to the adult population, the modifiable behavioral risk factors also lead to other forms of NCDs- mental health illnesses and injuries- which are the common causes of morbidity and mortality in this group. Besides, interventions targeting this group create a critical opportunity to curb NCDs everywhere. Adolescence and youth is a time of experimentation and identity formation when individuals adopt certain risk behaviors and such behaviors continue to adulthood and increase their risk of developing NCDs and suffer their consequences.

According to WHO 70% of premature deaths in adults worldwide are the result of behaviors begun in adolescence. Therefore, interventions that address the precursors of these modifiable risk factors of NCDs could encourage positive health behaviors, and discourage negative ones in young people and reduce the risk of NCD significantly in the adult population. The positive behaviors established during childhood or adolescence is more likely to be carried through adulthood. The same with the risk behaviors and the earlier people begin using harmful substances such as alcohol, the greater the risk of abuse and dependence and it will be difficult to change these behaviors later in life.

Session 10.3 Prevention of Cervical Cancer in Ethiopia

Cervical cancer is one of the leading causes of cancer deaths globally. It is caused by persistent infection with one or more of the high risk or oncogenic types of human papilloma virus (HPV). HPV is sexually transmitted, and the most common viral infection of the reproductive tract. Almost all sexually active individuals will be infected with HPV at some point in their lives and some may be repeatedly infected. The peak time for infection is shortly after becoming sexually active.

The majority of HPV infections resolves spontaneously and do not cause symptoms or disease. However, persistent infection with specific types of HPV (most frequently, Genotypes 16 and 18) may lead to precancerous lesions. If untreated, these lesions may progress to cervical cancer. Globally, around 70% of invasive cervical cancers are attributable to infection with HPV-16 and 18. Genotype 16 was the most frequent HPV identified in samples from Ethiopia, followed by other genotypes HPV 52, 58, and 18.

Cervical cancer is one of the three most prevalent cancers in Ethiopia; breast cancer is the most common of all (30.2%), followed by cancer of the cervix (13.4%) and colorectal cancer (5.7%). About two-thirds of reported annual cancer deaths occur among women. It is also one of the commonest cancers in young adults including brain and other central nervous system tumors, breast and colorectal cancers. According to FMOH Cervical Cancer Prevention guideline, in 2010, it was estimated that 20.9 million women were at risk of developing cervical cancer in Ethiopia with an estimated 4,648 and 3,235 annual numbers of new cases and deaths, respectively.

There are different factors that contribute for the development of cancer among adolescent and youth in Ethiopia which are early initiation of sex, practicing risky sexual behaviors among adolescents including multiple sexual partners, unprotected sex, transactional and trans-generational sex practices.

Approximately 40% of cancers are preventable through interventions such as tobacco control, promotion of healthy diets, physical activity, vaccination and protection against exposure to environmental carcinogens. In Ethiopia, the innovative Health Extension program and the Health Development Army have huge potential, and could be instrumental for the successful implementation of cancer preventive activities in the country.

Prevention of Cervical Cancer among Adolescent Girls

The primary prevention interventions for cervical cancer are cost-effective and focus on reducing exposure to the modifiable risk factors at individual and community levels. The

primary prevention can be achieved through behavioral change approaches and the use of biological mechanisms, including HPV vaccination. Abstinence from sexual exposure, being mutually faithful and consistent condom use can reduce the risk of HPV transmission. Condoms only offer partial protection against HPV transmission, because the virus can exist on body surfaces not covered by the condom, such as the perianal area and anus in men and women, the vulva and perineum in women, and the scrotum in men. Despite this, consistent and correct condom use is highly recommended

Advocacy for HPV vaccine is also part of the prevention interventions against cervical cancer and targets key stakeholders: policymakers, health professionals, adolescents, women, men and the community at large. Although girls are at a greater risk of the infection and are targets for the vaccination, appropriate messages should also consider boys.

The Federal Ministry of Health has developed a national guideline for the prevention and control of cervical cancer in 2015. This guideline outlines the key interventions including the HPV vaccination program.

HPV Vaccination Program:

HPV vaccination program may be cost-effective in countries where high-quality cervical cancer screening is not widespread, and vaccination coverage is high (>70%). If used, HPV vaccination should be a part of a coordinated strategy, including appropriately targeted messages to different audiences.

Adolescent girls of age 9-14 years are the current target for HPV vaccinations. Delivering HPV vaccine to these target groups requires a systematic approach such as, school based, health facility based, outreach or a combination of either structure. So far, HPV immunization has already been introduced and being demonstrated in two districts (Gomma and Ahferom), in the public sector in Ethiopia. **The vaccine is given to girls in the age range of 9-14 years in 2 doses, 6 months apart. Gardasil, a quadrivalent vaccine, that address HPV genotypes 6,11,16 and 18 was used with the aim of preventing the viral risk factor for cervical cancer and other ano-genital warts. Since the first year of this small scale demonstration project is showing a promising result,** promotion and scale up of implementation of HPV vaccine programs for adolescents nationally is commendable.

Prevention of cancer especially when integrated with other programs, such as, immunization, reproductive health, HIV/AIDs, occupational and environmental health, offers the greatest public health potential and most cost effective long-term method of cancer control.

Community Mobilization, Education and Counseling:

- Outreach, community mobilization, health education and counseling are essential components of an effective cervical cancer prevention and control program to ensure high vaccination coverage, high screening coverage and high adherence to treatment.
- Outreach strategies must reach and engage young girls and women who would most benefit from vaccination and screening, respectively, as well as men and boys and leaders in the community, and key stakeholders.
- Community mobilization and health education are essential tools for overcoming common challenges that impede access to and utilization of preventive care; these common barriers include social taboos, language barriers, lack of information and lack of transportation to service sites.
- Health education ensures that women, their families and the community at large understand that cervical cancer is preventable.
- Health education messages about cervical cancer should reflect the national policy and should be culturally appropriate and consistent at all levels of the health system.
- Health-care facilities should have a private room that can be used to provide individual women with information and counseling, if appropriate, to help them make the best choices for their health.
- Health-care providers should be trained to discuss sexuality in a non-judgmental way and to address issues related to cervical cancer and human papilloma virus (HPV) while protecting patient privacy and confidentiality.
- It is critical that educational messages emphasize that women with abnormal screening results must return for follow-up.

Session 10.4: Injury during Adolescence and Youth

Definition:

Injury is any physical harm or damage to someone's body caused by an accident or an attack. Injuries are defined as damage to a person caused by an acute transfer of mechanical, thermal, electrical, chemical, or radiation energy or by the sudden absence of heat or oxygen. There are two classes of injuries. Unintentional injuries are a subset of injuries for which there was no evidence of predetermined intent, and the definition included motor vehicle injuries, suffocation, drowning, poisoning, burns, falls, sports and recreation. Intentional Injuries are injuries inflicted purposefully by someone else or oneself such as: Interpersonal violence (homicide, sexual violence), Self-Harm (e.g. Attempted suicide, self-mutilation) and war, civil insurrection.

Burden of Injury

The World Health Organization (WHO) estimates that around 875 000 children and adolescents under the age of 18 years die every year as the result of injury, although recent community-based studies conducted by UNICEF suggests that this number could be much higher. Aside 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 of these injuries on society is tremendous: every day, thousands of families are robbed of their children and thousands have to learn to cope with the consequences of their injury, which, in some cases, can be both long-lasting and profound.

Unintentional injuries are the leading cause of death among young people, especially road traffic accidents. Of the estimated 195,000 adolescents killed each year in traffic accidents, more than 60% are boys (WHO GPE 2000). Many of these traffic accidents are related to the use of alcohol and other psychoactive substances. For every young person killed in traffic accidents, an estimated 10 more are seriously injured. More than 95% of all unintentional childhood injury deaths occur in low-and middle-income countries. Within the high-income countries there is also a strong socioeconomic gradient of child and adolescent injury, with children from poor families being considerably more likely to sustain an injury than their more affluent counter parts.

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

In Ethiopia, injuries due to road traffic accidents, physical fights and drowning account for 9% of the mortality caused by NCDs (WHO, 2008). In 2013 alone, there were 2,581 road traffic fatalities with 377,943 registered vehicles (WHO, 2013). This translates to 68 deaths per 10,000 vehicles, 18 deaths per 100,000 people, or 15,000 annual deaths. Ethiopia bears one of the highest burdens of road traffic deaths while comparatively the density of vehicles is lower than other similar countries.

In the recent STEPS survey report by EPHI (2015), about 3% of respondents in all age groups were involved in a road traffic accident during the 12 months period before the survey. More men (3.3%) were involved in road traffic crash than women (1.9%), but there was no rural (2.6%) and urban (2.8%) difference. Among adolescents and youth (15-29), the prevalence was 2.7% (3.2% male and female 2%). In the report, the prevalence of non-road traffic accidents was 2.4% (3% among males and 1.6% female). The common non road traffic accidents were fall, burn, poisoning, cut, drowning, animal bites and violent injuries (EPHI, 2015).

Ethiopia has put in place an institutional framework for road traffic safety with the National Road Traffic Council as the lead agency and is implementing a national road safety strategy. However, safer vehicle standards are partially in place and not comprehensively implemented. Safety laws despite being passed are not adequately enforced. Emergency and mobile ambulance services are limited. The same WHO report indicated that fewer than 10% of the seriously injured were transported by ambulance during the same year. Community actions to promote road safety (including the passing of safety laws that are well enforced) and public education that targets adolescents and youth on how to avoid accidents are key challenges.

Consequences of Injuries:

Consequences of losing a child unexpectedly leaves families and communities with emotional wounds that take decades to heal and which, for many parents, never do. The pain is even greater if simple measures could have prevented the incident that caused the death in the first place. Even when the outcome is not fatal, the medical costs and the special care that is often needed for a severely injured or disabled child can place a huge financial burden on parents and create challenging practical and emotional difficulties for families.

Examples of injury-related impairments:

- Physical and/or cognitive limitations due to neuro-trauma
- Paralysis due to spinal cord trauma
- Physical limb deformation or/and Partial or complete amputation of limbs
- Psychological trauma
- Sensory disability such as blindness and deafness

Preventing injuries and violence: the role of the health sector

The prevention of violence and injuries also shares with other public health priorities the fact that the solutions usually require the involvement of a range of sectors – addressing the underlying economic, social, legal and environmental factors. Health sector takes the coordinating role across sectors to mitigate incidence of injury and violence.

Effective strategies to prevent violence and injuries include setting and enforcing laws on a range of issues from speeding and smoke detectors to hot water tap temperatures and window guards, among others; reducing the availability and use of alcohol; limiting access to firearms, knives, pesticides and certain medications; implementing vehicle and safety equipment standards; installing barriers controlling access to water, including wells and swimming pools; and improving emergency trauma care. These are all strategies where both national and local government officials from across multiple sectors can play a role.

Preventing youth violence requires a comprehensive approach that addresses the social determinants of violence, such as income inequality, rapid demographic and social change, and low levels of social protection. Even though multi-sectoral actions are required for effective prevention response, community, schools and health facility-led prevention interventions are key ones.

Prevention of injury at community: Community level awareness activities and community mobilization could target risk factors such as limiting access to firearms, knives, pesticides and medications. Ensuring safety of living environments of adolescents and youth are also important aspects of community level prevention. For instance, construction of speed bumps, installation of barriers around swimming pools and water points and putting in place smoke detectors (when feasible) around houses are important prevention features.

Safety features for motor bicycle drivers and seat belt during vehicle driving and enforcement of laws preventing use of alcohol and khat during driving are also important.

Measures that prevent access to alcohol and illicit drugs for younger adolescents and substance abuse prevention programs need to be instituted. Moreover, community policing can further support the prevention of interpersonal violence and violence perpetrated by families on adolescents and youth.

Health Development Army supported by HEWs lead the community level prevention and community mobilization efforts. The community mobilization not only targets prevention efforts but also addresses beliefs and Harmful Traditional Practices causing injury among adolescents and youth. Media-led awareness raising activities both involving the print and electronic media could also be used to address wider segments of the community.

These are all strategies where both national and local government officials across multiple sectors can play a role.

Prevention of injury at schools: Awareness raising activities, life skill programs and bully prevention activities are among the activities that are done at schools level. Parents-Teachers-Associations (PTAs) ensure the collaboration of parents towards prevention of injury and parental counseling on prevention of different forms of injury are among prevention strategies. Screening for and referral of mental health problems predisposing to injury and pre-health facility care (First Aid) and early referral of injured patients are important prevention measures which could be implemented at schools with the support from the health system.

Prevention at health facility: Health facilities at all health tier level should lead prevention of injuries through various approaches. Health facilities at all levels routinely conduct health

education and SBCC activities as part of their routine operations. Health facilities also conduct screening of youth and adolescents at risk of injury such as those with mental illness, with disabilities etc. Health facilities down the health tier conduct referral services to the next tier to prevent disability and death. Table one summarizes the possible prevention interventions the health sector can engage in.

Table 10.1: Selected Violence and Injury prevention interventions among adolescents and youth

Intentional and Unintentional Injuries	Role of the health sector
Reducing the availability of alcohol during high-risk periods	Lead
Reducing economic inequalities	Advocate, collaborate and evaluate
Strengthening social security systems	Advocate, collaborate and evaluate
Intentional Injuries	
Life skills training programmes	Advocate, collaborate and evaluate
Preschool enrichment, to strengthen bonds to school, raise achievement and improve self-esteem	Advocate, collaborate and evaluate
Home–school partnership programmes promoting the involvement of parents	Advocate, collaborate and evaluate
Educational incentives for at-risk high-school students	Advocate, collaborate and evaluate
Family therapy for children and adolescents at high risk	Lead
School-based programmes to prevent violence in dating relationships	Advocate, collaborate and evaluate
Training health-care providers to detect intimate partner violence and to refer cases	Lead
Self-inflicted injury	
Restricting access to the means of self-inflicting violence – such as to pesticides, medications and unprotected heights	Lead
Preventing and treating depression, alcohol and substance abuse	Advocate, collaborate and evaluate
School-based interventions focusing on crisis management, the enhancement of self-esteem, and coping skills	Advocate, collaborate and evaluate
Unintentional injuries	
Road traffic accident	
Introducing and enforcing motorcycle helmet laws	Advocate, collaborate and evaluate
Speed-reduction measures	Advocate, collaborate and evaluate
Introducing and enforcing laws on blood alcohol concentration limits	Advocate, collaborate and evaluate
Drowning	
Use of personal floatation devices	Advocate, collaborate and evaluate
Introducing and enforcing laws on pool fencing	Advocate, collaborate and evaluate

Teaching how to swim	Advocate, collaborate and evaluate
Covering bodies of water, such as wells	Advocate, collaborate and evaluate
Safety standards for swimming pools	Advocate, collaborate and evaluate
Properly trained and equipped lifeguards	Advocate, collaborate and evaluate
Falling	
Safety mechanisms on windows, such as window bars in high-rise buildings	Advocate, collaborate and evaluate
Stair gates	Advocate, collaborate and evaluate
Impact-resistant surfacing material on playgrounds	Advocate, collaborate and evaluate
Safety standards for playground equipment	Advocate, collaborate and evaluate
Muscle-strengthening exercises and balance training for older adults	Advocate, collaborate and evaluate
Checking and if necessary modifying potential hazards in the home, where there are individuals at high risk	Advocate, collaborate and evaluate
Educational programmes encouraging safety devices to prevent falls	Advocate, collaborate and evaluate
Source: WHO. Preventing Injuries and Violence: a Guide for Ministries of Health. World Health Organization. 2007	

Care for the injured

Critical to reducing the immediate consequences of youth violence are improvements in pre-hospital and emergency care, including access to care. Although the ultimate goal must be to prevent injuries from happening in the first place, much can be done to minimize the disability and ill-health arising from the injuries that do occur despite the best prevention efforts.

Providing quality adolescent and youth friendly support and care services, including appropriate referral linkage to victims is therefore an essential component of any response to intentional and unintentional injuries. Appropriate services for victims of non-fatal injuries can prevent future fatalities, reduce the amount of short-term and long-term disability, and help those affected to cope with the impact of the injury event on their lives.

Summary:

- Cardio-vascular diseases (CVDs), diabetes, cancer, chronic respiratory diseases and mental health problems are the major non-communicable diseases worldwide.
- Cervical cancer is a preventable disease and it is one of the prevalent cancers in Ethiopia.
- Cervical cancer is caused by sexually transmitted HPV, which is the most common viral infection of the reproductive tract.

- There are different factors that contribute for the development of cancer among adolescent and youths in Ethiopia which is early initiation of sex, practicing risky sexual behaviors among adolescents including multiple sexual partners, unprotected sex, transactional and trans-generational sex practices.
- Primary prevention interventions are cost-effective approaches to reduce exposure to the modifiable risk factors at individual and community levels.
- Abstinence from sexual exposure, being mutually faithful and consistent condom use can reduce the risk of HPV transmission.
- HPV vaccination program may be cost-effective in countries where high-quality screening is not widespread, vaccination coverage is high (>70%), and the cost of a two-dose course is low.
- Injury is one of the public health problems among adolescents and youth. Unintentional injury specially, road traffic accident are the leading causes of mortality in this population.
- The consequences of injury ranges from physical disability to psychological harm.
- The role of the health system in preventing injury among adolescents and youth is to take a lead, advocate and bring the other stakeholder together to act up on.

Annex 1

Spot checks

1. Among sexually active adolescent girls Cervical cancer mostly caused by:
 - A. The sexually transmitted Human Papilloma Virus (HPV)
 - B. Gonorrhoea
 - C. Syphilis
 - D. Unknown cause
2. What are the different factors that contribute for the development of cancer among adolescent and youths?

3. List the Primary prevention interventions of cervical cancer among adolescent girls?

4. What percentage of invasive cervical cancers is attributable to infection with HPV-16 and 18?

a.25%	b.55%
c.70%	d.100%

5. Which of the following **is not** a risk factor for cervical cancer?
- a) Smoking
 - b) Early age of sexual intercourse
 - c) Multiple Pregnancy
 - d) Multiple sexual partners
6. During counseling, the Adolescent should be told about the relationship between HPV and the risk of cervical cancer. a) True a) False

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Chapter 11: Common Mental Health Problems and Psychoactive Substance Use during Adolescence and Youth

Session 11.1 Session Outline and Learning Objectives

Duration: 90 Minutes

Session outline

- Adolescent and Youth Common Mental Health
- Use of Psychoactive Substances by Adolescent and Youth

Learning objectives:

By the end of this chapter participants will be able to:

- Identify the common mental illness during adolescence.
- Describe common patterns of substance use (tobacco, alcohol, other psychoactive substances) in adolescence, including experimentation.
- Communicate effectively with an adolescent about substance use, use disorder and implement an appropriate intervention plan as needed.
- Describe evidence-based approaches to prevention of substance use and substance use disorders
- Demonstrate the ability to promote healthy behaviors among adolescents and youth

Session 11.2: Adolescent and Youth Mental Health

Common mental health burden in adolescents and youth

WHO defines mental health as: “a state of well-being in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make contributions to his or her community”. It should be also noted that the definition does not refer exclusively to the absence of “mental illness”, but also addresses the concept of “mental wellness”.

Worldwide 10-20% of children and adolescents experience mental disorders. Half of all mental illnesses begin by the age of 14 and three-quarters by mid-20s. These conditions are the leading cause of disability in young people in all regions. If untreated, these conditions severely influence adolescent’s development, their educational attainments and their potential to live fulfilling and productive lives. Adolescents with mental disorders face major challenges with stigma, isolation and discrimination, as well as lack of access to health care and education facilities, which violets their fundamental human rights. The National Mental Health Strategy of Federal Democratic Republic of Ethiopia valued integrating mental health with the existing primary health care level activities and to make sure that the mental health services are accessible for everyone including adolescents and youth.

A systematic review conducted to determine rates of psychopathology in children and adolescents in sub-Saharan Africa in 2012 reported an overall prevalence of 14.5% for up to 16 years of age. In Ethiopia, mental illness in children and adolescents is estimated to be between 17 and 23% in the country, though lower estimates were found in a rural setting.

Table 11.1The burden of mental health Problem in Ethiopia

Mental Illness	Prevalence/incidence per 10,000 population
Schizophrenia	50
Bipolar disorder	50
Depression	500
Suicide	0.77
Suicide attempt	320
Alcohol problem drinking	370
Alcohol dependence	150
Cannabis use	150
Childhood mental illness	1200-2500
Source: FDRE-Mental Health Strategic Plan	

The most commonly reported mental disorders among adolescent and youth are depression, anxiety, eating disorder, attention deficit hyperactivity disorders and substance misuse. The less common ones include: panic disorder, post traumatic distress, borderline personality disorder, schizophrenia are reported in the some population. In Ethiopia, there is limited evidence as to which disorder is common in these groups.

Recognizing Mental health problems in Adolescents and youth: although these problems are fairly common often go unnoticed, because change of mood and temporary deviant behaviours are part of the normal adolescent process and many young people will experiment with drugs or certain behaviours as part of normal exploration of their own identity. Unless one makes closer look to the duration, persistence, and impact of the symptoms, the symptoms may be dismissed as mere reflection of adolescence turmoil. Moreover, often young people are reluctant to seek help when they are in-need.

Thus it is imperative for one to look into the following three aspects of the symptoms adolescent presented with:

Duration—Consider as potentially harmful any problems that last more than a few weeks; reassess mental state on several occasions

Persistence and severity of fixed symptoms—Loss of normal fluctuations in mood and behaviour

Impact of symptoms—School work, interpersonal relations, home and leisure activities

The following symptoms need careful assessments by the clinician:

- Signs of overt mood depression (low mood, tearfulness, lack of interest in usual activities)
- Somatic complaints such as headache, stomach ache, backache, and sleep problems
- Self-harming behaviours
- Aggression
- Isolation and loneliness
- Deviant behaviour such as theft and robbery
- Change in school performance or behaviour
- Use of psychoactive substances, including over the counter medications
- Weight loss or failure to gain weight with growth

General approach when assessing Adolescents with mental illness or Substance use disorders

1. The service provider should clearly communicate the value of hearing the story from an adolescent's point of view and must be careful to **reserve judgment and not assign blame**. Some adolescents approach the interview with apprehension or hostility, but open up when it becomes evident that the clinician is neither punitive nor judgmental.
2. It is advisable to interview the adolescent alone first and involve their attendance later. That is because they may be concerned about **confidentiality**, and the service provider can assure them that permission will be requested from the adolescent before any specific information is shared with parents, except situations involving danger to the adolescent or others, in which case confidentiality must be sacrificed.
3. Adolescents can be approached in an open-ended manner; however, when silences occur during the interview, the clinician should **attempt to reengage the patient**.
4. The service provider must be aware of his/her own responses to adolescents' behavior (counter transference) and stay focused on the therapeutic process even in the face of defiant, angry or difficult teenagers.
5. The service provider should set appropriate limits and should postpone or discontinue an interview if you feel threatened or if patients become destructive to property or engage in self-injurious behavior.
6. Every interview should include an **exploration of suicidal thoughts, assaultive behavior, psychotic symptoms, substance use, and knowledge of safe sexual practices along with a sexual history**.

Once rapport has been established, many adolescents appreciate the opportunity to tell their side of the story and may reveal things that they have not disclosed to anyone else.

Risk factors of mental health problems in AY:

Risk factors of mental health problem in adolescents and youth can be classified in to biological, psychological, social factors, and environmental factors. The biological factors range from exposure to toxins during pregnancy to malnutrition and substance abuse by the adolescents/youth. Good physical health and intellectual functioning are considered protective biological factors against mental health problems in this age group.

The psychological factors such as maladaptive personality traits, learning disorders, experiencing sexual, physical, emotional abuse and neglect are considered some of the risk factors of mental health problems in this age group. In the contrary, good self-esteem, social skills, ability to learn from experience are some of the protective factors.

The social factors classified further in to family, school and community level factors. Young people living in families with parental mental disorder or substance abuse, conflict between parents, marital violence, and breakdown, are at greater risk of mental disorders. Experiencing death of a family member could also increase the risk of developing mental health problems in the same population. Students who experienced academic failure, bullying in school could increase the risk of mental health disorders in these population. Schools should provide appropriate environment to support attendance and learning and provide adequate education to help curb the risk of mental health disorders. Creating opportunities for involvement in school life, positive reinforcement for academic achievement could serve as a positive energy to prevent mental health disorders by schools. The community factors such as community disorganisation, discrimination and marginalisation and exposure to violence are also considered important risk factors in this population.

The environmental factors include man made calamities like war and natural disaster like flooding, earth quake and landslides. This are emotionally overwhelming circumstances that affects significant portion of the affected community with both acute psychological crises and long term mental health problems like trauma related mental illness and other mental health problems.

Consequences of Mental Health Problems in AY:

When unrecognized, mental health disorders are associated with low educational performance, increased risk taking behaviour, substance use, indulging in crime, poor sexual and reproductive health, self-harm and inadequate self-care. All these contributed to increased lifetime risk of morbidity and premature death. In addition, these mental health problems will continue to develop in to more disabling condition later in life if not recognized and this will have both social and economic cost to the society.

Activity 11.1:

1. What are the common mental health problems you have faced in your daily service provision in general and among adolescents and youth in particular?
2. Do you think AY are prone to mental health problems? Why?

Depression:

This is one of the affective or mood disorders in which the primary disturbances are abnormalities in mood states and their regulation. These are prevalent and serious disorders in children and adolescents and a major source of morbidity and mortality in the pediatric age group.

According to DSM-IV-TR, a major depressive episode is characterized by low mood or loss of interest for **at least two weeks** associated with at least **four additional symptoms** that include changes in appetite and weight; changes in sleep and activity; lack of energy; feelings of guilt; problems thinking and making decisions and recurring thoughts of death or suicide. And there must be a change from previous functioning.

Interventions

- School-based programs targeting cognitive, problem-solving and social skills; early home-based family counseling programs are important interventions. Educating adolescents in positive thinking, challenge negative thinking styles and improve problem-solving skills is found to be preventive of depressive episode in those at risk.
- Targeted group-based interventions and cognitive behavioral therapy are effective in reducing depressive symptoms. Exercise is found to be effective in improving self-esteem and reducing depression score.
- Psychotherapy: interpersonal psychotherapy (IPT)

Anxiety disorders:

Anxiety is a general term for several disorders that cause nervousness, fear, apprehension, and worrying. These disorders affect how we feel and behave, and they can manifest real physical symptoms. Mild anxiety is vague and unsettling, while severe anxiety can be extremely debilitating, having a serious impact on daily life. Anxiety disorders can be classified into several more specific types. The most common are briefly described below.

Generalized anxiety disorder: is marked by uncontrolled excessive worrying, accompanied by difficulty in concentrating, irritability, sleep problems, and often fatigue. The anxiety and worry are usually described as being pervasive and uncontrollable, leading to functional impairment in social, recreational, educational, and occupational areas.

Panic disorder: is characterized by recurrent spontaneous panic attacks, often associated with physiological and psychological signs and symptoms. As with other mental health problems in adolescence, anxiety disorders are often accompanied by other conditions, particularly depression.

Specific and Social Phobias: specific phobias are characterized by an excessive and unreasonable fear response that persistently occurs when a child is exposed, or anticipates exposure to a specific object or situation. Common examples of these phobic objects include animals, insects, blood, heights, or enclosed spaces. Social phobia is fear of social or performance situations where adolescents may feel like they are being scrutinized, especially during exposure to unfamiliar people. It is important that this fear of social situations include

response to peers and not just adults. Children exposed to phobic stimuli respond immediately with increased anxiety that may escalate to the point of a panic attack.

Interventions

- As many anxiety disorders during adolescence are accompanied by physical symptoms, careful evaluation is needed at least a complete medical history and a comprehensive physical examination to exclude conditions such as hypoglycaemic episodes, migraine, seizure, and other neurological problems.
- Targeted group-based interventions and cognitive behavioral therapy are effective in reducing anxiety.
- A cognitive-behavioral program can address: skills to cope with anxiety; builds emotional resilience, problem-solving abilities and self-confidence;
- Onset of panic disorders can be reduced through a short-term cognitive workshop for those who have experienced a first panic attack.
- CBT(cognitive behavioral treatment) also used to treat established anxiety disorders, in both individuals and groups.
- Pharmacotherapy-SSRIs are generally used as first-line drugs when medication is required thus link with psychiatric clinic.

Suicide

It is a fatal act that represents the person's wish to die. There is a range, between thinking about Suicide and acting it out. Some persons have ideas of suicide that they will never act on; some plan for days, weeks, or even years before acting; and others take their lives seemingly on impulse, without premeditation. Suicidal ideation occurs in all age groups and with greatest frequency in children and adolescent with severe mood disorders.

Completed suicide occurs about five times more often in adolescent boys than in girls, although the rate of suicide attempts is at least three times higher among adolescent girls than among boys. **Suicidal ideation is not a static phenomenon; it can wax and wane with time.**

The most important risk factors for suicide are: 1) psychiatric disorders (mostly depression and schizophrenia),2) past or recent social stressors (e.g. childhood adversities, sexual or physical abuse, unemployment, social isolation, serious economic problems), 3) suicide in the family or among friends or peers, 4) low access to psychological help and 5) access to means for committing suicide. Additional risk factors in suicide include exposure to family violence, impulsivity, and substance abuse.

The rates for suicide depend on age, and they increase significantly after puberty. Universal features in adolescent who resort to suicidal behaviors are the **inability to synthesize viable solutions to ongoing problems and the lack of coping strategies to deal with immediate crisis.** Therefore, a narrow view of the options available to deal with recurrent family discord, rejection, or failure contributes to a decision to commit suicide.

The most common method of completed suicide in children and adolescent is the use of firearms, which accounts for about two thirds of all suicides in boys and almost one half of suicides in girls. The second most common method of suicide in boys, occurring in about one fourth of all cases, is hanging; in girls, about one fourth commits suicide through ingestion of toxic substances. Carbon monoxide poisoning is the next most common method of suicide in boys, but it occurs in less than 10%; suicide by hanging and carbon monoxide poisoning are equally frequent among girls and account for about 10% each.

Direct questioning of children and adolescent about suicidal thoughts is necessary, because studies have consistently shown that parents are frequently unaware of such ideas in their children.

Interventions

- School-based programs: this comprehensive program encompasses the implementation of a suicide prevention school policy, teacher training and consultation, education to parents, stress management and life skills curriculum for students and the establishment of a crisis team in each school.
- Classroom-based didactic and experiential programs increase short-term knowledge of suicide and knowledge of suicide prevention with no evidence of an effect on suicide-related attitudes or behaviors. Community-based creative activities have some positive effect on behavioral changes, self-confidence, self-esteem, levels of knowledge, and physical activity.
- Hospitalize high-risk groups until the acute suicidality is no longer present.
- Emergency room discharge plans include a written contract with the adolescent, outlining the adolescent's agreement not to engage in suicidal behavior and providing an alternative if suicidal ideation reoccurs
- A telephone hot-line number provided to the adolescent and the family in case suicidal ideation reappears.
- Early intervention in primary care and prescription of psychoactive drugs; training of general practitioners in recognizing and treating depression in primary care can improve the quantity and quality of early depression treatment.
- Reducing access to the means to commit suicide

- Psychotherapy; treatment directed to the underlying problem such as mental illnesses can be initiated.

Psychotic Disorder: Psychotic disorders are mental disorders which are characterized by impairment in a person's perception of reality. It can be manifested by abnormal sensory perceptions (hallucinations), thought abnormalities (including disorders of thought content or process), and behavioral disturbances (including catatonia and disorganized behavior)

Schizophreniform disorder

The diagnosis of schizophreniform disorder is for individuals who meet diagnostic criteria for schizophrenia, but whose symptoms and impairments have not lasted at least 6 months.

Brief psychotic disorder

This disorder is characterized by one or more of delusions, hallucinations, disorganized speech, or grossly disorganized or catatonic behavior, for at least 1 day, but less than 1 month, and with full return to pre-morbid functioning following recovery. Possible etiologies such as medical illnesses, head injuries, or drugs should be considered and ruled out. While organic causes are unlikely without positives in the history or physical, it is essential to eliminate them as possibilities.

A complete physical and neurologic examination is indicated, with consultation with other medical specialties indicated in some cases.

Laboratory work-up for first episode of psychosis should include: serum electrolytes, glucose, renal and hepatic function tests, a thyroid screen, serum folic acid and B12, syphilis serology, HIV antibody testing, a complete blood count, erythrocyte sedimentation rate (ESR), a urine drug screen, and urinalysis. Neuroimaging (CT or MRI of head), and electroencephalography (EEG) are usually included in the work-up.

A pregnancy test is recommended in girls of reproductive age. Chromosomal analysis should be considered for patients who have physical or behavioral features suggestive of a developmental syndrome. Other laboratory investigations may be included based on the history and physical examination, and other relevant data, such as family history, which might suggest the presence specific medical condition.

Intervention

Early identification and treatment of psychotic adolescent and youth may reduce psychiatric morbidity and improve the patient's long-term functional outcome. Conversely, delays in diagnosis and the initiation of appropriate treatment could result in reduced potential for optimal recovery.

A multimedia campaign to increase mental health literacy promotes early help-seeking and early detection mechanism to enhance early detection and treatment. Preventing mental illness, WHO 2004

Options of intervention for clinical high-risk adolescent and youth: Cognitive behavioral psychotherapy, general supportive psychotherapy, and family-focused treatment (e.g., psycho-education, stress management, communication training, problem-solving skills training).

Activity 11.2. Case study

EE is a 12-year-old girl who was recently forced to move to a new neighborhood because her grandmother died and the family's economic situation changed. Before, she had been a cheerful girl who attended school and was helpful with her younger siblings. In the last month, she has been refusing to help or getting angry when her mother asks her; she also has frequently said that she is not hungry and does not want to eat with the rest of the family. Her mother is worried about her but also very annoyed that EE is not being helpful in this time when the family must adapt to new surroundings. EE's mother does not understand the change in her daughter and thinks it might be because she is becoming an adolescent.

Brainstorm on the following points:

1. List the behavioral changes observed on EE?
2. What do people think about people with problems like EE's?
3. What do people assume are the causes of these sorts of problems?
4. If people try to help children like EE, what do they do or suggest?
5. What gets in the way of getting help for children like EE?

Session 11.3: Use of Psychoactive Substances by Adolescent and Youth

Alcohol, tobacco and other psychoactive substance are posing greater challenge in terms of morbidity and mortality worldwide. Tobacco alone is responsible for six million deaths each year. Alcohol use is also responsible for significant proportion of morbidity including injuries everywhere. Both alcohol and tobacco use have shown increment over the years especially among AY, female and in developing countries where use was not common previously. Besides, uses of such substances commonly co-occur with other morbidities such as mental illnesses.

Ethiopia has also witnessed increased use of these substances in urban population, and among young people. In addition to alcohol and tobacco, which are legal substances, khat is also another psychoactive substance which is legally grown and purchased in Ethiopia. Few studies have appreciated the magnitude of use and their risk factors in Ethiopian context. According to these studies, AY who have parents or friends who use these substances are more likely to engage in the same behavior; and those who use substance are the one who have more friends. Moreover, AY perceive girls who use tobacco as modern and consider them to be attractive.

Substance use can be viewed on a continuum with experimentation (the mildest use), regular use without obvious impairment, abuse and dependence.

- **Substance dependence:** is a state where the brain and body have adapted to the use of the substance to the point where it is difficult to stop or even cut back on intake. Symptoms of dependence can include tolerance, withdrawal, heavier use of the substance than was intended, an unsuccessful desire to cut down or control use, and reduction of social or occupational activities because of substance use. In addition, the user knows that the substance causes significant impairment, but does not give it up.
- **Substance abuse:** symptoms of abuse are recurrent substance use in situations that cause physical danger to the user, recurrent substance use in the face of obvious impairment in school or work situations, recurrent substance use despite resulting legal problems, or recurrent substance use despite social or interpersonal problems.

What are substances?

According to the WHO orientation document, “these are both legal and illegal, psychoactive substance or drugs which when consumed can affect the way people see, hear, taste, smell, think, feel and behave”. Further divided into depressants, stimulants, opioids and hallucinogens.

- Depressants
 - Alcohol (wine, beer, spirits, home-brew)
 - Sedatives/hypnotics (sleeping pills containing benzodiazepines, methaqualone, barbiturates, chloral hydrate)
 - Volatile solvents (aerosol sprays, butane gas, petrol/gasoline, glue, paint thinners, hair spray, nitrites, solvents, felt-tip-marker fluid)
 - Date rape drugs (flunitrazepam, rohypnol, GHB, ketamines).
- Stimulants
 - Nicotine (cigarettes, cigars, pipes, chewing tobacco, snuff)
 - Cocaine (crack, crystal, coca products)
 - Amphetamines (methylenedioxymeth-amphetamine [MDMA or ecstasy], dextroamphetamines, methamphetamines)

- Caffeine (coffee, tea, soft drinks)
- Opioids
 - Heroin, morphine, opium, buprenorphine, methadone, pethidine
 - Cough syrup with codeine.
- Hallucinogens
 - Lysergic acid diethylamine (LSD)
 - Mescaline, psilocybin, peyote, tryptamines
 - Cannabis (marijuana, ganja, hashish, bhang, pot, grass).

Alcohol: Harm from drinking alcohol can occur in the absence of dependency. Most of the people who are harmed by and who harm others through drinking are not “dependent”. These people are frequently not recognized as having an alcohol problem.

- **Hazardous use:** creates risk to physical or mental health by making other conditions worse (perhaps through not taking medication), impairing judgment, making it more likely that someone will engage in high risk behaviors (sexual, driving, harmful social relationships)
- **Harmful use:** already see some damage to health (physical or mental) or to others.
- **Dependence/addiction:** strong desire to drink, difficulty controlling use, continued use despite harmful consequences, priority to drinking over other activities, increased tolerance, physical withdrawal.

Again, someone doesn’t have to be dependent to be harmed. For example, many young drinkers, especially in low-income communities, do not drink constantly and thus don’t develop dependence. But they will drink very large quantities of alcohol periodically at social events (sometimes to quell anxieties about meeting others). The resulting dis-inhibition can lead to risky behavior; the large amount they drink can lead to acute alcohol poisoning, with death resulting from not breathing, striking their head, or choking on their vomit.

Tobacco:

People with mental health problems are more likely to smoke than the general population. Smoking is a health hazard to the smoker and to those around him or her. Risks to others come from smoke and, with cigarettes. Smoking increases the risk of developing a number of health problems including asthma, heart disease, and a number of different forms of cancer. Use of shisha is thought to be even more harmful than cigarette smoking because, despite the use of a water filter, the smoke inhaled is stronger than the smoke of cigarettes. Shisha is sometimes also mixed with marijuana. There is both psychological dependence and physical nicotine dependence with an unpleasant (though not dangerous) withdrawal syndrome.

Cannabis/marijuana:

After smoking, the onset of effects is within 1-3 hours. Users experience relaxation, increased appetite and thirst, difficulty concentrating, problems with learning and memory, loss of coordination, poor judgment, inappropriate social behavior and at higher doses there can be hallucinations. There is tolerance to many of the effects of cannabis, but not physical dependence. Psychological dependence on cannabis use does develop in long-term users.

One of main risks of using marijuana seems to be a role in precipitating or exacerbating psychotic disorders. It's thought that marijuana use may increase the risk of becoming schizophrenic in people with a family history or other risk factors. Evidence from Norwegian military study has shown that use of marijuana early in life increases the chance of developing schizophrenia three folds later in life. Use of marijuana also makes management of schizophrenia and bipolar illness more difficult because it contributes to mood changes and impairs the ability to take medication regularly.

Inhalants:

A range of readily available, volatile solvents and gases are used as inhalants including aerosol sprays, butane gas, petrol, glue, paint thinners, solvents, and amyl nitrite ("poppers"). In many parts of the world, these substances are widely used among children living on the street or not in families. They are inexpensive and easy to purchase (or to take from places of work), and produce powerful and rapid effects. They have a combination of sedative and hallucinogenic effects. They can be acutely fatal – for some of the chemicals, nearly any exposure would be considered an "overdose". Most are capable of causing irreversible brain and liver toxicity.

Recognising the value of substance use from an AYs' viewpoint, and Communicate effectively with an AY about their use

Young people use substances for different reasons: Discovery and experimentation, role model of other substance users (peers, parents, other adults), marketing of substances, and easy access to substances, among others.

- Parents, other adults in close contact with young people, peers, TV personalities and sports stars who use substances can all serve as **role models** for young people's experiments and regular use of substances.
- When substances are easily **available and affordable** to young people, substance use will increase.
- **Marketing strategies** for promoting substance use
 - o *This is especially evident in marketing of alcoholic beverages and tobacco, now increasingly in the developing countries*

Communicate effectively with an adolescent about substance use and implement an appropriate intervention plan as needed. It is important to include questions on substance use routinely during general history-taking because AY substance users will often come to the Clinic with a wide range of presentations (e.g. Headache, poor school performance, depressive mood, insomnia). The visit may well be an opportunity to discuss substance use and prevention. Health Care Providers should exercise effective listening skills when they communicate with AY.

- Determine systematically the risk situation
- Is the adolescent presenting 'normal' exploratory behavior or is his/her health seriously in danger? It is developmentally normal that teens explore and are not adequately perceiving risks.

The **HEADSSS** assessment tool (**H**ome, **E**ducation, **A**ctivities, **D**rugs, **S**exuality/**S**uicide/**S**afety/**S**upport) includes questions on this domain that should be asked in a non-judgemental open way(WHO Job AID P26). The HEADSSS, or SSHADESS, is very useful to get psychosocial information in a developmentally appropriate way. Within this approach the health care provider moves smoothly from less personal questions to more personal, intimate questions that are potentially threatening to the adolescent. (see also Chapter 4)

SSHADESS is a strength-based psychosocial assessment. It was developed by Kenneth Ginsburg, a modified HEADS screen, as it offers a few advantages:

- It begins with strengths. How is life going? This demonstrates that we do not only view youth in the risk context. Then,
- School is addressed before home, home is an intimate subject that may rise sensitive issues too early. School is a safer subject that allows a general view of functioning. Moreover, when an adolescent is in crisis, school usually suffers and therefore can serve as a marker for stress.
- A wider range of emotions are screened rather than just focusing on depression or suicide additional emotions are screened .

AY Health Providers should be trained in posing open-ended questions that invite thought, discussion and debate rather than closed ended ones. They should also be trained in being non-judgemental and most importantly trained to listen.

A strength-based psychosocial assessment

Strengths	S	What do you like doing?
School	S	What do you enjoy most about school?
Home	H	Who do you live with?
Activities	A	What kind of things do you do just for fun?
Drugs	D	Do any of your friends talk about ...
Emotions	E	Have you been feeling stressed?

Sexuality	S	Are you attracted to anyone?
Safety	S	Are there a lot of fights at your school?

Modified from “WHO HEADSSS” psychosocial assessment, Ginsburg K. Reaching Teens, AAP 2014. The effect of a substance is shaped by the substance itself, the person, the mode of use and the environment. Negative consequences of substance use may be physical or psychosocial. As physical symptom like: 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, and etc. Other symptoms an AY can present with are 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 behavior.

Thus a health care providers has to do routine assessment which provides unique opportunity to identify substance use in the early stages apply the HEADS or the SSHADESS assessment approach, match his/her intervention to the stage of change of the AY substance user, manage in the same setting or arrange referral care. Discuss ways of reducing the risk and the potential harm of their substance use (e.g. Eating before drinking alcohol) and as a health care provider advocate for environments that allow ‘safe’ exploratory behaviour for youth; Counselling at the school-setting; Empowerment of parents.

Interventions targeting use of Psycho-active substance use

Effective regulatory interventions for addictive substances which can be implemented at international, national, regional and local jurisdictional levels include taxation, restrictions on availability and total bans on all forms of direct and indirect advertising.

These policy interventions have led to the prevention of substance use disorders by reducing the harm from addictive substances. Other effective preventive policy measures have included media interventions, comprehensive community interventions and, to a lesser extent and school-based interventions.

Comprehensive community interventions: these have been widely used to encourage smoking cessation. Although some community-wide programs show success, for most the effects are small and certainly less than predicted given the effort and cost expended. However, even a modest effect on smoking behavior can translate into a large public health impact if implemented countrywide.

School and family-based prevention Program: intensive interventions typically addressing family functioning and Mass media campaigns are effective in reducing substance use/abuse. In addition, school-based interventions based on a combination of social competence and social influence approaches have shown protective effects against substance use. Moreover, early identification and referral of cases from the lower level health care facilities are mandatory to maintain the continuum of care. Depending on the severity of their problem, inpatient care, relapse prevention and rehabilitation services should be provided.

Counseling is often sufficient to help people control hazardous use of alcohol. Harmful use may require counseling plus intensive support over a long time.

Dependence on alcohol requires careful detoxification and then long-term support to prevent a relapse (which is common).

Summary:

- Mental health disorders and substance use are common health problems of young people.
- Depression, anxiety, eating disorder, attention deficit hyperactivity disorders and substance misuse are the commonest forms of mental health disorders in this population.
- The risk factors of mental health disorders are largely preventable and could be targeted at family, community and school level.
- Identifying mental health disorders in this population requires careful history taking and evaluation of the symptoms as some of the changes are just part of the normal developmental process of adolescents.
- Alcohol, tobacco, marijuana and inhalants are commonly used by adolescent and youth. Substance use can be viewed as a continuum with experimentation (the mildest use), regular use without obvious impairment, abuse and dependence.
- Substance use co-occurs with the other mental health disorders and through check for use is important while treating young people with mental health disorder.
- Family, schools and community at large are places where interventions against substance use could be implemented.

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Annex I. Case Studies mental health

1. YY 16 years-old

A divorced mother comes to consultation with her son YY, a 16 year-old only child, complaining about the fact that he is withdrawn and has hardly talked to her for two months. The boy himself denies any problem, despite the fact that he is skipping school often

YY Step 2 HEADSSS interview

Over the last three months, YY skipped school several times because of headaches. His grades are dropping. He stays alone in his room, playing his guitar. The boy sees his father every two weeks, and the father doesn't seem to be troubled by his son's situation. Until the age of 14, YY was a bright, talkative, active kid. After his father left home two years ago to live with other women, YY's situation has gradually worsened with conflicts around the issue of social outings

and school duties, and a deterioration of his behavior at school. He quit his football club 4 months ago, and has not seen his friends for two months. The consultation was prompted by the fact that the mother discovered that he had cut himself (arms)

2. CC 17 yrs old

CC is in secondary school with Science as her major. She suffers from severe attacks of asthma, which hits her in school in spite of heavy medication of steroids. But when she arrives in the Emergency room she is fine. She also has problem walking up steps, she feels as if she cannot breathe

HEEADSS:

- HOME.: frequent quarrels with parents and friends , very emotional . Spreads her things all over the house and can't find them, for instance in time to go to school
- School: has a hard time with school work , never gets started with tasks. Often just gets stuck in the halls, talking to people and misses her lessons. Knows everybody, but has no friends. Tires people out. Makes schedules of things to do but cannot follow them. Restless in class, has to play with something or wiggle her foot to be able to concentrate. Always very tired and has a hard time to do her home work, is just too tired. Has started many sports activities and hobbies but gets tired and quits

Use the developmental grid to get further

3. KK 16 years old

Since the age of 13 she has been experiencing extreme knee pains. Finally an orthopedic surgeon performed a nerve blockage. Her knee pains disappeared but instead she got severe back pains. She cannot walk. She spends most of her days in bed, she uses a wheel chair and she seldom goes to school

HEEADS:SS

at home , stays in her room, watching movies, fond of Titanic , knows everything about that film and other films, talks to everybody about films.

But dominates and rules the family activities, extremely strict with different rules, which everybody has to follow

Her parents are happy that she stays home and does not run around at night with boys. At school, will barely pass all subjects, spends most her time alone or talking to the adult person supervising school breaks. Does not want to go to school at all, wants home tutoring

Medical exam: Cannot clearly specify her back pain, uninterested to work with physiotherapist, neurological exam normal. Examine her developmental situation! Use one of the grids Discuss

4. SS 12 yrs old: step 1:

Frequent stomach complains keep him out of school

He has been investigated extensively by the local GP, without any diagnosis, considered healthy

Heads: No problems at home, rarely stomach-aches

School: stays alone, is very quite, does not do much, needs constant pushes to get going. Does not fulfill the goals

Activities: Likes to play with his younger brother, 9 year old, and his friends, likes to play football and Hide-and-seek

Now evaluate him with the bio-psychosocial grid. **Your conclusion?**

SS 12yrs old , Step 2

Further investigations reveals: that he was evaluated at age 7 and found to have a slight mental retardation

The parents choose not to believe it and let him start in the regular school without any support

The first few years were OK with a few friends and not many demands in school

Your conclusions?

Chapter 12: Adolescent and Youth Nutrition

Session 12.1 Session Outline and Learning Objectives

Duration: 120 Minutes

Session outline

- Nutrition Needs in Adolescent and Youth
- Malnutrition and its Consequences in Adolescent and Youth
- Nutrition Interventions for Adolescents and Youth

Learning Objectives

At the end of this chapter participants will be able to:

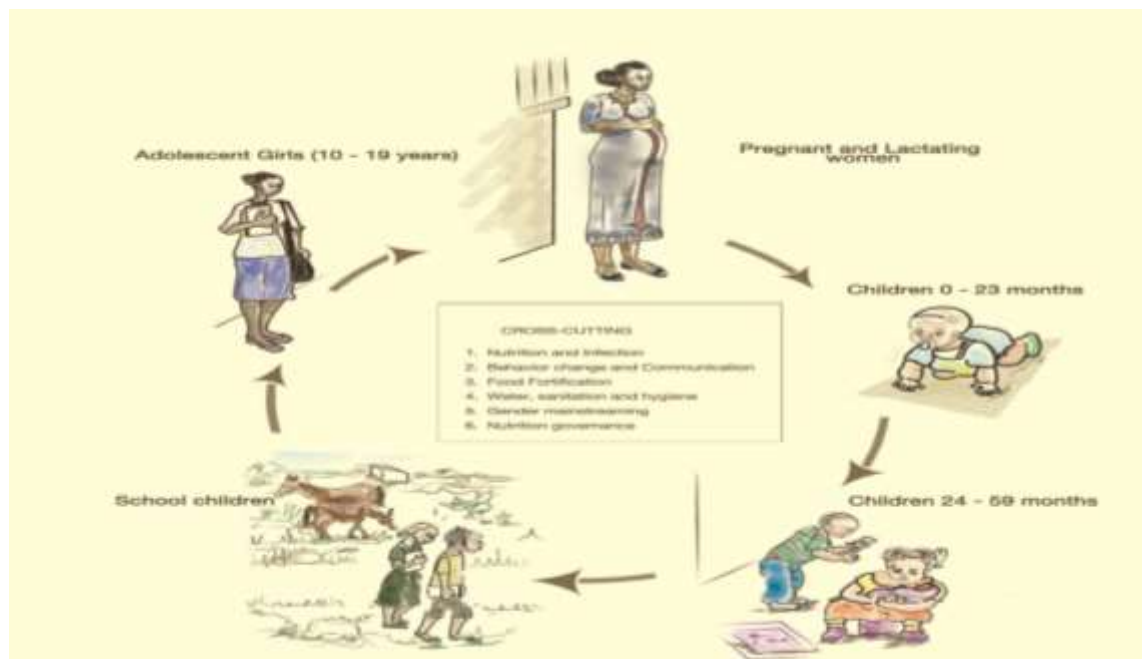
- Describe nutritional needs of adolescents and the factors affecting their nutritional status
- Explain the types of malnutrition and its consequences in adolescents
- Recognize the different nutrition assessments and intervention for adolescents
- Comply with the need to give special attention to adolescents' nutritional needs

Session 12.2: Nutrition Needs in Adolescents

Why Adolescent Nutrition matters?

- The period of adolescence (10-19yrs) is a period of intense growth; and hence overall nutrient needs are high to for optimum growth and development. Example: the body needs more iron when it is growing rapidly and to replace loss through menstruation.
- Adolescents gain up to 50% of their adult weight, more than 20% of their adult height, and 50% of their adult skeletal mass during this period.
- Adolescence is the time in life next to the critical window of the first 1,000 days to break the malnutrition cycle when the velocity of growth actually increases.
- Adolescent pregnancy is a worldwide concern, particularly in areas of poverty and social disadvantage and complications of pregnancy and childbirth are the leading cause of death in young women between 15 to 19 years.
- Improving adolescent girls' nutrition and delaying first pregnancy break intergenerational cycle of malnutrition.
- Preparing for the demands of childbearing and breastfeeding is timely in adolescent girls and, above all, preventing premature pregnancy and its associated risk for both mother and child.
- Adolescence is a timely period for adoption and consolidation of sound dietary habits
- Improving adolescents' nutrition behaviors is an investment in adult health. Adolescent nutrition prevents adult diet-related chronic diseases, such as cardiovascular disease, cancer, and osteoporosis.

Figure 12.1: Life cycle approach of addressing malnutrition



Adolescent Nutrition Requirements

Energy and Nutrient Needs

Energy needs of adolescents are influenced by activity level, basal metabolic rate (BMR), and increased requirements to support pubertal growth and development. Basal metabolic rate is closely associated with the amount of lean body mass.

Protein needs of adolescents are influenced by the amount of protein required for maintenance of existing lean body mass and accrual of additional lean body mass during the adolescent growth spurt.

Table 12.1: Recommended calorie and protein intake of adolescents

Age in year	Kcal /day	Protein g/day
Female		
11-14	2200	46
15-18	2200	44
19-24	2200	46
Male		
11-14	2500	45
15-18	3000	59
19-24	2900	58

Minerals and vitamins

Iron: For both male and female adolescents, the need for iron increases with rapid growth and the expansion of blood volume and muscle mass. The onset of menstruation imposes additional iron needs for girls. Meat, Fish, liver, Chicken, Green vegetables such as Spinach, Swiss chard and legume such as lentil and dried beans and grains such as Teff and millet are sources of iron.

Calcium: there is greater need for calcium during adolescence because of the dramatic increase in skeletal growth and peak bone mass is attained during this period. Calcium reduces the lifetime risk of fractures and osteoporosis. Milk and milk products, vegetables like Spinach and Broccoli are good sources of calcium.

Other minerals Such as iodine, Zinc and folate are also necessary during adolescence for growth, sexual maturation and DNA, RNA and protein synthesis.

Vitamins: Vitamin A, Vitamin E and Vitamin C are very important during adolescence for reproduction, growth and immune functions.

Fiber: Dietary fiber is important for normal bowel function, and may play a role in the prevention of chronic diseases, such as certain cancers, coronary artery disease and type 2 diabetes mellitus. Adequate fiber intake is also thought to reduce serum cholesterol levels, help maintain moderate blood sugar levels, and reduce the risk of obesity. Significant sources of

fiber in the diet of adolescents include whole grain breads, potatoes, popcorn, tomatoes and corn.

Healthy diet

- Aiming for regular meals and healthy snacks
- Eating food from all of the food groups each day to meet the nutritional requirements.
- Balancing nutrient rich food with moderate amount of other food such as sweets

Dietary diversity

Dietary diversity means eating a variety of food groups at every meal. Adolescents should eat at least four or more groups as indicated in the table below.

Table 12.2 Ways on how to consume diversified meal

 Eat Diversely! SURE programme Ministry of Health & Ministry of Agriculture					
For good health eat at least 4 different food groups at every meal!					
STAPLES	LEGUMES/NUTS	VEGETABLES	ANIMAL FOODS	FATS	FRUITS
Millet 	Lentils 	Kale 	Egg 	Cooking oil 	Mango 
Sorghum 	Peas 	Broccoli 	Fish 	Butter 	Papaya 
Maize 	Broad beans 	Carrot 	Beef 	Sesame Seeds 	Avocado 
Teff 	Chick peas 	Orange sweet potato 	Lamb 	Linseed 	Banana 
Barley 	Beans 	Pumpkin 	Poultry 	Sunflower seeds 	Grapes 
Wheat 	Ground nut 	Cabbage 	Milk 	Pumpkin seeds 	Pineapple 
Oats 		Squash 	Yoghurt 	Avocado 	Guava 
		Tomatoes 			Orange 

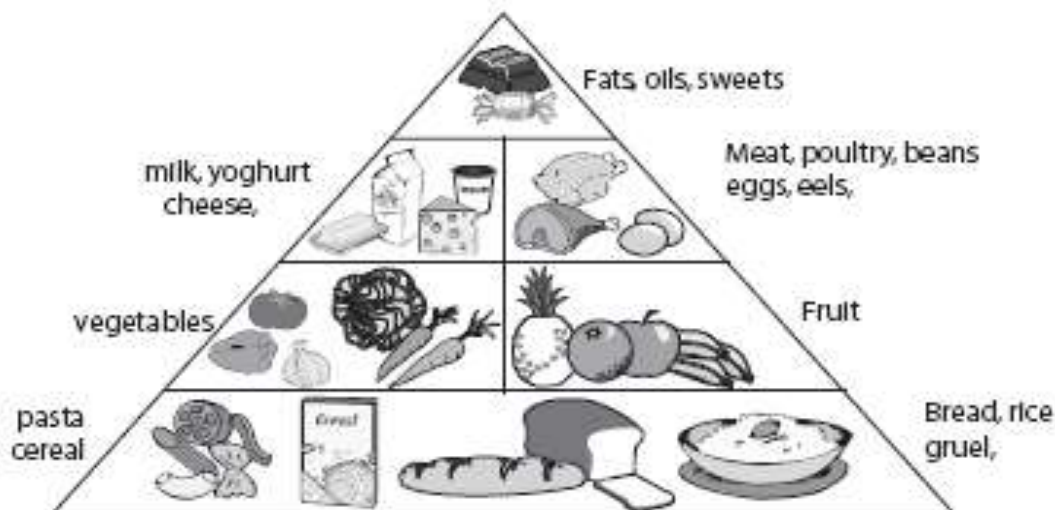


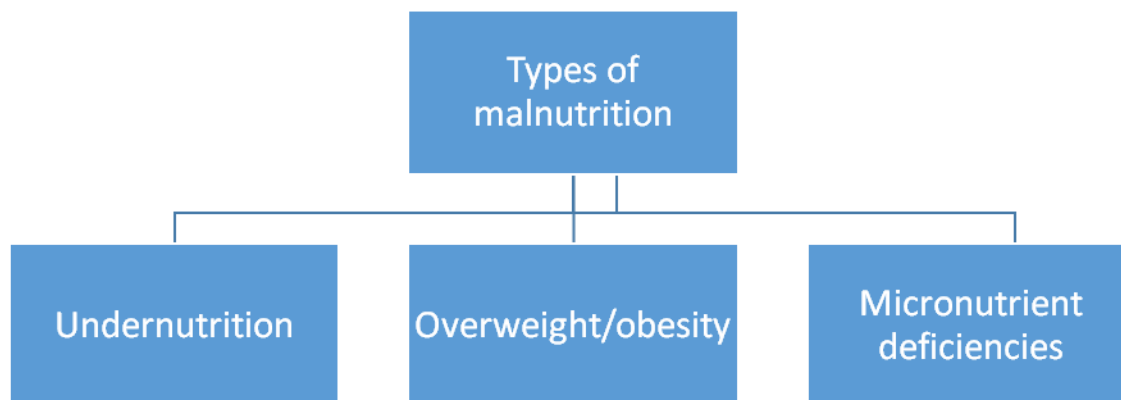
Figure 12.1: Food Pyramid

The food pyramid also tells us how much of each group of food should be eaten. The energy giving foods are the ones that need to be eaten the most, then the fruit and vegetables to help build immunity and provide micro nutrients and then the protein and animal source food to help us grow and provide micro nutrients. Finally fats and oil and sugars should be eaten in smaller amounts.

Session 12.3: Malnutrition and its Consequences in Adolescents

Types of malnutrition

Adolescents and youth experience under nutrition, overweight/obesity and micronutrient deficiencies. Substantial rates of growth and development, with increased demand for energy, protein, micronutrients and minerals coupled with other personal, socio-cultural and economic factors make the period vulnerable for malnutrition. Figure 3: Types of malnutrition



Under Nutrition

Underweight: represents depleted body fat and/or lean tissue stores. Although there are no expert guidelines for classifying underweight based on body mass index (BMI), the World Health Organization defines underweight/thinness as a BMI for age below the 15th percentile for age and sex. The consequences include:

- Higher rates of morbidity and mortality
- Abnormal menses, sub fertility and amenorrhea
- Risk for pregnancy complications and poor fetal outcomes, including prematurity and low birth weight;
- Delay the onset of puberty in male and female adolescents and fatigue, lack of energy and increased susceptibility to infection.

Micronutrient Deficiencies

Iron Deficiency Anemia: is marked by low levels of hemoglobin in the blood. Iron is a key component of hemoglobin, and iron deficiency is estimated to be responsible for half of all anemia globally. Other causes of anemia include hookworms and other helminthes, other nutritional deficiencies, chronic infections, and genetic conditions. In Ethiopia, nearly one fourth of women in the reproductive age have anemia, majority are mildly. The proportion of women with any anaemia is notably higher in those below the age of 24, and in rural than in urban areas (25 percent versus 16 percent).

Adolescent girls are at particularly high risk of developing iron deficiency since the body needs more iron when it is growing rapidly and when frequent blood loss occurs during menstruation. Iron deficiency generally results when dietary iron intake cannot meet required needs and iron reserves in the body are depleted in order to support the body's physiological demand. Iron needs are highest in males during peak pubertal development because of a greater increase in blood volume, muscle mass and myoglobin.

Consequences of Iron Deficiency includes: decreased maximum aerobic capacity, decreased athletic performance, lowered endurance, decreased work capacity, impaired temperature regulation, depressed immune function, and increased rates of infection, impaired cognitive functioning and memory, decreased school performance, compromised growth and development, increased lead and cadmium absorption, increased risk of pregnancy complications and prematurity and fetal growth retardation.

Symptoms Associated with Iron Deficiency Anemia: Fatigue, lethargy, dizziness, headaches, shortness of breath, ringing in ears, pallor, flattened, brittle nails (spoon nail), angular stomatitis (cracks at mouth corners), glossitis, blue sclera (whites of eyes), pale conjunctivae.

Overweight/ Obesity

Obesity is a disorder of energy metabolism involving excessive adipose tissue stores (body fatness), which may be associated with medical or psychosocial morbidity. The prevalence, as well as the severity of obesity in adolescents is increasing at an alarming rate, making it one of the most serious health problems affecting this age group.

Risk factors of Overweight: The interaction of genetically determined body size and fatness with an environment of low energy expenditure and caloric excess is the primary cause of adolescent overweight. Overweight during adolescence is associated with significant immediate and long term health risks such as:

Medical complications:- insulin resistance and hyper insulinemia, Type 2 diabetes mellitus, elevated total and LDL cholesterol and triglyceride levels, lowered HDL cholesterol level, aortic

and coronary artery fatty streaks, lesions and calcification, hypertension, gallstones, hepatitis, asthma and menstrual dysfunction.

- Overweight in adolescents frequently continues into adulthood.
- Up to 80% of adolescents may remain overweight as they mature, particularly if severely overweight or if they have an obese parent.

Factors affecting Adolescent Nutrition

- Food availability: lack of access to food in general which mostly leads to under nutrition.
- Social environment, in terms of peers which plays a strong role and community perception such as food taboos, gender disparity, specific for adolescents.
- Psychological factors: eating patterns, religious and cultural patterns and practices, eating disturbances
- Body image perception
- Personal cultural beliefs
- Parental model: parental food preferences.
- Availability and access to of fast food outlets, school tuck-shops, food stores and vendors in the vicinity may play a role in adolescent's decision-making.
- Mass media and advertising, etc.
- Livelihood factors...sedentary lifestyle and limited exercise; heavy physical work; habit of smoking and binge alcohol consumption
- Excessive intake leads to overweight and obesity
- Excessive nutrient losses and mal absorption due to diseases
- Increased requirement during heavy exercise and early pregnancy

Consequences of child under nutrition on the general public

Undernutrition has negative consequences on individual, community and nations due to the losses in individual physical and cognitive capacity. When a child is undernourished, he or she will have an increased chance of experiencing specific health problems, his/her brain is less likely to develop at healthy rates, and that child is more likely to have cognitive delays. Stunted children are more likely to repeat grades in school or drop out. This will impact them when they enter the labor force. On the whole, stunted workers are less productive than non-stunted workers and are less able to contribute to the national economy. Negative effects of iron deficiency on cognitive performance in adolescents are evident and adolescence with poor cognitive performance are at a greater risk of failing at school.

Intergenerational cycle of under-nutrition

Small girls are likely to become small women who are more likely to be mothers of small babies so that the malnutrition cycle will continue. In addition to under nutrition, there is growing

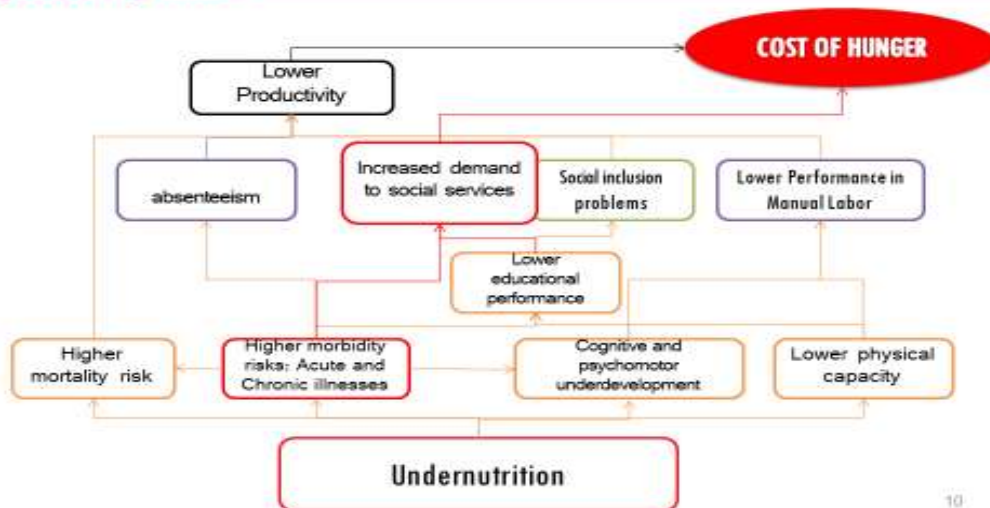
evidence that fetal malnutrition involved as a risk factor for chronic diseases in later life, in particular coronary heart disease, type-2 diabetes, and metabolic disease. See Fig 12.4

Figure 12.4: Intergenerational cycle of under nutrition



Figure 12.5: The effects of child undernutrition on individuals and the general public

The effect of child under-nutrition on individuals and the general public.



Session 12.4: Nutrition Intervention for adolescents

Nutrition intervention

The primary goals of nutrition intervention are the promotion of normal physical and emotional growth and development, and the prevention of nutrient deficiencies and excess. Adolescence provides a window of opportunity for **nutrition intervention**.

The nutrition intervention targeting adolescents & youth should be directed at multiple-risk behaviors. The interventions should be effective in addressing malnutrition, micronutrient deficiencies, and diet related chronic illnesses as well. The increasing number of obese adolescents should also be given due attention in the presence of widespread nutrition inadequacies. The intervention framework emphasizes improving access to food on top of all, at the same time prioritizes the population that are at higher risk for malnutrition and its consequences like pregnant adolescents, and adolescents with HIV/AIDS and special needs.

An integrated service approach should be considered to make the interventions effective and sustainable. Comprehensive and integrated program directed at multiple-risk behaviors are more likely to be successful than separated short term interventions.

Nutrition Assessment and Counseling

Nutrition assessment is a tool used to identify those adolescents who are at risk of under/over-weight/obese; micronutrient deficiency; and to assess related risk factors. The screening for adequacy of dietary intake and nutritional status of adolescent and youth should be conducted periodically and as required. It is advisable to include common indicators of nutritional risk like growth (underweight and over overweight), physical activity, hyperlipidemia, hypertension, iron deficiency anemia, food insecurity, eating disorder, pregnancy, abnormal blood sugar, substance and alcohol use, and excessive intake of foods and beverages that have high fat or sugar contents. It helps in identifying subjects who may be at nutritional risk or potentially at risk, and who may benefit from appropriate nutritional intervention.

Nutrition assessment should be rapid and simple. It begins with history and an accurate measurement of height and weight, and calculation of BMI (body mass index). These data should be plotted on age and sex appropriate WHO 2007 growth charts to determine the nutritional status. Table 12.3 describes the classification. The result of this assessment should be accompanied by an in-depth nutritional assessment for those with abnormal results and/or positive risk factors. (See table 12.4)

Table12.3: Recommended BMI for Age cutoff, WHO 2000 Growth reference 5-19 yrs

BMI (kg/m ²)	Classification
≥ 95 th percentile	Obesity
85 th to < 95 th percentile	Overweight
15 th to < 85 th percentile	Healthy Weight
< 15 th percentile	Thinness/Underweight

$$\text{BMI} = \text{Weight in Kg} / \text{height in m}^2$$

Steps to plot and interpret BMI-for-age

Step 1: Obtain accurate weights and height measurements

Step 2: Select the appropriate growth chart (based on the age and gender of the child being weighed and measured)

Step 3: Record the data

Step 4: Calculate BMI

Step 5: Plot measurements

Step 6: Interpret the plotted measurements

In-depth Nutrition Assessments

- A complete and in-depth nutrition assessment should include a survey of all available medical, psychosocial and laboratory data.
- Detailed information on general dietary intake, adequacy as well as information specific to the identified health risk, should be obtained through rigorous dietary assessment.

(See Table 12. 4)

Table12.4: Elements of a Nutrition Assessment for Adolescents

	Medical and Psychosocial History	Growth and Development	Diet and Physical Activity	Routine screenings and Laboratory Tests
Components of an initial Nutrition screening	Medical history Psychosocial history Socioeconomic status and history	BMI for age	-Meal and snacking patterns -Nutrient and non nutrient supplement use -Food security -Food allergy intolerances -Special dietary practices -Alcohol consumption -Physical activity and competitive sports	Hemoglobin (females) Serum cholesterol or blood lipids Blood pressure

Table 12.4: Elements of a Nutrition Assessment for Adolescents

	Medical and Psychosocial History	Growth and Development	Diet and Physical Activity	Routine screenings and Laboratory Tests
Indications of an in-depth nutrition assessment	<ul style="list-style-type: none"> - Chronic disease - Substance use - Poverty - Depression - Eating disorder - Body image disorder - Pregnancy or lactation 	<ul style="list-style-type: none"> Underweight Overweight At-risk for overweight Delayed sexual maturation Short stature or stunting 	<ul style="list-style-type: none"> - Food insecurity - Meal skipping - inadequate micronutrient intake - Excessive intake of total or saturated fat - Food allergy or intolerance - Vegetarian diet - Competition in competitive sports - Fasting - Alcohol consumption 	<ul style="list-style-type: none"> Hypertension Hyperlipidemia Iron deficiency anemia

Activity 12.1 Discussion

- What are the current adolescent nutrition interventions in your specific area?
- What are different factors affecting adolescent nutrition in your specific area?
- What needs to be done to improve adolescent nutrition services?
- What are the roles of different sectors to improve adolescent nutrition interventions?

Nutrition Education and Counseling

One of the keys to effective nutrition education and counseling of adolescents is a good understanding of normal adolescent psychosocial development. Adolescents are striving to achieve independence yet they are highly influenced by the beliefs and behaviors of peers. They are developing abstract reasoning skills, however they may revert to more concrete cognitive skills when faced with new challenges or perceived stressful situations. These aspects of adolescent development need to be integrated into all nutrition education and counseling efforts, whether they occur as classroom nutrition education presentations or individual counseling sessions.

General Consideration for Nutrition Education and Counseling

- Nutrition education involves teaching the client about the importance of nutrition, providing educational materials that reinforce messages about healthy eating.
- Teaching adolescents skills essential for making dietary change, and providing information on how to sustain behavior change.

- Use the information gathered during nutrition screening during nutrition education and counseling sessions. *Adolescents who have one or more indicators of nutritional risk should be included for counseling.*
- Prior to beginning the education process, it is helpful to assess what the adolescent already knows about nutrition, how ready they are to adopt new eating behaviors, and if there are any language or learning barriers that may need to be addressed in order to facilitate the nutrition education process.

Motivation to make behavior changes can be easily assessed using a 0 to 10 score. Once adolescent's motivation to make behavior change has been assessed, nutrition educators must determine the best course of action to facilitate dietary change.

Steps of adolescent nutrition dietary assessment and counseling:

1. Establish a relationship (confidence building)
2. Setting the agenda;
 - a. Measure height and weight, record age and sex
 - b. Get a 24hrs recall of food intake (Annex 1)
 - c. Get opinion for any change in the adolescent's diet
3. Assess current dietary intake or dietary changes made
 - a. Ask adolescents to assess his/her diet on a scale of 0-10 by giving a number rating (1=very poor and 10=Excellent)
 - b. Ask why adolescents chose ___ number
 - c. Try to elicit specific reasons for choosing number, i.e. shortage, knowledge, preference
 - d. Ask about previous nutrition counseling (initial visit only). If follow-up, check on previous recommendations
 - e. Conduct the 24hr recall food intake and food frequency questionnaire
4. Interpret dietary intake or change
 - a. Plot BMI for age on WHO 2007 growth charts and interpret percentile (Annex 2)
 - b. Help teen to interpret their perception of their BMI for age percentile
 - c. Help teen to interpret the 24hrs nutrient mix and ask how he/she feels about diet vs recommendations
5. Determine Readiness to Make Dietary Change
 - a. Ask adolescents to assess willingness to change on a scale of 1-10.
 - i. 1-3 = not ready 4-7 = ambivalent 8-10 = ready
 - b. Ask why that number was chosen. Try to get specific reasons
6. Tailor Interventions Based on Readiness to Change and make appointment

Table 12.5. Tailored Intervention Stages

Stage 1. Adolescent is Not Ready to Make Dietary Change	Stage 2. Adolescent is Ambivalent About Dietary Change	Stage 3. Adolescent is Ready to Make Dietary Change
<i>Practitioner Goal:</i> To increase Adolescent’s knowledge of need for good nutrition and to educate.	<i>Practitioner Goal:</i> To motivate and empower adolescents and to understand factors related to ambivalence	<i>Practitioner Goal:</i> To help adolescents develop a plan and to define and negotiate specific strategies
Ask what would be needed to increase Adolescent’s willingness to make dietary changes.	Explore hesitancy. Ask about likes and dislikes in current diet or request a list of pros and cons of making dietary change	Ask what adolescent thinks needs to be changed
Ask how you could help Adolescent to become ready to change.	Ask about “healthy eating” habits or pros of making change first to set positive tone. Then ask cons of unhealthy habits	Ask for specific ideas or methods.
Reinforce your respect for the adolescent even if Adolescent’s chooses not to make changes	Ask what adolescent feels the next step should be	Help set small, realistic goals for 1-2 changes and make suggestions on how to measure change.
Offer advice example “I would recommend you increase your vegetable intake.	Offer to maintain contact periodically to check on adolescent’s progress	Choose rewards for achieving goals.
Ask open ended questions.		Make a follow-up appointment to monitor progress
Offer advice (with permission) and emphasize choice and personal responsibility		
<i>Source: Adapted from Berg-Smith SM, Stevens VJ, Brown KM, et al. A brief motivational intervention to improve dietary adherence in adolescents. Health Education Research: Theory and Practice 1999;14(3):399-410.</i>		

Case study

Scenario: Counseling Adolescents
<p>BB age 16 came to health facility for nutrition services. She weighs 35 kg and height of 1.5m. BB gets the least attention regarding diet in the family and she also believes that she is already grown and usually doesn’t get adequate and variety of food. She commonly misses breakfast and sometimes dinner. She has fatigue and dizziness and not able to attend and concentrate on school.</p>

Demonstrate how you can counsel BB using steps of dietary assessment and counseling and classify BMI for Age.

Promotion of healthy eating and Physical Activity

The development of healthy eating behaviors and physical activity patterns helps to optimize health status and promote mental and physical wellbeing. Unfortunately, many adolescents engage in health compromising behaviors such as frequent dieting, meal skipping, and frequent consumption of foods high in total and saturated fats, sodium and sugar. In addition, physical activity is not common among adolescents. Meeting the challenge of improving physical activity and dietary habits of adolescents requires the integrated efforts of parents, health care providers, schools, communities, the food industry, policymakers and the adolescents themselves, all working together to create more opportunities for healthful eating.

Promotion of Healthy Eating:

- Eating food from all of the food groups each day to meet the nutritional requirements.
- Balancing nutrient rich food, fruits and vegetables with minimizing other foods such as sweets and fats.
- Aiming for regular meals and healthy snacks.

Promotion of physical activity

- Engage in regular physical activity and reduce sedentary activities to promote health, psychological well-being and a healthy body weight.
- To reduce the risk of chronic disease in adulthood: Engage in at least 30 minutes of moderate-intensity physical activity, above usual activity, at work or home on most days of the week.
- For most people, greater health benefits can be obtained by engaging in physical activity of more vigorous intensity or longer duration.
- To help manage body weight and prevent gradual, unhealthy body weight gain in adulthood: Engage in approximately 60 minutes of moderate- to vigorous-intensity activity on most days of the week while not exceeding caloric intake requirements.

Summary:

- Adolescence is a period of intense growth, and with corresponding high nutritional needs.
- Adolescence is a period to have a second chance for a catch-up growth.
- Carbohydrates, proteins, Iron and calcium are some of the important nutritional requirements during adolescence.
- Underweight, iron deficiency anemia and overweight are common nutritional problems adolescents are exposed to; with consequence which pass in to adulthood.
- Nutritional assessment of adolescent is the first step in nutritional intervention for adolescents; BMI for age are the measurement used for assessment.
- Nutritional education and counseling can help to influence adolescent nutrition positively.
- Social Behavioral Change Communication (SBCC), prevention of parasitic infection, iron supplementation and prevention of malaria are effective interventions in prevention of iron deficiency anemia.

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- Growth Chart, Percentile BMI for Age. www.cdc.gov/growthchart

Annex 1: 24 Hours Food Intake Recall form

24 Hour Food Recall

NAME _____ Age _____ DATE _____

“I would like to know what you’ve eaten within the past 24 hours. Please tell me everything you ate or drank, including meals, snacks, beverages, candy and alcohol? Why don’t you start with the last thing you’ve had to eat or drink today and we’ll go backwards.”

Nutrients diet may be lacking in: _____

Nutrients diet may be excessive in: _____

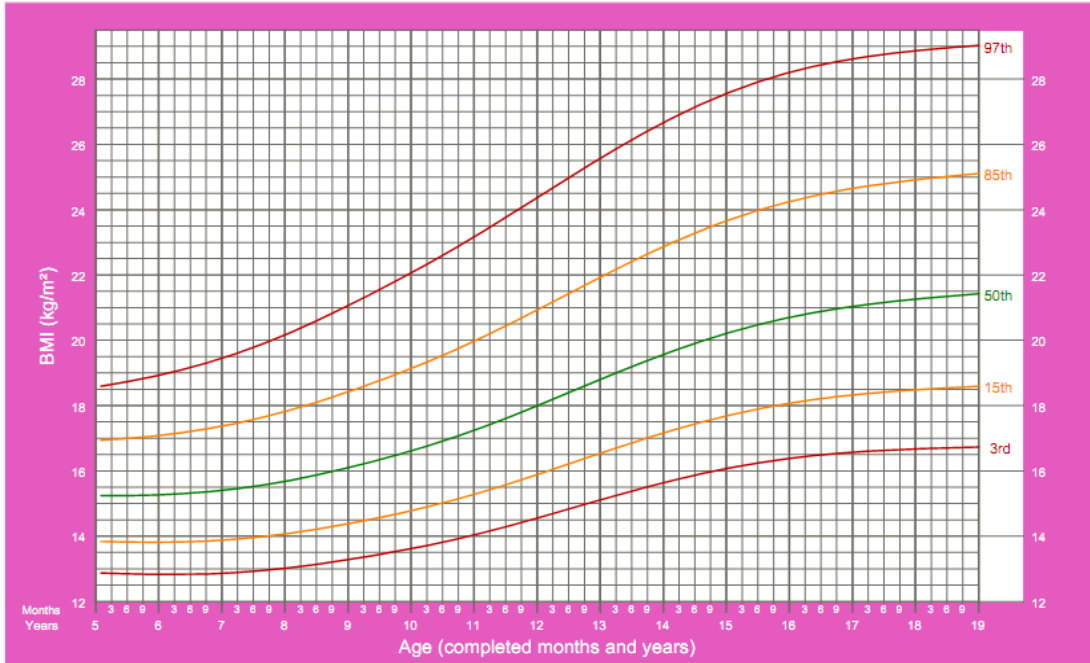
				Staples	Legumes/nut	Fruits	Vegetables	Animal source foods	Fats, Oils, Sweets
Time	Place	Food or Beverage	Amount	This Side For Office Use					

Adapted from Story M, Stang J. eds. Nutrition and the pregnant adolescent: a practical reference guide. Minneapolis, MN: Center for Leadership, Education and Training in Maternal and Child Nutrition, Division of Epidemiology, University of Minnesota; 2000 (Appendix C1, p. 236). <http://www.epi.umn.edu/let/pubs/nmpa.shtm>.

Annex 2: W.H.O, BMI for Age for girls and boys chart

BMI-for-age GIRLS

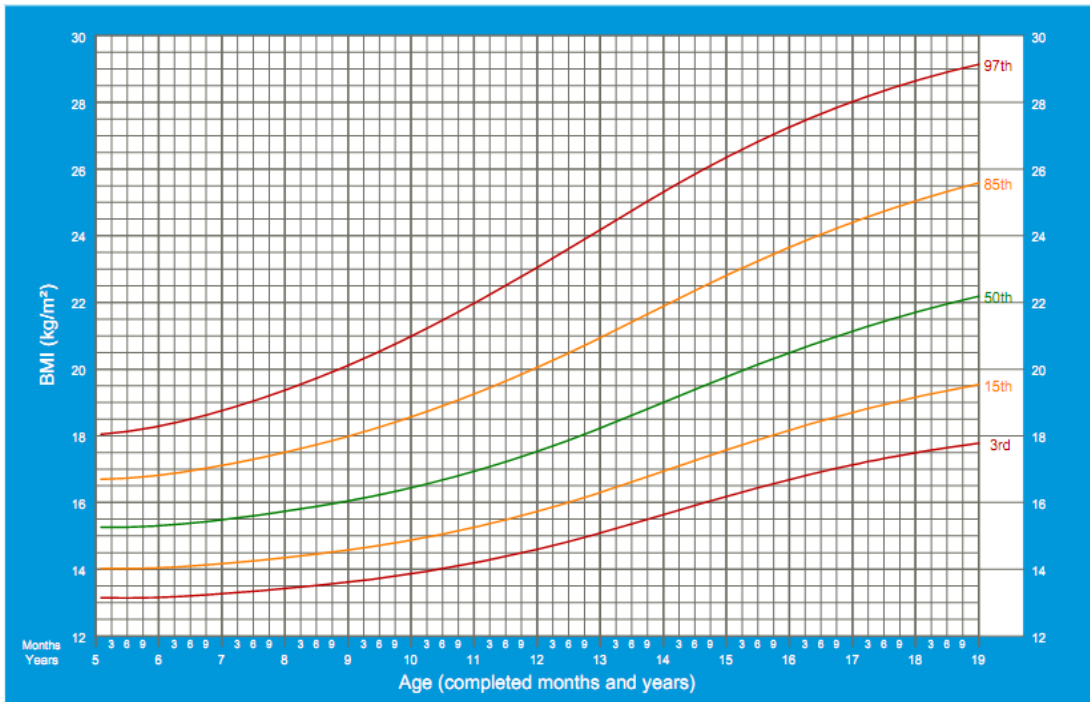
5 to 19 years (percentiles)



2007 WHO Reference

BMI-for-age BOYS

5 to 19 years (percentiles)



2007 WHO Reference

Chapter 13: Bioethics and Autonomous Decision Making in Adolescent & Youth Health

Session 13.1 Session Outline and Learning Objectives:

Duration: 75 Minutes

Session outline

- Concepts and definitions
- Applications of Bio-ethics and Ethical Guidelines
- Compassionate, Respectful and Caring Services to Adolescents and Youth

Learning objectives:

By the end of this chapter, participants will be able to:

- Describe the step by step process of addressing bio-ethical issues by applying the concept and principles of bio-ethics
- Able evaluate the adolescent's capacity for autonomous decision making in the actual matter
- Describe the characteristics of a compassionate, respectful and caring (CRC) health worker responsible for adolescent health
- Demonstrate attitudinal change towards adolescent health care from CRC perspective

Session 13.2 Concepts and Definitions

Bio-ethics

Ethics is a branch of philosophy dealing with standards of conduct, and moral judgment. It is a system of principles concerning the actions of the providers on her/his relationships with clients, clients' family members, other health care providers and supportive staffs, policy makers and society as a whole.

It is a science or study of moral values which is the ideas of life, customs, and ways of behaving with society and provides implicit standards and values for the professions. Ethics is also defined as the distinction between what ought to be and what won't, between right or wrong, good or bad. Health care ethics pertain to how health professionals fulfill their responsibilities and provide care to clients.

Professional values

Values are standards for decision making that endure for significant time in one's life. Values have four parts: **Thinking, choosing, feeling** and **behaving**. A value system is an enduring set of principles and rules organized in to hierarchy. When choosing between alternatives and making decisions, value system help people decide which values are most important.

Activity 13.1

- A. List ethical principles you know...
- B. What is value, and list professional values?
- C. In difficult situation, what do you choose to do? Check one option.
 - a. I use my common sense
 - b. I ask my superior
 - c. I ask my religious adviser
 - d. I discuss with my co-workers
 - e. I discuss with the ethical board in my region
 - f. Other options - describe

The essential values and behaviors of professionals:

Altruism: It refers to the desire to help someone to help another person even if it involves a cost to the helper. The key component here is selflessness - an unselfish regard for the welfare of others. It concerns for the welfare of others expressed in caring, commitment, compassion, generosity and perseverance. Altruistic service provider gives full attention to the client when giving care; assists other personnel in providing care when they are unable to do so; express concern about social trends and issues that have implications for health care.

Equality: ensuring everyone has equal opportunities, rights, privileges, or status.

Providers with this virtue ensure that people are treated as equals, that people get the dignity and respect they deserve and that their differences are celebrated. They care about individual's needs irrespective of personal characteristics, interact with other providers in a non-discriminatory manner, and express ideas about the improvement of access to nursing and health care.

Esthetics: qualities of objects, events, and persons that provide satisfaction. It includes appreciation, creativity, Imagination and sensitivity in service provision. Esthetical service provider adapts the environment so that it is pleasing to the client; creates a pleasant work environment for self and others; present self in a manner that promotes a positive image of providers.

Freedom: capacity to exercise choice with confidence, hope, independence and openness. Freedom has self- direction and self-discipline. It honors individual's right to refuse treatment. It supports the rights of other providers to suggest alternatives to the plan of care. It also encourages open discussion of controversial issues in the profession.

Human dignity: Human dignity signifies that the human beings have a special position that places them over the natural and biological position in nature. As a moral being having freedom, autonomy, capacity of moral reasoning and responsibility, adolescents and youth are assigned a dignity that determines their value and position in the world. Consideration, empathy, humanness kindness, respectfulness and trust Safeguards the individual's right to privacy. Addresses the individuals as they prefer to be addressed Maintain confidentiality of clients and staff. Treats others with respect, regardless of background

Justice - upholding moral and legal principles with courage, integrity, moral and objectivity. A provider with this value acts as a health care advocate; allocates resources fairly, reports incompetent, unethical, and illegal practices objectively and factually.

Truth – denotes faithfulness to fact or reality. Accountability, authenticity, honesty, inquisitiveness, rationality and reflectiveness are elements of truth. A trustworthy provider documents care accurately and honestly; obtains sufficient data to make sound judgments before reporting infractions of organizational policies; and Participates in professional efforts to protect the public from misinformation about the health profession.

Bio-ethics and its principles

Bio-ethics looks at how to maintain respect for, and protection of, the individual in the light of our expanding knowledge of life sciences and their applications in the areas of **clinical practice, research, and policy and public health**. Bio-ethics principles are being applied in diversified health-care works - confidentiality in clinical practice and decision-making like in terminal

illnesses; informed consent in research that involves human being; and priority setting and selection of interventions with respect to equity and public health policies.

After the Second World War scientists from North America and Europe realized that physicians and researchers had been involved in unacceptable research interventions. The Nuremberg code, which was endorsed by the main medical societies of developed countries, is considered as one of the very first official document testifying to the emergence of bioethics and focuses on the conditions in which all research involving human subjects should be run. It therefore stresses the importance of 'informed consent', thus ensuring that a 'competent' person, asked to be part of a study, must be fully informed of the risks and potential benefits of the research.

It also requires that the research must bring a potential benefit which cannot be obtained in any other way. In 1964, the Helsinki declaration (developed by the World Medical Association) built on the Nuremberg code and stressed the importance of the concept of 'competency'.

In 1978, the Belmont Report stressed the four principles which have offered a landmark in the history of modern bioethics. These are:

Autonomy:

It refers to a one's right to make their own decisions for oneself and act on these freely. It implies the capacity to make one's own decisions about one's own life. In the domain of health care, respecting adolescents and youth autonomy includes obtaining informed consent for treatment; facilitating and supporting patients' choices regarding treatment options; allowing patients to refuse treatments; disclosing comprehensive and truthful information, assessment, diagnoses, and treatment options to patients; and maintaining privacy and confidentiality

Non Maleficence -

It aims to protect clients from harm, emphasizing on negative liberty. It stresses the Hippocratic principle of "*primum non nocere*" (first do no harm). Nonmaleficence requires intentional avoidance of actions that cause harm. In other words, the health care provider commits himself to relieve suffering and pain, to prevent illness and promote health of the adolescents and youth. The ultimate goal is to increase the benefits and minimize the risks linked with any intervention.

Beneficence - Consists of performing deeds of mercy, kindness, friendship, charity and the like. Beneficence means people take actions to benefit and promote the welfare of other people. Because of professional standards and social contracts, health service providers have a responsibility to be beneficent in their work. Health-care information and services should benefit the adolescent and youth by improving their physical, mental, and social wellbeing.

Justice (and Equity)

It emphasizes that adolescents and youth have the right for full access to proper health care and not to be discriminated against or stigmatized. It ensures that adolescents and youth should get a fair share of social and medical resources. In general, it ensures that policies and public health interventions don't encourage social inequities or exclusion of certain groups according to racial, ethnic, age, sex, religious or political criteria.

The application of bioethics is by no means only limited to the use of the four Belmont principles mentioned earlier, (referred to as the *Principlism* approach) but has evolved in several other directions: In Europe and in other parts of the world including the United States. Rather than providing a formula or a set of rigid criteria for addressing ethical problems, most bioethicists would propose a flexible approach, using the so-called '**deliberative**' approach. Such a deliberative process is usually run with the involvement of several stake-holders, often including the subject himself. Its objectives are to focus less on the strict application of the four Belmont principles, but rather to have an in-depth discussion of the specific / unique characteristics of each situation and what should be considered as good or bad for all involved parties.

In this respect, other important values have emerged besides the four Belmont values, such as, in the field of clinical care, **dignity, integrity, solidarity, participation and vulnerability**.

Moreover, with the emergence of public health and health promotion, with the increased number of preventive interventions directed at the whole population or to young people, new ethical issues have appeared: how to choose priorities in respecting the needs of the whole population? Should one focus on vulnerable groups or rather on the whole population? How to take into account religious and cultural issues when developing preventive strategies?

Session 13.3 Applications of Bio-ethics and Ethical Guidelines

The application of ethical guidelines is strongly linked with the legal framework. The concept of **competence, confidentiality and informed consent** should be considered for people who are under the age of majority, as often times there are conflicts with the law, and ethics. Understanding the country specifics with reference to the legal framework is necessary.

Age concepts:

Age of majority: is the threshold of adulthood as it is conceptualized in law. It is a chronological moment when children legally take control over themselves, their actions, and their decisions, thereby terminating the legal control and legal responsibilities of their parents over them.

Mature Minors – is a concept relevant in some countries where under-age minors are given adult responsibilities. For instance, young girls who become mothers

Age of license: is the age at which the law permits an individual to perform specific acts and exercise certain rights, with or without any restrictions. Like

- Allowed to vote
- Leave school without a diploma
- Enter legally binding contracts
- Operate motor vehicle
- Purchase or consume alcoholic beverages
- Can engage in relationship and marriage

The UN Convention of the Rights of the Child (UN-CRC)

- the right to life and development (art 6)
- **the right to be heard (art. 12)**
- **the right to express his own rights and the right for autonomy (art. 12 & 14)**
- **the best interest of the child (art. 3)**
- the right to be protected from violence (art. 23)
- the right not to be discriminated against (art 2)

NOTE: You can download the complete text of the CRC: <http://www.unicef.org/crc/>

Dealing with conflicts and Ethical dilemmas

Bio-ethics works ultimately to benefit, not to harm or minimize the damage. However, in practice, health-care providers may encounter conflict of interests of several stakeholders, patients, and other factors. For instance when should an HIV +ve orphaned boy be informed his status, should he start dating, if he has already started... when should he tell? Can a chronically sick adolescent (adolescent cancer patient) request for euthanasia?

An ethical dilemma is a situation in which an individual is compelled to choose between two actions that will affect the welfare of a sentient being, and both actions are reasonably justified as being good, neither action is readily justified as being good, or the goodness of the actions is uncertain. One action must be chosen, thereby generating a dilemma for the person or group who is burdened with the choice.

Dilemmas and conflicts should be viewed through these lenses: **consent, confidentiality and competence** (autonomous decision making capacity). **They are called the three important C's** in dealing with conflicts and dilemmas.

Consent

Informed consent: an individual who is considered competent has the right to make his/her own decision about any health intervention that involves him/her. This may include laboratory tests (a young has right to give informed consent to HIV test at age 14, being prescribed medication, and undergoing surgery). On another note, if the adolescent who is not considered competent, still has the right to be informed of interventions that involves him/her. In such cases, we need to get *Informed Permission* from the surrogate decision maker such as parents and an *assent* from the adolescent or youth. Such information should be adapted to his level of understanding. However, he/she can't say no if the intervention is considered to be in his best interest. Adolescents and youth who are competent have the right to demand that his/her health-care provider doesn't disclose any information to any other person without permission from the adolescent.

Evaluating autonomous decision making capacity - competence

Autonomous decision making capacity refers to the fact that a person is able to understand the situation that requires a decision. All adolescent and youth who have attained their majority are considered as competent unless they suffer from major psychiatric disturbance. Nonetheless, there are competent adolescents who have not reached their majority. In assessing competency, these four must be considered:

- Understanding the disclosed information about the nature of the decision and the procedure,
- Appreciation of the effects of treatment (or failure of treatment on one's actual/future health
- Ability of reasoning in the process of deciding about the treatment, with a focus on abilities to compare alternatives in the light of their consequences,
- Expressing a choice about participation

Assessing minor competence: during assessment of a minor's capacity to make an autonomous decision, health-care provider should deliver the information in a simplified and an unambiguous way as to make sure the adolescent fully understands what the issues are. Check out this understanding by asking him/her to rephrase the information which has been presented and how he/she understands the long-term consequences. So, minor's competence requires understanding of long term consequences, and this is based on advanced cognitive thinking which often is increased with age. An adolescent might not understand long-term consequences, but he/she might have a good understanding and knowledge of the conditions

of his/her particular disease. Then, the adolescent can be considered as competent in particular area.

Summary of Steps to address ethical dilemma and autonomous decision making:

- Define the ethical dilemma
- Identify contributing factors, e.g., legal framework, medical facts
- Identify main stakeholders involved
- Check that adolescent fully understands the issues by asking him to rephrase the information which has been presented
- Explore with him/her the medical and non medical consequences of each option
- Discuss the advantage and disadvantages linked to each option
- Discuss different ethical values involved
- Discuss which are the best options for the client with him/her and if possible, with stakeholders

Final decision depends on the result of the competence assessment, and this **decision is often negotiated**. If she/he is judged totally competent then the decision depends on her/him with the support of service provider. However, if she/he is not judged competent, then the decision depends on the service provider and parent/guardians.

Activity 13.2

Discuss the following points referring to the case stories in Annex 2

- What are the ethical dilemmas?
- What is the unique in this situation of adolescents and youth which raises ethical dilemmas?
- Does the client understand his/her situation?
- Why is this a challenging situation?
- Has he the right to autonomous decision making?
- Who are the stakeholders?
- What are the best interests of the boy/child?
- What are the rights of the boy/child?
- What are the rights of the parents?

Note that:

- There are no right or wrong decision after a bio-ethical analysis
- It does not tell you what to do
- It helps stakeholders – and the adolescent him/herself - analyse their thinking and more clearly see what is in the best interest of the adolescent depending on the circumstances in any particular case.

Session 13.4 : Compassionate, Respectful, and Caring Services to adolescents and youth

What is CRC: it means serving patients, being ethical, living the professional oath and being a model for young professionals and students. It's a movement that requires champions who identify with their profession and take pride by helping people. It requires in some ways a cultural change and a change in attitude, manners and approach to health care delivery.

Medical care without compassion cannot be truly patient-centered. Compassion, which lies at the intersection of empathy (in this case, understanding patients' concerns) and sympathy (here, feeling patients' emotions), combines a response to the distress of others and a desire to alleviate that distress.

Compassionate care addresses the patient's innate need for connection and relationships and is based on attentive listening and a desire to understand the patient's context and perspective. For most clinicians, compassionate care matters because it is fundamental to the practice of medicine, ethically sound and humane. However, strong evidence also supports the impact of compassionate care on health outcomes, costs and other essential aspects of care.

Caring, Respectful and Compassionate health professionals have the following four essential characteristics:

- Consider patients as human beings with complex psychological, social and economic needs and provide person-centered care with empathy
- Effective communication with health care teams, interactions with patients and other health professionals over time and across settings;
- Respect for and facilitation of patients' and families' participation in decisions and care; and
- Take pride in the health profession they are in and get satisfaction by serving the people and the country.

Compassionate, client-centered care is a top priority to improve the quality and equity in Youth friendly service delivery to address the health needs adolescent and youth.

Summary

- Ethics is a branch of philosophy dealing with standards of conduct, and moral judgment. It is a system of principles concerning the actions of the providers on her/his relationships with clients, clients' family members, other health care providers and supportive staffs, policy makers and society as a whole
- Health care ethics pertain to how health professionals fulfill their responsibilities and provide care to clients, and service providers should give attention to ethical principles: to respect autonomy & dignity, beneficence, non maleficence, and justice/equity.
- Young people are quite explicit about what they want from health-care providers, hence competence in terms of knowledge, attitude and skills on how to deal with them is very crucial
- Professional values are standards for decision making that endure for significant time in one's life. Values have four parts: Thinking, choosing, feeling and behaving
- CRC means serving patients, being ethical, living the professional oath and being a model for young professionals and students.
- Caring, Respectful and Compassionate health professionals have the following four essential characteristics:
- Compassionate, client-centered care is a top priority to improve the quality and equity in Youth friendly service delivery to address the health needs adolescent and youth.

**Annex one
SPOT CHECK**

1. A competent client has the right to refuse unwanted therapy. Does this necessarily include a right to demand any therapy? Explain.

2. What is CRC?

3. Which of the following is **not** the characteristics of a professional delivering CRC?
 - A. Pride in the profession
 - B. Have effective communication
 - C. Consider clients as a patient and keep everything secret.
 - D. Respects families' participation in decision of care

Annex 2:

Case studies for Ethics Exercise

Case 1: Yohannes is an adopted adolescent, who was found to be infected with HIV upon his arrival in his region of adoption. Until recently, he has performed well at school and the infection was under control with the parents making sure that Yohannes was taking his medication. For the last couple of months, however, Yohannes has become rebellious at home as he feels that his parents are overprotective and too concerned about his life and his medical condition. Moreover, his medical situation has deteriorated. Yohannes feels different from his peers, who do not have to take a medication every day and admits that he has stopped regularly taking his medication; as a result, his blood tests have worsened. His attitude changes from consultation to consultation, sometimes he agrees to continue the treatment but lately he is more resolute to stop his medication for a while, as he thinks he will feel better. Yohannes has recently met a girlfriend with whom he has had sexual intercourse on several occasions. His parents don't know that he has a girlfriend. The girlfriend does not know his HIV status, but Yohannes says that he always uses a condom. The girlfriend wants to switch to hormonal contraception as a sign of mutual trust between them, and asks that Yohannes shares the expenses. While Yohannes asks for total confidentiality on all the issues that he rises, his parents insist that the doctor give them some insight into their son's situation. Additionally, the doctor thinks his girlfriend should know about Yohannes' HIV status but is not sure how to solve the implied ethical dilemma

Case 2: A 15-year-old boy and his parents are seeing you in the office for disruptive behavior in the classroom and at home that is concerning for psychoactive substance use disorder. Both parents have demanded admission at a rehabilitation center, while the boy is sitting alone on the examination table, refusing to be admitted, repeating "I don't want to be there."

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Chapter 14: Adolescent and Youth Responsive Health System and Services

Session 14.1 Session Outline and Learning Objectives

Duration: 70 Minutes

Session outline
<ul style="list-style-type: none">• Health-care Services, the Need for Adolescents and Youth• Integrated Management of Common Conditions

Learning objectives:

By the end of this chapter participants will be able to:

- Explain the role of health services to promote adolescent health
- Describe the characteristics of adolescent and youth responsive service outlets;
- Able to outline strategies that promote adolescent and youth friendly services
- Discuss why integration is beneficial for an effective management of common conditions in adolescence.
- Describe quality of health-care services for adolescents and youths in a comprehensive manner
- Apply Quality assessment tool and plan for appropriate QI action
- Apply in clinical practice the laws and policies that affect adolescent health-care provision

Session 14.2: Health-care Services, the Need for Adolescents and Youth

The country developed national strategic plan which will be implemented through evidence-based interventions. Globally, such interventions have included improving immunization coverage, tackling substance abuse, treating mental health, offering reproductive and sexual health services, and preventing accidents and injuries. The programme also recognizes that while the health sector has a special role to play in leading this effort, improving adolescent health requires involvement from multiple other sectors, including education and finance and involvement of adolescents themselves. Thus, key implementers of Adolescent Development Health need to understand the role of other sectors involvement during implementation of Adolescent health.

The term **health services** refers to a clinical service, which often includes some information provision and advice; and aimed at preventing health problems; detecting and treating them if and when they arise. The term **health facility** refers to a recognized institution that provides health services, ranging from small clinics providing a limited range of primary level services, to large hospital complexes providing a range of tertiary-level health and social services.

The term **gatekeepers** includes both those who interface with adolescents on a regular basis, such as their parents, teachers and youth leaders, and those who do not, such as policy-makers and administrators. Identifying and working with these **gatekeepers** is an essential part of any public health initiative, especially those that address adolescents.

It is well recognized that the role of health-care providers is to help ill adolescents and youth get back to their good health. Health care providers also have an important role to play in helping adolescents and youth to stay healthy, and help them develop into healthy, competent and caring adults. Health services/health care providers play a critical role in the development of adolescents and youth as well as their health, by:

- Treating conditions that give rise to ill health or cause concern to adolescents and youth;
- Preventing health problems that can end young lives or result in chronic ill health or disability;
- Supporting young people who are looking for a route to good health, by monitoring progress and addressing concerns;
- Interacting with adolescents and youth at times of concern or crisis and looking for a way out of their problems;
- Making referral links with other services, such as mental health and counseling services, which can support adolescents and youth.

Health workers can also play an important role as a change agent by using their high credibility in their own community and helping educators, religious leaders, political leaders and other gatekeepers understand the needs of adolescents and youth, and the importance of working together to meet these needs.

Young people in crisis need counseling and community support beyond what health services alone can offer. This support comes from parents, families, teachers, trained counselors, 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.

Why Adolescent and Youth Friendly and responsive Service?

Adolescent and Youth may be reluctant to seek help when they encounter health problems which are common and not serious by its nature; it is also possible for them to seek for medical care for the same reason; however, when the health problem involves sensitive matter, it is difficult for them to turn into their adult figure such as their parents or to seek help from health care workers; instead they tend to solve the problem by themselves or with their peers. This could affect their health negatively and expose them to a vicious circle of risky behavior and health problems.

Despite the presence of a health system that provides the services, young people's health service utilization is usually affected by external factors.

Adolescents and Youth have in many surveys expressed their views about what they want from health services.

- A welcoming facility, where they can “drop in” and receive service quickly;
- Their privacy and confidentiality be kept but do not want to seek parental permission to attend;
- A service in a convenient place at a convenient time that is free or at least affordable;
- Service providers who could treat them with respect and free of judgment;
- A range of services in one place, at the same time.

In order to attract Adolescent and Youth and increase their health service utilization, the service has to understand unique nature of adolescents and responsive to all adolescent health

problems. Thus, those who plan and provide services cannot only think about the wishes of adolescents; but services must be organized in the dimensions of quality to be equitable, accessible, acceptable, appropriate, effective and affordable. In addition, services for this age group must demonstrate relevance to the needs and wishes of young people.

Characteristics of adolescent friendly health services

Although the adolescents and youth are heterogeneous in their needs and expectations from the health system, they all agree on two things, they want to be treated with respect and know that their confidentiality is respected.

The following points will guide what roles should the health services have and how they need to be organized to provide services that are in a friendly, supportive, respectful, non-discriminatory and non-judgmental manner for adolescents and youth.

Adolescent-friendly policies that

- Fulfill the rights of adolescent as stated in the UN convention on the rights of the child and other instruments and declarations
- Guarantee privacy and confidentiality and promote autonomy, so that adolescents can consent to their own treatment and care.
- Ensure that services are either free or affordable by adolescents.

Adolescent friendly procedures

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

Adolescent friendly health care providers

- Technically competent in adolescent specific areas and offer health promotion, prevention, treatment, and care relevant to each client's maturation and social circumstances
- Have interpersonal and communication skills
- Motivated, nonjudgmental and considerate
- Devote adequate time to clients or patients, act in the best interests of their clients, treat all clients with equal care and respect

Adolescent friendly support staff

- understanding and considerate

- treating each adolescent client with equal care and respect

Adolescent friendly health facilities

- Safe environment at a convenient location
- Convenient working hours
- Offer privacy and avoid stigma
- Provide information and education material.

Community involvement and dialogue

- Promote the value of health services
- Encourage parental and community support.

Community based, outreach and peer-to-peer

- Services to increase coverage and accessibility
- Appropriate and comprehensive services that address adolescent's physical, social and psychological health and development needs
- A comprehensive package of health care and referral to other relevant services

Effective health services for adolescents

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

Efficient services

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

How are Services Best Delivered to Adolescents and Youth?

Adolescent-responsive health services can be delivered in hospitals, health centers, health posts in schools, or in community settings.

Services at health Facilities

Basic health promotion and prevention services are provided at lower level health facilities (Health post), and at the community; in addition to what is given at the community level basic health service are provided in all health centers and Hospitals. At all levels of health facilities properly oriented health workers who understand the adolescents and youth are needed; these health workers are expected to deliver the service in an empathetic approach, so that young people are willing to attend.

Regular monitoring of the service using QoC assessment tool that address the friendliness of the service and client satisfaction surveys using exit interviews could help inform interventions that target the quality of such services. In addition, provision of on-job training and encouraging health workers to use clinical protocols and guidelines in their practice could enhance the quality of service along with peer assessment and good quality supervision and management.

Services Located at other centers

School Health intervention: schools provide a natural entry point for reaching young people with health education and services; since this is the place Adolescents and youth are easily found in great number. According to the World Bank report, the primary and secondary school enrollments are above 70%. Thus, schools are uniquely positioned to reach majority of adolescents and youth with health services especially with preventive health services.

Having specific health needs can adversely affect adolescent development, growing autonomy and the emerging identity. It can be a challenge to manage these conditions in adolescents within the context of all the other changes that are taking place. The management of these conditions requires comprehensive care and support addressing both medical and psychosocial issues in an ongoing manner.

School health programs are common in both high and low income countries. 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.

Activity 14.1. Each participant has to write only one item for the points below.

1. Write one reason why a school is a partner on the green card you are given
2. Write the deficit in the system.

Below are some key points as to why schools are partner and the deficit in the system:

The school as partner

- Health promotion
- Development of individualized plans for adolescents with specific health needs with the support of the health providers and the family
- Improve the integration of adolescents with specific health needs in the school setting:
Inclusion of all youth

Deficits of the current system

- Lack of shared understanding and perspectives between medical system and school
- Success of integration depends on individual commitment of teachers and parents
- lack of regulatory framework and process-mapping including flow of information

Other challenges faced by school health from other countries experience include:

- weak alignment of services with health priorities,
- poor human resource capacity and scarcity of school health workers,
- inadequate engagement of families and teachers in school-based health promotion,
- lack of financial resources and
- Unclear role among school nurses, school doctors and general practitioners.

There is diversity in how school health services are organized. Varying models provide all or some of the following services including individual clinical care, group-based health promotion, prevention, infectious disease control, screening, case management for chronic conditions and referrals for further health services. A review of school health system from 102 countries showed that services were given in around 16 areas. The top five include:

- Vaccinations
- Sexual and reproductive health education
- Vision screening
- Nutrition screening and nutrition health education.

However, important areas such as mental health, injury and violence prevention were not given sufficient consideration in the routine service provision.

Youth centers: Among the range of service delivery platforms for health and other SRH services, youth centers are among the major ones. The platforms are efforts to take services to where adolescents are since significant number of adolescents may not visit the health sector. In youth or community centres, health professionals provide health and other services.

According to a study by UNICEF, the youth centers provided several services such as, recreation (indoor and outdoor games) facilities; access to library and internet (ICT); voluntary counseling and Testing (VCT) and Reproductive Health (RH) services for in-school and out-of-school youth. The most frequently used services by the adolescents and youth were the library, indoor games, outdoor games and café.

In general, many youth were happy about the services provided at the centers. What is working well include: the minimal fee or free services charge nature of services; awareness raising efforts on variety of topics such as HIV/AIDS and VCT; and the availability of various services in one place.

What is not working well include: most of the users are in-school youth and the system failed to reach out-of-school youth; most service users were male and the service were mostly located in Urban areas.

Activity 14.2. Discuss the following points in group and present the summary of your discussion

1. What are the advantages of youth centers as service delivery outlet for adolescents and youth?
2. What are the challenges/limitations of the existing youth centers as service delivery outlet for adolescents and youth

Session 14.3: Integrated Management of Common Conditions

Rationale for the Integrated Management of Common Conditions

There is strong theoretical and research evidence that suggest a holistic approach to promotion of adolescent and youth health and treatment of their common conditions. It is understood that many of young people's deviant behavior are linked. In addition, the major causes of mortality and morbidity in this group share common risk taking behavior; and certain risk behaviors are interrelated and tend to co-exist among these young people; for instance, alcohol consumers may tend to engage in khat consumption or risky sexual practice.

There are practical experiences for the integrated approach to health especially in the reproductive health area; international initiatives and strategies encourage such integration. An example of such integration is dealt below:

Generic application to SRH, HIV, Nutrition

There are different stakeholders that need to interplay for interventions for adolescents and youth to be effective.

The Global strategy for women's, children's and adolescents' health (2016-2030) calls for the adoption of a multi-sector approach to improving the health and well-being of women, children and adolescents. Likewise, the 2006 UNGASS declaration underscored the need for integrating HIV/AIDS and reproductive health services. The same applies for the integration of HIV AIDS services for adolescents and youth with maternal and infant health services.

Activity 14.3.

Discuss in groups the advantages of integration for the management of common conditions of adolescents and youth.

The integration of HIV/AIDS

Sexual and reproductive services are beneficial since:

- Both serve the same target population - the sexually active - men, women and young people
- Both promote safe and responsible sexual behavior
- The integration has potential to increase dual protection and condom use
- The service reduces MTCT and stigma associated with HIV/AIDS
- The integration minimizes missed opportunities to increase access and coverage for vulnerable and high-risk groups
- The integration builds on existing programs, structures and institutions and promotes universal access to both services
- The integration provides tailored sexual and reproductive health services for people living with HIV
- The integration is also potential for cost savings, eliminates duplication, promotes coordination and efficiency
- The integration is likely to increase impact on prevention

Integrating HIV AIDS with maternal and child health

- Develop policies to provide appropriate HIV/AIDS management options for pregnant women, mothers, their infants and families
- Ensure that all four prongs of the strategy for PMTCT of HIV are in place
- Provide basic package of HIV/AIDS services in antenatal care settings
- Integrate antenatal syphilis screening and treatment with PMTCT
- Strengthen maternal health services for women living with HIV/AIDS (infant feeding counseling, family planning, access to HIV care, treatment and support)
- Provide counseling on reproductive choices for PLWHA and their partners

Activity 13.4. Case study

A 13 year-old girl who comes to the health center with her mother was referred by the school physician because she is gaining weight although she has practically stopped growing. There are 3 other younger children in the girl's family, which left their country three years ago for political reasons. The father is unemployed and the mother works as a housekeeper. The girl started regular menses two years ago. She never eats breakfast, eats few vegetables and fruits, and no meat. She is quite sedentary, does not like the school exercise class, and spends several hours a day watching TV. Although the mother says her daughter complains about the size of her hips, the girl denies this. She has very few friends. Past history is unremarkable except mild asthma treated with antihistamines and inhaled corticosteroids. There is no family history of early cardiovascular disease or type II diabetes. From the school visit report, you calculate a BMI of 26, which is above the 97th centile for age and gender and is in excess of 36 % above normal weight for height. The girl did not want to come and does not want to be examined. The mother insists on an exam, and wants a blood test to rule out a hormonal problem. After the mother has left the examining room, the girl explains that having gained weight rapidly bothers her and that she feels different from her peers. She thinks a dietician cannot help her and she doesn't know what to do. You propose that she makes another appointment at the clinic, you will then examine her. You explain the possible options, emphasizing to her how important it is that she reflects on her choices and her future, and ask her to be open to discussing the situation with other professionals. At the end of the visit you summarize your findings for the mother, indicating that a blood test, which the daughter would not be easily accept, is not required at this time and could be discussed at a later stage.

Summary

- Adolescent-Responsive health service can be delivered at all level of health delivery points and in the community through HEP
- The service at community level includes at youth centers , schools and through social media (internet
- Service can be given anywhere where young people are available.)
- Other special groups in the community can be reached through outreach services
- Health problems of adolescents such as chronic conditions need the coordination of parents, school and the health sector
- There are broad range of service delivery platforms for delivering health services to adolescents and youth including schools and youth centers. Within each platform, the focus, content and organization of the services can vary.
- **Key characteristics of AY responsive service rendering health facilities summarized as:**
 - Availability of trained staff in AY **health orientation program/training responsive providers**

- Having drugs, supplies and IEC materials and services needed for adolescent & youth
- Separate service areas for adolescents & youth
- Youth involvement in the provision of IEC (Health Education) & AY responsive services

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Annex 1

Spot Checks

SPOT CHECK 1

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

.....
.....

SPOT CHECK 2

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

They.....

They.....

They.....

SPOT CHECK 3

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

.....
.....
.....

SPOT CHECK 4

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

1. Not adolescent friendly 2. Somewhat adolescent friendly 3. Very adolescent friendly