Report

Adolescent Health
State level Training of Master Trainers

Organized by:
Public Health Department, Maharashtra
and
State Health System Resource Centre, Maharashtra

Supported by:
UNFPA, Maharashtra State

Conducted by:
PROGNOSIS Management and Research Consultants, Pvt. Ltd, Pune

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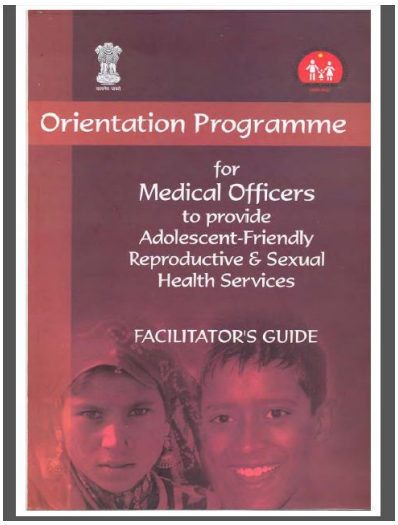
Adolescents (10-19 years) in India represent about 23% of the population. A large number of them get married early, work in vulnerable situations, become sexually active at an early age and are influenced by peer pressure. These factors have serious social, economic and public health implications. It is important to influence the health-seeking behavior of adolescents as their situation is central in India's health, mortality, morbidity and population growth scenario.

In the last 2-3 years about 140 adolescent clinics were established all over the state but the number of adolescents availing services in these clinics is negligible, the use of services is limited. In view of this, it was felt necessary to orient and strengthen the capacities of District level officers on adolescent health services so that they can act as Master Trainers for the health staff working under them. State level training of Master Trainers on adolescent health was organized by Public Health Department and State Health Systems Resource Centre (SHSRC), Maharashtra in the month of November 2013. It was supported by UNFPA, Maharashtra State. The training was held at three places namely, Nagpur, Aurangabad and Lonavala covering 85 District RCH Officers, Outreach RMOs and Corporation Medical Officers from 33 districts. The PROGNOSIS Management & Research Consultants Pvt. Ltd, Pune shouldered the responsibility of conducting these trainings. The main objective of the training programme was to orient and equip District level Officers from the Public Health dept. as master trainers in adolescent health and needs of adolescents.

Objectives:

Three days training was designed keeping in mind the following objectives:

- To make participants more knowledgeable about the characteristics of adolescent development
- To make them able to understand the needs of adolescents
- To make them better equipped with information and resources thereby implement and monitor adolescent -friendly health services in their area and ensure quality of care



Programme modules and agenda:

The manual prepared for Medical Officers to facilitate the functioning of adolescent-friendly health clinic was used to impart adolescent health. It consists of ten modules based on the present needs and health issues of adolescents and the guidelines regarding the quality of care pertaining to adolescent health clinic. Participants can avail this guide from Health and Family Welfare Training Centers. Soft copies of this module were distributed to all participants, along with the handouts designed for training.

Inauguration:

- The commencement of programme was done by lighting lamp and welcome speech by Dr. Gawande, Executive Director, State Health System Resource Centre.
- **Nagpur:** The programme was inaugurated by Dr. Gawande, Executive Director State Health System Resource Centre**,** Pune and senior officers attending training by lighting the lamp at Hotel Rahul.
- **Aurangabad**: The programme inauguration was done by Dr. Gawande, Executive Director State Health System Resource Centre**,** Pune, Dr. Bhatkar, Principal, HFWTC, Aurangabad and Dr. Kamalapurkar, Asst. Director, State Family Welfare Bureau by lighting the lamp at Hotel Bagga International.
- **Lonavala**: The programme was inaugurated by Dr. Gawande Executive Director State Health System Resource Centre**,** Pune and Dr. Kamalapurkar, Asst. Director, State Family Welfare Bureau by lighting the lamp at Biji's hill retreat resort.

Methodology

The teaching methods used were participatory so that participants can share their experiences, ideas, views freely. It gives opportunity to the individuals to draw on his/her experience and learn in active way. It also enables a more equal relationship between participants and facilitators.

It was also kept in mind that the participants are with extensive clinical experience of working with adolescents and adolescent health issues.

A range of methods and approaches from direct input in the form of mini lectures to problem- solving in small groups were used during the training programme. Brainstorming was also used to know the views of participants on some adolescent issues. Case studies and role-plays on different issues were given to express the thoughts and ideas of participants during the three days training period. Quiz sessions were conducted based on adolescent health problems, so that perception of participants an understanding of these problems gets revived and comprehensible.

Table 1: Designation wise distribution of participants

	ADHO	DRCHO	RMO OUTREACH	MHO	MO	Epidemiologist	MS-SDH	RCH Nodal officers
Nagpur (26)	--	11	11	4	--	--		
Aurangabad(36)	3	11	12	5	4	1	--	--
Lonavala(32)	2	5	6	3	11	--	1	4
Total(94)	5	24	26	11	12	1	1	4

Modules covered on the first day of the training:

MODULE I- INTRODUCTORY MODULE

a. Introduction of the participants

The introduction of the participants was conducted in innovative manner. The chits of paper with numbers in pairs (1-1, 2-2…) were kept on the table. The participants were asked to pick up one chit of paper each. Then they were asked to find his/her own pair of number, after finding out partner , they were asked to introduce himself/herself based on following points

- Name
- Designation and where he/she is working
- Number of years of work experience
- Fondest memory from your adolescence
- Troublesome experience from your adolescence

This introduction was found very interesting and also helped in rapport development. Some participants said that they could not recollect any good or bad memory from adolescence. Most of them introduced their partner very well. There was a variety of adolescent memories such as influential and good teachers, non-availability of books during school days, peer pressure, love affair etc. Listing down of the experiences narrated by participants helped as references in further sessions such as emotional and social changes during adolescents.

b. Expectations of the participants from training

The participants were asked to write their expectations on ZOPP cards. The main expectations were as follows:

- Training should be informative, innovative, and participatory
- Training should be delivered by expert person
- Complete information on adolescent health
- How to implement ARSH activities at PHC in addition to its routine work
- How to start ARSH clinic in corporation area
- How to attract adolescent group to the clinic

- Monitoring and evaluation indicators for adolescent health services
- Involvement of other departments in ARSH
- Life skills in adolescents
- Proper counseling skills and process
- What are the common adolescent problems
- Effective communication and counseling with adolescents
- How to motivate people to talk about sex education
- How to communicate without inhibitions with adolescents
- Tools of communication at individual or family level
- All scientific information about social, psychological and physical problems of adolescents
- Training should not be restricted to module; problems on situations in actual field should also be discussed. A field visit to ARSH should be arranged

The expectations listed down by participants were displayed in the concluding session of three days programme, where all the participants agreed that all their expectations were fulfilled in the three-days training programme.

c. Pre and post-training questionnaires

Every day, pre-training questionnaire were administered to each participant before starting the sessions so as to assess level of information they have. The same questionnaire (post-training) was given in the evening, after completion of the sessions to assess the information they acquired/gathered during the day. Three different questionnaires were prepared for three days depending on the topics covered during first, second and third day.

Important note: Dr Kamalapurkar, Asst. Director, SFWB told the participants that henceforth ARSH programme will be called as “Adolescent Health Programme” to avoid the stigma related to “R-reproductive” and “S-sexual” words.

MODULE II: ADOLESCENT GROWTH AND DEVELOPMENT AND ITS IMPLICATIONS

Objectives:

The main aim of this module was:

- Define the term "adolescence"
- Describe the nature of changes during adolescence and their implications on health
- Describe how the experiences of adolescents in the past compare with the experiences of adolescents today

- Identify important reasons for investing in adolescent health and development

a. Definition of adolescence

The session started with the definition of adolescence and it was explained that adolescence is a phase of life which has its own special needs. It is also characterized by acceleration of physical growth and psychological and behavioural changes.

b. **Group work on Changes during adolescence and its implications**:

The participants were divided into 3 or 4 groups depending on the number of participants. First group was asked to list down the physical changes and its health implications, second group was asked to list down sexual changes and its implications and so on. 25 minutes were given for discussion and then one person from each group presented it. All the groups tried to cover almost all the points. Each presentation was followed by discussion to clarify the doubts.

After all the presentations trainer added few points and summarised the session.

c**. Sexual experiences and its consequences**

It was an interactive session and the sexual experiences were discussed at large. The sexual experiences and its consequences shared by participants were as follows:

- Early pregnancy and parenthood (within and out of marriage);Higher MMR
- Unsafe abortions and its related complications
- Higher percentage of low birth weight(LBW) babies and increased infant morbidity and mortality
- STI including HIV/AIDS
- Economic impact-hindrance to academic and career progression because of pregnancy

Consequences that are more in adolescents even if it has been 'safe sex'

- Emotional impact-guilt, stress, anxiety, suicide
- Social impact- stigma(especially if unmarried)
- Emotional social and economical impact may be more in case of adolescents (even if it is safe sex) because they are not mature enough to handle these consequence

c. **Adolescent sexuality impacts the following health indicators**:

- Increased total fertility rate(TFR)
- Low Contraceptive Prevalence Rate (CPR)
- Increased Maternal Mortality Ratio (MMR)
- Increased Infant Mortality Rate (IMR)
- Increased under-5 Mortality rate
- High abortion rate
- High STI incidence/ prevalence rate
- High HIV incidence/ prevalence rate

d. Myths and misconceptions leading to health risk

The next session was on the myths and misconceptions leading to health risk behaviour and the participants shared the following:

- Visiting sex workers to prove/ check whether they are man enough
- Seeking " virgins" for sex
- Girls may also seek to prove that they are woman enough
- Belief that many of their friends are doing it
- Sexual intercourse with virgin cure gonorrhea
- One drop of semen is equal to 1000 drops of blood
- Masturbation causes weakness and impotency

e. Present important reasons for investing in adolescent health and development

- Facts such as high maternal mortality amongst adolescents, prevalence of anaemia, RTIs in young women, unmet need of contraception etc. and its correlation with the health indicators (high TFR, MMR & IMR)was discussed in detail.

a. The following points which are compelling reasons for investing in adolescent health and development were discussed:
   - Adolescents comprise a sizeable population
   - Early marriage is common
   - Female mortality rates are higher than males
   - Malnutrition and anaemia are rampant
   - Drug abuse is a emerging problem in adolescents
   - Crimes against adolescents are prevalent

- Trafficking and sex work has increased
- Premarital sexual relations are increasing
- Unintentional injuries contribute to morbidity and mortality
- Misconceptions about HIV/AIDS are wide spread

b. A short brainstorming on the fact that different stakeholder have different perspectives on priorities of adolescent issues was conducted. Different perspectives were as follows:

- Parent's perspective: examination marks, growth career, happiness, good citizen, marriage
- Teacher's perspective: examination of marks, all round development, career, civic sense, safe behaviour
- Health sector perspective: growth, health protection and promotion, safety, early pregnancy, HIV/ STI
- Administrator's /policy maker's perspective: healthy and productive population
- Adolescents themselves: body image , career, sexual concerns, general health

The module was summarised as follows:

- *Period of adolescence is a period of rapid physical growth, sexual development and emotional-social changes*
- *Adolescents are vulnerable to health implications due to the normal developmental changes*
- *Investing in adolescents will be a "demographic bonus" later on by improving maternal and child health and improving overall health indicators*
- *There is also an economic benefit to the country -- healthy adolescents grow into healthy adults*

MODULE III: COMMUNICATING WITH THE ADOLESCENT CLIENT

Objectives:

By the end of this module, participants were able to:

- Identify effective communication skills
- Identify effective counselling skills to use when interacting with adolescent clients

a. COMMUNICATION

A session was started with the brainstorming session on what is communication? Varied answers were received which were noted down on the chart paper and discussed. Then process of communication was explained briefly.

The main purpose of communication i.e. to change or guide the other person's behaviour was discussed. It was also emphasized that while working with adolescents the persuasive function of the communication is most useful.

a.1 Types of communication

1. Verbal and non-verbal communication

Speech (verbal) is used for a variety of purposes to describe feelings, to communicate ideas, to provide information, to persuade others, to argue and so on. The important elements of verbal communication are talking, listening, voice etc.

Non-verbal communication is communicating without using words e.g. with a look, an expression, a gesture etc.

2. One way and two way communication

The importance of two way communication especially for adolescents was emphasized more.

a.2 Barriers to effective communication

Barriers to effective communication were listed down through a brainstorming session and case study method. The outcome was as below:

- Physical barriers: too much noise and distraction
- Lack of privacy both audio and visual
- Inability to make the adolescent feel comfortable
- Use of medical terms-complicated ,unfamiliar words for adolescent
- Too much information given in one session
- Own perception beliefs and values clash with the adolescent's needs
- Warning, threatening
- Teaching, instructing

The barriers to sexual and reproductive health information and services such as lack of confidentiality, privacy etc. were also discussed.

b. COUNSELLING

The last session of first day was on counselling. The principles of counselling and the "**GATHER**" approach were explained to them. Then the participants were divided into 4-5 groups depending upon the number of participants. Each group was given a scenario for role play. 15 minutes were given for preparation and then all the groups presented the role plays. After every role-play all the participants expressed their views and commented on the performance of the group.

c. **LIFE SKILLS**

WHO definition of Life skills:

Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life.

The need and importance of life skill for adolescents were also discussed.

Health sector in India may not be in a position to have direct involvement in imparting Life Skill Education to adolescents. However health sector needs to play a major role for its advocacy and up scaling. It should also work closely with the education and social sector to assist and guide their LSE initiative so that they can incorporate the specific health sector agenda.

The module was summarized as below:

- *Communication is exchanging thoughts, feelings and ideas in speech or writing. It also involves non-verbal actions while communicating.*
- *Counseling is communicating to help people make informed decisions and provide confidence to enable them to put their decisions into action*
- *Effective counseling can gradually bring about behavior change in adolescents*
- *Life Skills are very important to cope up with different life situations*

Modules covered on the second day of the training

Recap: Second day session was started with the recap of the previous day. Two participants reviewed all the sessions held on the previous day.

MODULE IV: ADOLESCENT- FRIENDLY REPRODUCTIVE AND SEXUAL HEALTH SERVICES

Objectives**:**

- Explain how health services can promote adolescent health.

- Understand the perspectives of adolescents themselves, healthcare providers and other adults on the provision of health services to adolescents
- Identify the characteristics of adolescent –friendly health services
- Describe approaches to make health services more adolescent –friendly
- Define quality of care and concept of quality implementation

a. Adolescents' needs

In the beginning, the needs of adolescents were discussed which are as follows:

- A safe and supportive environment that offers protection from stress, abuse, injury, disease and opportunities for full development such as education, nutrition, physical /mental development etc.
- Information on growing up process and skills to understand and
- interact with the outside world
- Develop life skills for problem identification, decision making, negotiation skills etc.
- Health services and counselling- to address the health problems and deal with personal difficulties

b. Common health problems that the adolescents face: Following problems were discussed:

- Menstrual disorder
- Amenorrhoea
- Genital tract infections (RTI & STI)
- Concerns regarding growth and development
- Need for contraception
- Behavioural problems
- Night ejaculation and masturbation
- Problems related to pregnancy and childbirth.
- Concern about size and bending of penis
- Smoking ,alcohol use
- Acne
- Tiredness, headache

c. Barriers in utilization of services by adolescents

Barriers were found out through group work. The participants were divided into three groups and following topics were given to them:

Group 1: What are the barriers related to clients (adolescents)

Group 2: What are the barriers related to health provider and policy

Group 3: What are the barriers related to health facility

30 minutes were given for discussion and preparation. Every group presented the points emerged through discussions which are as follows:

c.1 Barriers related to clients (adolescents):

- Discomfort with real or perceived clinic conditions
- Discomfort with real or perceived attitudes of providers
- Concern that the staff will be hostile or judgemental
- Belief that the services are not intended for them
- Concern over lack of privacy and confidentiality
- Shame especially if the visit follows coercion or abuse.
- Fear of being examined by provider of opposite sex.
- Fear of medical procedures
- Ignorance or lack of information about health risk and services available
- Poor understanding of their changing bodies and needs.
- Insufficient awareness of pregnancy and STI/ HIV risks
- Lack of information of what services are available and location of services

c.2.1 Barriers related to health providers:

- Untrained providers and staff for adolescent health and development
- Providers and staff not sensitive about adolescent needs.
- Judgemental and attitude of providers and staff towards adolescent needs and concerns
- Providers and or staff refuse services to adolescents (this factor may be more in the government health setting as compared to private setting)
- Providers unwilling to provide sufficient time to the adolescent client for interpersonal communication
- Provider attitude biased towards boys versus girls.
- Overburdened by other work/programmes
- No accountability of adolescent clinic/programme

c.2.2 Policy factors:

- Discrimination against adolescent sometimes by requiring minimum age or parental consent.
- Unclear laws and policies regarding services for adolescents both married /unmarried and boys/girls
- Not involving adolescent boys and girls during formulation of policies related to their needs and concerns.
- Cost of services is high and unaffordable by adolescents
- No policy for sexual and reproductive health education to be given to adolescents
- No control over media for not spreading misconceptions regarding SRH issues

c.3 Barriers related to health facility:

- Lack of designated or special health services for adolescent at the facility
- Lack of privacy and confidentiality
- Unfriendly environment
- Timings are not suitable and convenient to the adolescents
- Does not provide services that adolescents want
- Distance
- Lack of basic amenities such as toilets, drinking water etc. at the clinic
- Lack of regular supplies of medicines, drugs etc.

d. Quality of care

Adolescent friendly health service or services to the adolescents mean that appropriate and effective service provision to all adolescents who approach the health facilities at any time for any services, in addition to a dedicated clinic for adolescents.

d.1 Standards for provision of Adolescent Friendly Health Service

- Enabling environment created for seeking services.
- Adolescents well informed about availability of health and services
- Health facilities provide specific package of services
- Health facilities deliver effective services to adolescents and adolescents feel at ease with the surroundings
- Service providers are sensitive to adolescent needs and are motivated to work with them
- Management systems are in place to improve/sustain the quality of health services

- All the standards from 1 to 7 were explained through power point presentation and lecture.
  - ✓ **Standard1.** Health facilities provide specified package of services that adolescents need.
  - ✓ **Standard2.** Health facilities deliver effective services to adolescents.
  - ✓ **Standard3.** Adolescents find environment at health facilities conducive to seek services.
  - ✓ **Standard4.** Service providers are sensitive to adolescent needs and are motivated to work with them.
  - ✓ **Standard5.** An enabling environment exists in the community for adolescents to seek services.
  - ✓ **Standard6.** Adolescents are well informed about the health services.
  - ✓ **Standard7.** Management systems are in place to improve /sustain the quality of health services.

d.2 Adolescent Friendly Clinics

- Manpower, separate designated staff - doctors as well as para-medical personals. Training of the health personnel is essential which is being dealt separately under training.
- Appropriate sign board, Mitra/ Maitra may consider
- Involvement of counselors appointed under VC TC
- Provision of essential investigation facilities
- Sensitization of heads of institutions.
- Formation of Adolescent Health Committee on similar lines with RKS involving youth & adolescent volunteers.

d.3 The concept of **peer educators** was explained to the participants

The module was summrised as below:

- *Adolescents need a safe and supportive environment that offers:*

-Protection and opportunities for development

-Information and skills to understand and interact with the outside world

-Health services and counseling to address their health problems

- *Health providers need to network and act to maximize use of resources through inter- sectoral approach*

- *A message of "**Be innovative"** was passed on to participants:*

Programme Managers can identify innovative ways and means to make the clinic more effective and adolescent friendly by being flexible and adaptable eg involvement of NGOs and FNGOs, Question Box.

MODULE V: SEXUAL AND REPRODUCTIVE HEALTH CONCERNS OF BOYS AND GIRLS DURING ADOLESCENCE

Objectives:

By the end of this module, participants will be able to:

- Understand sexuality
- Describe common sexual and reproductive health concerns and problems of adolescents.
- Address issues related to menstruation
- Address myths and misconceptions related to nightfall and masturbation

a. Sex and sexuality

The participants were asked to define the terms "sex" and "sexuality" through an interactive session. They were also encouraged to talk about their concepts about these two terms. The difference between the two terms was explained to them.

The responses for sexuality were as below:

- ✓ Affection towards partner
- ✓ Physical and emotional involvement of both the partners
- ✓ Sexual capability of individual
- ✓ Due respect to sexual activity
- ✓ Motive for sexual intercourse
- ✓ Orgasm
- ✓ Sexual attraction
- ✓ Starts from birth and ends at death
- ✓ Sexual abuse etc. etc.

b. Synonyms of body parts

To make participants comfortable with sexuality and language used to discuss sexuality issues, seven sheets of papers having a word related to sexuality (intercourse, testes, ovaries etc.) with some space for writing were pasted around the hall. The participants were instructed to move around the hall and write slang words or phrases or local terms commonly used for each of the words on the sheets of the paper. The participants were rather reluctant to do so. They were again encouraged to complete the activity, then some participants were asked to read it out for all.

The responses were as follows:

1. Breasts-Vakshsthal,Stan,Than,Ambe,Mamma,Amma,Ball,Fui,Chati,Swabhav
2. Scrotum-Gotya,Thaila,Pishavi,Golya,Angur,Aand,Pota
3. Fallopian tubes-Garbhanalika,
4. Vagina-Yonimarg,GuptaAvyav,Yoni,Puchhi,Bhok,Gand,Mayang
5. Uterus-GarbhachiPishavi,Otipot,Garbhashay,Thaili,Bachhadani,Gola,Oti
6. Ovaries-Streebijkosh, Gath, Aandashay
7. Masturbation-Muthmarne,GadiMarne,HathkiSafai,Apla Hat Jagannath,Galane
8. Penis-Ling,Hatyar,Baburao,Lavada,Dengnu,Land,Shishtan,Bulla,Nunni,Talwar
9. Testes-Aand,Andkosh,Aandgoli,Bijand
10. Sexual intercourse- Sambhog, Hepane, Chodane, Kamkrida, Palang match, Ratikrida, Fuking, Zavane, 61/62, Sambanth yene, Ekatrayene, Lagne, Udane, Thokane, Chadhane, Sukh, Make love
11. Nightfall-Dhatukosh, Saphed, Faultzala, Galane, Dhatu, Viryapatan, Swapndosh, Dhatudosh, Dhat jane, Sheeghrapatan
12. Semen-Bindu, Themb, Pani,Virya, Dhatu
13. Nipples-Bond, Stanagra, Mamma, mau

The participants felt embarrassed during this activity. Some of them commented that this type of activity should not be conducted in the training, but at the same time some of them supported it. It was explained to them that it is remove inhibition and to make you mentally prepared to hear and speak such slang words which you may think as “bad”. It was also stressed that this activity is conducted to get more relaxed while talking about body parts. These participants are expected to conduct trainings for their staff and hence should be comfortable to discuss the issues regarding sexuality.

c. Gender

Then a session on “gender” was taken. A discussion on following topics was carried on: difference between sex and gender, stereotyped roles of men and women, rights of adolescents, gender equity and equality etc.

d. Understanding different terms

The terms like health, sexual health, reproductive health etc. were discussed.It was followed by differences in all these terms.

e. Sexual health related issues and concerns

It was explained to the participants that adolescent boys and girls have many concerns related to sexual and reproductive health. The needs of young adolescents of 10-14 years is different from those of older adolescents example: the need and concerns of 10-14 years is more regarding their growth and menstruation and the concerns of 15-19 years is more regarding sex, pregnancy and contraception. To understand these concerns the participants were divided into six groups and each group was given a case study for discussion. Each group presented their case study it was followed by discussion. The points came out were as follows: The concerns of different groups of adolescents are different, the married were concerned about the continuation of pregnancy, child bearing etc. while others are concerned about their looks, peer pressure etc.

f. Menstruation

The participants were asked to list areas in menstruation that adolescent girls do not feel comfortable with and the responses were:

Excessive bleeding, irregular menstrual cycle, backache, discomfort in lower abdomen, scanty menstruation etc. All the participants mentioned that the girls are more concerned about the isolation during menstruation and it is being observed in most of the families. The girl is not allowed to do many household chores during this period.

The other concern was regarding the material being used to soak the blood. The participants are now advising adolescent girls especially from rural area to use sanitary napkins which are available with ASHA at the cheaper rate. It was also emphasized that maintenance of menstrual hygiene is very important for a girl to protect herself from infections. However the girls should not have a feeling of sickness during menstruation, they should carry on their usual routine.

g. Counseling about hygiene in boys

- Wash genitals daily
- Gently retract foreskin back and wash the tip of the penis . Secretions accumulate under the foreskin and could cause infection if not cleaned regularly
- Use cotton undergarments only and change it daily.

h. Night falls or wet dreams:

The information regarding night fall was given and the misconceptions regarding it were also dealt with through discussion and interactive session.

i. Masturbation

The participants were informed about the masturbation. It was also made clear that both boys and girls can relieve sexual feelings and experience sexual pleasure through masturbation. The doubts and misbelieves were discussed and resolved.

The module was summarized as below:

- *Understanding sexuality helps making one comfortable in discussing this sensitive issue with adolescents*
- *Information helps to dispel myths and correct inaccuracies*
- *Reassurance and counseling on sexual issues help adolescents to make informed choices , and make them more confident*

MODULE VI: NUTRITION AND ANAEMIA IN ADOLESCENTS

Objectives:

- Describe the importance of special nutrition needs of adolescents
- Explain the magnitude of anaemia in adolescent girls and its consequences
- Describe prevention and management of anaemia in adolescent girls
- Illustrate measures to prevent and treat anaemia

a. Why adolescents have special nutritional needs

A brainstorming session was conducted on this topic and the answers were as follows:

- It is growing phase of life
- They do more physical activities and hence need more food
- They need more strength and energy
- As girls attain menarche they need to have nutritious diet
- They consume more calories etc. etc.

It was emphasized that adolescent growth and development creates special nutritional needs and it relates to the fact that adolescents gain up to 50% of their adult weight, more than 20% of their adult height and 50% of their adult skeletal/bone mass during this period.

b. Factors influencing nutrition of adolescents

The participants were divided into six groups and were given the scenario for role play. 15 minutes were given for preparation and then all the group carried out role plays. The participants were asked to comment after each role play and it was followed by discussion clarifying doubts. The common factors influencing nutrition were lack of knowledge, poverty, gender discrimination, poor dietary intake of food and vegetables rich in iron and folate, eating pattern of adolescents etc.

Note: This topic was covered under WIFS programme and hence not taken in detail

The module was summarised as follows:

- *Both boys and girls require adequate and good quality food during adolescence- continuous and rapid growth and development*
- *Because of gender and social conditioning, girls are more vulnerable to poor nutritional status, leading to anaemia, reduced physical and mental performance and maternal morbidity and mortality later*
- *Last chance to catch up with growth and development*
- *Quality and quantity of food will help in adult life too*
- *Counseling for nutrition should:*
    - *Stress the importance and constituents of balanced diet in simple terms related to common and easily available food items*
    - *Address issues related to gender discrimination and social malpractices related to nutrition, food habits of adolescents and body image concerns*

Modules covered on the third day of the training

Module VII: Pregnancy and Unsafe Abortions in adolescents

Objectives:

- To identify factors that influence adolescent pregnancy and childbirth

- To identify risks associated with adolescent pregnancy and childbirth, in married as well as unmarried adolescents, and the manner in which they differ from those in older women
- To discuss the nature and scope of illegal abortion in adolescents
- To list factors contributing to illegal and unsafe abortions in adolescents
- To identify consequences of post-abortion complications in adolescents

Brain storming session was conducted to get ideas from the participants about the magnitude of adolescent pregnancy and abortions in adolescents in their health centres. It was noted by most of the participants that they provide services for adolescent pregnancies very often, but services related to abortions in adolescents are not that often and provided sometimes.

Group work for factors contributing to pregnancy and abortions in married/unmarried adolescent girls:

The participants were divided into three groups to discuss the factors:

- Group 1- Biological and socio-cultural factors contributing to adolescent pregnancy
- Group 2- Service-delivery factors contributing to adolescent pregnancy
- Group 3- Factors leading adolescent girls to resort to unsafe abortions

15 minutes were given for discussion and then each group presented their group work:

b.1 Biological and socio-cultural factors contributing to adolescent pregnancy were as below:

- Exposure to media, urbanization
- Norms and traditions like early marriage and pregnancy is expected to follow soon after marriage etc.
- Vulnerability of adolescents to sexual abuse , sexual exploitation etc.

b.2 Service-delivery factors contributing to adolescent pregnancy

- Lack of access to information regarding sexual health
- No access to contraceptive information

b.3 *Factors leading adolescent girls to resort to unsafe abortions*

- Fear of expulsion from school
- Non affordability
- Son preference
- Unfriendly attitude of service providers
- Social stigma
- Accessibility

a. Common complications of pregnancy and abortions in adolescents

The participants were divided into four group to discuss common complications. Topic given to first two groups was same i.e. complications of pregnancy and child

birth in adolescents. The remaining two groups had discussion on complications of abortions in adolescents. 10 minutes were given to discuss the topics.

The presentations had following points:

c.1 *Complications of adolescent pregnancy*

- Pregnancy induced hypertension-more risk during adolescence
- Higher severity of malaria, which may lead to anaemia
- Anaemia
- Pre-term delivery,IUGR
- Antepartum haemorrhage, postpartum haemorrhage etc.
- Pre-eclampsia
- Puerperal sepsis

c.2 *Complications of abortion in adolescents:*

- Haemorrhage sometimes may lead to death
- Various infections
- Secondary fertility
- Increased likelihood of ectopic pregnancy
- Depression

b. Management of adolescent pregnancy

To understand the management of adolescent pregnancy, flipchart was shown and it was emphasized that there is a difference between married and unmarried adolescent pregnancy. The married adolescent gets covered in routine health care programmes but it is difficult to trace out the unmarried pregnant adolescent.

c. Management of post- abortion complications

The participants were divided into five groups and five different scenarios were given to them for carrying out role-play. All the participants were very enthusiastic and participated well in role-plays. It was followed by comments and discussions on following points: advice given to anaemic adolescent pregnant girl, need of non-judgemental attitude towards unmarried pregnant girl, need for information and counselling on contraception etc.

The module was summarised as follows:

- *Adolescents have a higher risk of poor pregnancy outcomes*
- *Adolescents opt for abortions because of socio-cultural and/or socio-economic reasons*
- *They tend to face more barriers than adults in accessing and using the health services they need*

Module VIII: Contraception for adolescents

Objectives:

- Review the eligibility of adolescents to use the various contraceptive methods available and the effectiveness of each of these methods.
- Consider which contraceptive methods are most appropriate for adolescents.

- Demonstrate counseling skills to help adolescent choose methods most appropriate for them and best suited to their needs.

a. Eligibility and effectiveness of contraceptives

Most adolescents begin their sexual activity without adequate knowledge about sexuality or contraception or protection against STIs/HIV. In India though adolescent's marriages are very common in rural areas, the couple is less likely to use contraception than adults. Most women who marry young have the first child early. For unmarried adolescents it is sometimes impossible to access contraceptives and the sexual activity often results in unplanned pregnancy.

To discuss the eligibility and effectiveness of contraceptives the participants were divided into 3-4 groups. The groups were asked list down all the contraceptives, its efficacy and eligibility of adolescent client. The groups actively participated in the exercise and it was followed by presentations. All the types of contraceptives including mutual masturbation, virtual sex, etc. were discussed during the presentations. After each presentation the points noted down by the groups were discussed and queries were sorted out e.g. Frequency of use of Emergency pills, adopting permanent methods below the age of 20 years etc.

b. Barriers to contraceptive use among adolescents

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

c. A debate was carried out on following topic:

- **Contraceptives information should be given to unmarried adolescents, but they should not be given the supply**

Most of participants opined that it is necessary to provide information on contraceptives to married as well as unmarried adolescent and they also get supply of the same.the summary of the debate was as follows:

- Briefly inform adolescent about the available contraceptive methods
- Provide information on the advantages and disadvantages of method(s) that the provider believes is (are) most appropriate in that situation
- Work with adolescent to help him/her choose a method
- Provide further information on the correct use of the method and on where supplies could be obtained for future use.

The module was summarised as below:

- *Most adolescents are becoming sexually active without adequate knowledge about sexuality, contraception or protection against STIs/HIV*

- *Rigid social norms act as barriers to access open and correct information regarding sexuality and reproductive health issues by adolescents*
- *Dual protection methods and Emergency Contraception are available for adolescents*

The last message given was:

Healthy adolescents are medically eligible to use all currently available methods of contraception.

Module IX: RTIs, STIs and HIV/AIDS in adolescents

Objectives:

- Describe factors responsible for RTIs/STIs in adolescents.
- Identify action point for prevention and management of STIs among adolescents.
- Address the myths related to HIV /AIDS and identify action points for reducing stigma and discrimination related to it.

a. Reasons for increased RTIs / STIs

The topic was introduced by the far reaching effects of Reproductive Tract Infections (RTIs) or infections of the genital tract. Sexually Transmitted Infections (STIs) are one of the most common infections among sexually active adolescents. It is observe that these infections are increasing day by day due to following reasons:

- Adolescents are anxious to do experiments without fear of any disease and as such indulge in unsafe sexual activities
- More prone to take risks
- Socio-Economic status makes them more vulnerable
- Vaginal and cervical epithelium in adolescents is immature
- Lack of awareness of disease and prevention
- Lack of access to services
- Poor hygiene practices
- Unsafe delivery and abortion
- Girls are more vulnerable

b. Consequences of RTIs and STIs for adolescents:

Following points were discussed through lecture and slides:

- Pelvic inflammatory disease(PID), Chlamydia infection during adolescence is more likely to result in PID and its squeal (such as infertility)
- Cancer of the cervix, exposure to infection (such as Chlamydia and Human Papilloma virus) during adolescence is more likely to result in cancer of the cervix,
- Tertiary Syphilis: Heart and Brain damage as a long term consequence of an untreated Syphilis infection,
- Stigma, embarrassment and discomfort associated with STIs can impair psychological development and attitudes towards sexuality later in life,

- Urethral stricture
- Infertility due to endometrial adhesions, fallopian obstruction
- Death due to septicemia, ectopic pregnancy that ruptures
- Neonatal/intrauterine infections

c. **Prevention of RTIs/STIs**

Following points were discussed through interactive session:

- Maintaining proper genital hygiene is important. Girls should also maintain good menstrual hygiene.
- Practicing responsible sexual behavior- practicing safe sex
- Avoiding (unprotected) sexual contact. If either of partner has an STI
- By not neglecting any unusual discharge-seeking help early
- Ensuring complete treatment of self & sexual partner
- Opting for institutional delivery or home delivery by a trained birth attendant
- Availing safe abortion services
- Awareness among adolescents and community
- Improve services(AFHS)

d. Management of RTIs/STIs

The participants were divided into 5 groups and one case study was given to each group to discuss the management of RTIs/STIs. The groups discussed these case studies for 10-15 minutes and then each group presented it, the points came out were as follows:

- The adolescents feel shy and embarrassed and hence avoid approaching adults.
- Many times adolescents are unaware of the symptoms, causes and consequences of the problem
- The adolescents need privacy and confidentiality to discuss such things
- The adolescents who come with such symptoms should be treated respectfully
- There should not be any kind of discrimination (gender, socio-economic status etc.)

e. HIV/AIDS

The participants were told that the exercise of “QUIZ” is to identify different attitudes and explore one’s own values about sensitive issues like sexuality, RTIs, STIs and HIV/AIDS.

The participants were asked to gather together. It was also told that those who “agree” with each statement should come and stand on trainer’s right hand while those who “disagree” should stand on trainer’s left hand. Those who are “neutral” or “undecided” can stay in the middle of the hall. The statements from the quiz were read one by one.

Statement 1: People who get HIV through sex deserve it because of the behaviour they practice

Statement 2: To have more than on sexual partner is acceptable

Statement 3: Women who get STIs are promiscuous

Statement 4: If a married woman has an STI, the provider should not tell her the infection was passed to her through sex with her husband because it might cause problems in her marriage.

Statement 5: Anal sex is a perversion

Statement 6: Oral sex is a wrong practice

Statement 7: It is easy to recognise a homosexual by his looks and style of dress

Statement 8: Sex without intercourse is not real sex

Statement 9: Condoms should be provided to adolescents if they request.

The participants could not take decision on some statements. Those who said “agree” in the beginning changed their mind and opted to “disagree” or “neutral” and so on. Lot of debate was undergone on each and every statement. Some answers were very conservative, rigid and /or stereotyped. Each group (agree/disagree and neutral) was trying to give justification of their answer and it was encouraged so as to carry on the discussion leading to express their views and attitudes.

At the end of the session it was made clear that there were no ”right” or “wrong” answers. The purpose of the exercise was to help understand view points that may be different from our own and to consider how it affects the effectiveness of counselling. It was also made clear that the health care providers should respect different view points on the subject and should not be judgemental or prejudiced while dealing with adolescents.

The module was summarized as follows:

- *RTIS and STIs among adolescents are preventable*
- *STIs can be treated adequately through proper use of antibiotics*
- *It is important for both partners to be treated simultaneously*
- *Untreated RTIS and STIs lead to serious complications*
- *VCT should be available to adolescents especially adolescent* pregnant mothers

Module X: Concluding module

This module focused on strategy for addressing ARSH in RCH-II and operationalizing adolescent-friendly health services in public health system. Brainstorming and lecture session was conducted in this module.

Three days training program was concluded with vote of thanks to participants, trainers and organizers. Feedback of all the participants was collected on a pre-structured feedback form. Some of the participants voluntarily submitted the verbal feedback.

Feedbacks given by participants were assessed and are presented in the tables below-

Table 2: Feedbacks received at Nagpur training

	Excellent	Above average	Average	Below Average	Very poor
Venue Convenience	4	4	10	1	
Logistical arrangements	7	3	8	1	
Timings	14	5			
Methodology	11	6	1		
Contents/Information given	14	5			
Resource persons' skills	16	3			
Reading material provided	7	3	6	1	2- not provided
Sequence of sessions	13	4	2		
Time allotted for sessions	12	3	4		

Table 3: Feedbacks received at Aurangabad training

	Excellent	Above average	Average	Below Average	Very poor
Venue Convenience	14	6	5		
Logistical arrangements	15	3	5		
Timings	16	5	4		
Methodology	19	4	2		
Contents/Information given	15	7	3		
Resource persons' skills	19	4	2		
Reading material provided	5	7	5	1	3
Sequence of sessions	13	9	3		
Time allotted for sessions	15	7	2	1	

Table 4: Feedback received at Lonavala training

	Excellent	Above average	Average	Below Average	Very poor
Venue Convenience	16	8	5		
Logistical arrangements	14	12	4		
Timings	16	7	6		
Methodology	17	10	1	1	
Contents/Information given	18	9	3		
Resource persons' skills	24	6			
Reading material provided	10	6	11	2	1
Sequence of sessions	13	11	6		
Time allotted for sessions	11	9	9		

Post-training questionnaire of all sessions:

An open-ended questionnaire based on modules covered in all three days was given to each participant. It was examined by the trainer and the results obtained are presented as below:

Table 5: Marks wise distribution of participants (n=69)

Marks	6	7	8	9	10	11	12	13	14	15
Number of participants	6	3	4	8	11	9	7	15	5	1

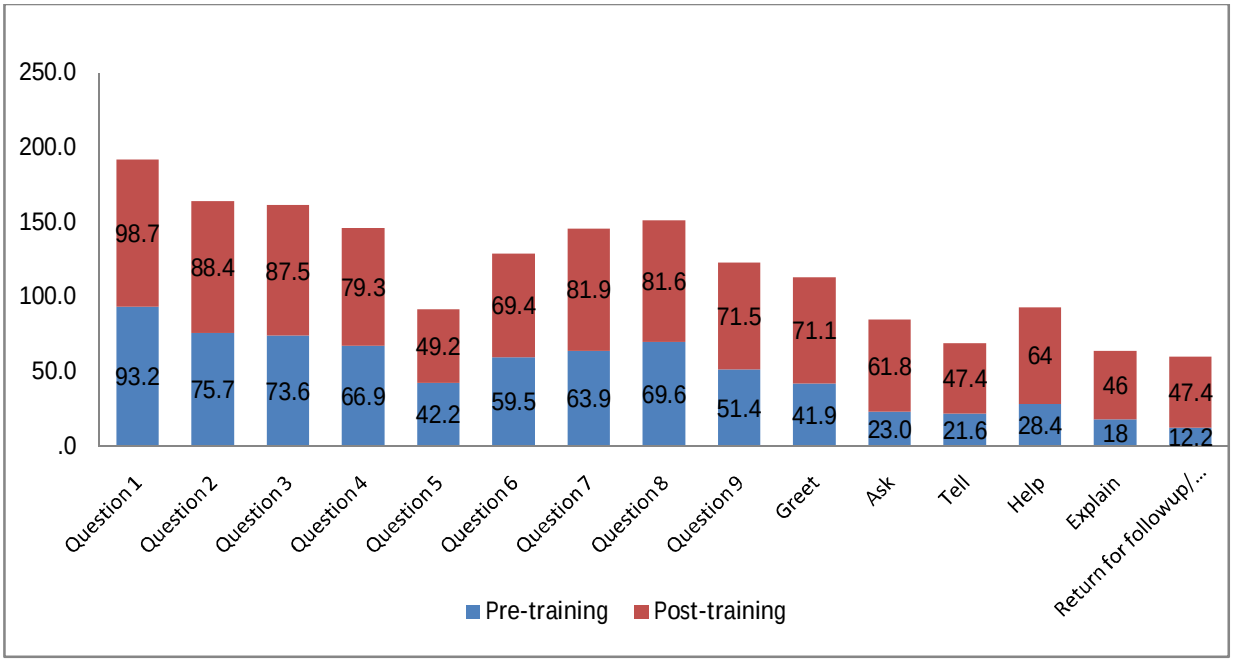
Pre and post test questionnaires of each day were analysed using SPSS. Comparison of correct answers given by participants in pre and post training test of all three days is presented in the following tables.

Table 6: Percentage of correct responses for Pre and post training test of day 1

Question Number	Pre-training		Post-training	
	Count	Percentage	Count	Percentage
Question 1	69	93.2	75	98.7
Question 1	56	75.7	67	88.4
Question 1	55	73.6	67	87.5

Question 1	50	66.9	60	79.3
Question 1	31	42.2	37	49.2
Question 1	44	59.5	53	69.4
Question 1	47	63.9	62	81.9
Question 1	52	69.6	62	81.6
Question 1	38	51.4	54	71.5
Principles of counselling				
Greet	31	41.9	54	71.1
Ask how you can help	17	23.0	47	61.8
Tell	16	21.6	36	47.4
Help	21	28.4	49	64
Explain	13	18	35	46
Return for follow up/referral	9	12.2	36	47.4

Figure 1: Pre and post training answers for day 1



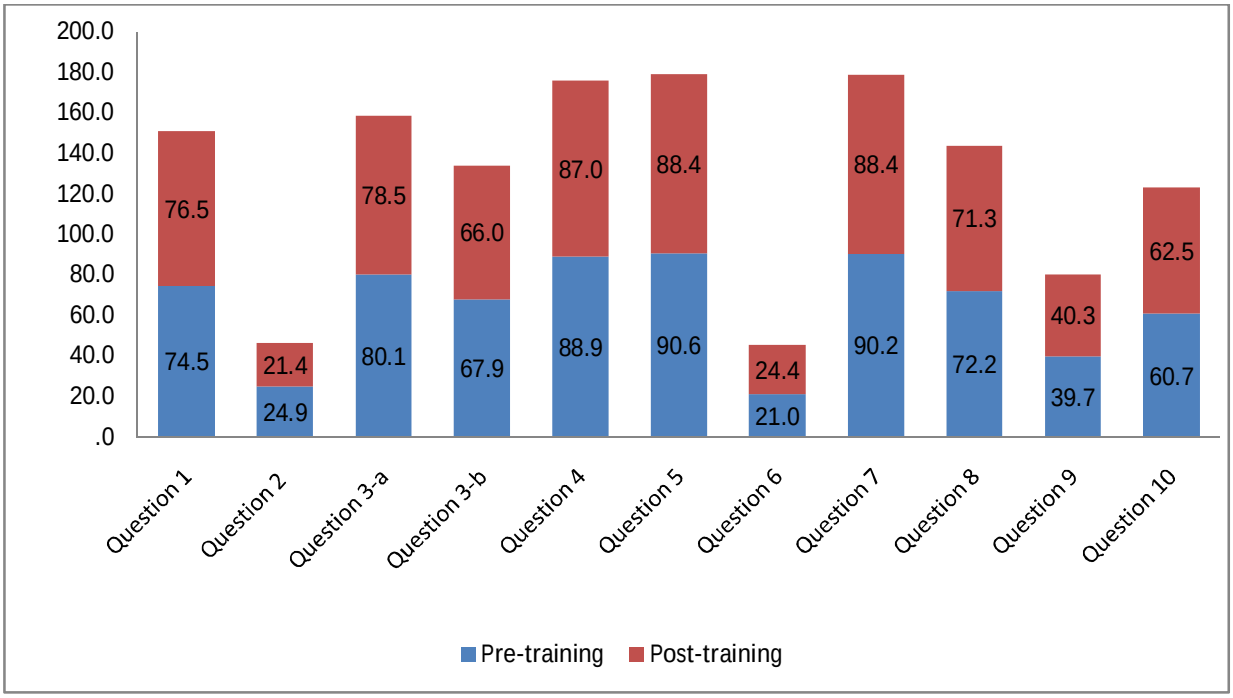
Percentage of correct answers increased after day 1 training.

Table 7: Percentage of correct responses forPre and post training test of day 2

Question number	Pre-training		Post-training	
	Count	Percentage	Count	Percentage
Question 1	54	74.5	60	76.5
Question2	19	24.9	15	21.4
Question 3-a	63	80.1	57	78.5
Question 3-b	53	67.9	48	66.0
Question 4	69	88.9	63	87.0
Question 5	71	90.6	64	88.4
Question 6	16	21.0	18	24.4

Question 7	70	90.2	64	88.4
Question 8	56	72.2	51	71.3
Question 9	31	39.7	29	40.3
Question 10	47	60.7	45	62.5

Figure 2: Pre and post training answers for day 2

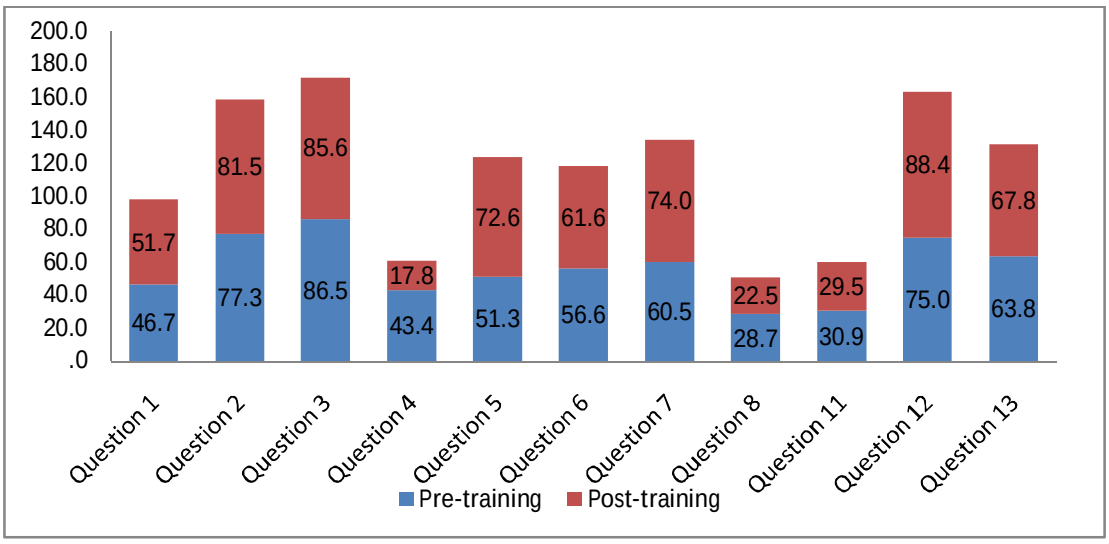


Percentage of correct answers increased for some questions after day 2 training.

Table 8: Percentage of correct responses for Pre and post training test of day 3

Question number	Pre-training		Post-training	
	Count	Percentage	Count	Percentage
Question 1	36	46.7	38	51.7
Question 2	59	77.3	60	81.5
Question 3	66	86.5	63	85.6
Question 4	33	43.4	13	17.8
Question 5	39	51.3	53	72.6
Question 6	43	56.6	45	61.6
Question 7	46	60.5	54	74.0
Question 8	22	28.7	16	22.5
Question 11	24	30.9	22	29.5
Question 12	57	75.0	65	88.4
Question 13	49	63.8	50	67.8

Figure 3: Pre and post training answers for day 3



Percentage of correct answers showed increase after day 3 training. Considering the increase in percentages of answers given by participants for all three days, it can also be said that the training was effective with regards of imparting the adolescent health.

Annexure 1:

Pre-training and post-training questionnaires

Adolescent Health-2013

State Level Training Of Master Trainers

Pre Training Questionnaire for Day 1

Name: **District:**

Designation: **Date:**

Please tick mark all the right options for each question.

Q.1 What are the important changes that take place in the individual as he/she goes through adolescence?

a) Physical b) spiritual c) emotional d) religious e) sexual

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

a) Undue anxiety and tension
b) Confusion, moodiness, irritation
c) Over nutrition
d) Experimentation, risk taking behaviour
e) Unsafe sex leading to unwanted pregnancy,STIs etc.
f) Under nutrition and anaemia

Q.3 Special attention groups of adolescents are……

a) Out of school adolescents and street adolescents

b) Adolescents with mental and physical disabilities

c) Orphan adolescents, those in foster care and institution

d) Sexually abused adolescents

e) School going adolescents

Q.4 We should invest in adolescents because--------

a) Adolescents comprise a sizeable population

b) Early marriage is uncommon

c) Malnutrition and anaemia are rampant

d) We love our children/adolescents

e) Premarital sexual relations are increasing

f) Crimes against adolescents are prevalent

Q.5 How do you think an adolescent feels when he/she walks into your health centre?

a) Shy b) comfortable c)Worried d)Resistant e)Defensive f) Embarrassed e) Confident

Q.6 How do you strike a rapport with an adolescent client?

a) Allowing sufficient time for the adolescent client to become comfortable enough to ask questions and express concerns

b) Hugging and kissing adolescents

c) Expressing non-judgmental views about the client's needs and concerns

d) Exhibiting honesty and forthrightness,including an ability to admit when one does not know the answer

e) Demonstrating sincerity and willingness to help

Q.7 What are the barriers to good communication?

a) Too much noise and distraction

b) Ability to make the adolescent feel comfortable

c) Own perception, beliefs and values clash with the adolescent's needs

d) Advising,judging, criticizing, blaming

e) Use of medical terms, complicated, unfamiliar words for the adolescent

Q.8 Good communication and counselling about sexuality in adolescents requires

a) Demonstrating patience and understanding of the difficulty adolescents have in talking about sex

b) Blaming the adolescent about his/her sexual behaviour

c) Considering the adolescent's age and sexual experience

d) Encouraging the adolescent to identify possible options

e) Exploring feelings as well as facts

Q.9 The purpose of counselling the adolescent on reproductive health issues is to help the adolescent to:

a) Exercise control over her/his behaviour

b) Provide solutions to the adolescent's problems

c)Cope with her/his existing situation

d) Give instructions or advise

e) Make decisions using a rational model for decision making

Q.10 The **GATHER** approach means:

G =
A=
T =
H =
E =
R =

Adolescent Health-2013

State Level Training Of Master Trainers

Pre Training Questionnaire for Day 2

Name: **Date:**

Designation: **District:**

Please tick mark all the right options for each question.

Q.1 **What health services do adolescents need?**

i. They want a welcoming facility, where they can "drop in" and be attended quickly
ii. They insist on privacy and confidentiality, and do not want to have to seek parental permission to attend
iii. They want a service in a inconvenient place at a inconvenient time that is expensive
iv. They want a range of services, and not to be asked to come back or referred elsewhere
v. All of these

Q.2 **Adolescents often do not make the best use of available health services because…**

(Please tick 3 of the most important reasons)

i. They fear that staff will inform their parents
ii. They do not like waiting or filling OPD cards
iii. They are not interested
iv. They do not recognise illnesses
v. They want to spend money on other things
vi. They do not like the way health staff deal with them
vii. They do not want to draw attention to themselves
viii. They find it easier to talk to their friends than to health care workers
ix. They do not know where to go

Q.3 **What are the most important characteristics of adolescent-friendly health services**

a) Related to staff
i. Trained providers and staff for adolescent health and development issues
ii. Providers unwilling to provide sufficient time to the adolescent client for interpersonal communication
iii. Provider attitude biased towards boys versus girls
iv. Non-judgemental attitude of providers and staff
v. Providers not sensitive to adolescents' needs

b) Related to health centre

i. Timings are not suitable and convenient to adolescents
ii. Privacy and confidentiality is well maintained
iii. Unfriendly environment
iv. Cost of services is reasonable
v. Lack of designated or special health services for adolescents at the health centre

Q.4 **What are the three dimensions of "Quality of care"**

i. Govt. programme
ii. recipients of services
iii. providers of services
iv. system in which services are provided

Q.5 **What problems are caused by lack of menstrual hygiene?**

i. vaginal discharge
ii. burning during urination
iii. constipation
iv. genital itching

Q.6 **Myths and facts regarding masturbation?** (Mark X for myth and √ for fact)

i. Most boys masturbate, but very few girls masturbate ☐
ii. People who masturbate too much are tired and irritable most of the time ☐
iii. Masturbation can cause pimples,acne and other skin problems in teens ☐
iv. People, who masturbate too much when they are young may, as a result have mental problems when they get older ☐
v. If the penis is small in size, the man is impotent and cannot have sex ☐

Q.7 **What can be done to make information and health services accessible to adolescents?**

i. Provide unscientific information
ii. Respond to their questions related to reproductive health
iii. Provide them reassurance and counselling
iv. Dispelling myths and misconceptions related to menstruation, masturbation and night fall

Q.8 **Why is nutrition important during adolescence?**

i. Helps in achieving rapid growth and full growth potential
ii. Helps adolescents to look good and smart
iii. Helps in timely sexual maturation
iv. Establishes good eating habits and sets the tone for a lifetime of healthy eating
v. Ensures adequate calcium deposition in the bones and helps in achieving normal bone strength

Q. 9 **What diseases can be caused by lack of proper nutrition?**

i. Anaemia
ii. Influenza
iii. Iodine deficiency disorder
iv. Chronic Energy Deficiency
v. Hepatitis

Q.10 **What are the consequences of nutritional anaemia?**

i. More capacity to work and thus increased productivity
ii. Increased risk to pregnant girls/women which may lead to miscarriage,low birth weight babies etc.
iii. It may increase susceptibility to infections by impairing the immune functions

Q. 11 **What are the signs and symptoms of anaemia?**

i. Breathlessness
ii. Pale face, nails, tongue and conjunctiva of eyes
iii. Stunted growth
iv. Good mental capacity
v. Tiredness, weakness and poor physical capacity

Adolescent Health-2013

State Level Training Of Master Trainers

Pre Training Questionnaire For Day 1

Name: **Date:**

Designation: **District:**

Please tick mark all the right options for each question.

Q.1 **What are the most common antenatal complications in adolescents?**

i. Bleeding during pregnancy
ii. Pregnancy-induced hypertension
iii. Over weight
iv. STIs/HIV
v. Higher severity of malaria
vi. Anaemia

Q.2 **In your opinion what are the most important issues for counselling pregnant adolescents?**

i. Counselling support in terms of the socio-cultural environment that has to be faced
ii. The access to health services for routine antenatal care and in case of emergency
iii. An opportunity to raise and discuss issues related to pregnancy should not be given
iv. The danger signs that need to be aware of
v. Since adolescents are more at risk of STIs/HIV, availability of voluntary counselling and testing services

Q.3 **What are the critical aspects in caring for the pregnant adolescent in the postpartum period?**

i. Prevention, early diagnosis and treatment of postnatal complications in the mother and her baby
ii. Ongoing contact through home visits on their return with their babies especially if they are married
iii. Information and counselling on breastfeeding,nutrition and care of the baby
iv. Special support on how to care for herself and her baby
v. Information on contraception to prevent next pregnancy

Q.4 **Roughly, what percentage of all maternal deaths are caused by unsafe abortion?**

i. 10%
ii. 20%
iii. 30%
iv. 40%
v. 50%

Q.5 **Some people say that if safe abortion services are made available and accessible to adolescents, it will encourage promiscuity. Do you agree with this?**

i. No, absolutely not
ii. Not sure
iii. Yes, absolutely

Q.6 **A 16 year old girl presents with complications due to unsafe abortion, which of these best describes how you feel about her situation?** (Please tick the 3 most appropriate answers)

i. I feel sorry for her----------
ii. I feel angry with her
iii. I feel angry with the man who is responsible
iv. I feel we have failed because she resorted to unsafe abortion
v. I feel sad that she did not choose option of safe abortion
vi. I feel pity for the life that has been aborted
vii. I feel angry with the person who did the abortion

Q.7 **As health-care providers, what should we focus on to prevent unsafe abortion among adolescents?** (Please tick the 3 most appropriate answers)

i. Improve confidentiality for adolescents seeking abortion
ii. Train modern and traditional health-care providers in abortion care
iii. Support efforts to provide information about the law to expand access to safe abortion
iv. Improve access to safe abortion for adolescents
v. Improve provision of contraception to all adolescents
vi. Encourage the authorities to stop untrained people carrying out abortions
vii. Emphasize abstinence from sex before marriage
viii. Encourage adolescents to got through with their pregnancies

Q.8 **Which contraceptive methods should not be used by adolescents**? (Please cross all unsuitable methods)

i. Abstinence
ii. Male condom
iii. Spermicide
iv. Combined oral pill
v. Progestin-only injectable
vi. Intra-uterine contraceptive device (IUCD)
vii. Fertility-awareness based methods
viii. Lactational amenorrhoea
ix. Withdrawal
x. Sterilisation
xi. Emergency Contraceptive Pills(ECPs)

Q.9 **Which contraceptive methods are protective against STI/HIV?** (Please write down two examples for each method)

i. Protective
ii. Not protective

Q.10 **Which contraceptive methods do not require the cooperation of the male?**

(Please write down two examples)

Q.11 **Are the boys more vulnerable to STIs than girls, in India?**

(Please tick one option)

i. Boys are much more vulnerable
ii. About the same for boys and girls
iii. Girls are much more vulnerable

Q.12 **What factors make adolescents more vulnerable to HIV?**

i. Sexual relations during adolescence are often unplanned and sporadic, and sometimes the result of pressure, coercion or force
ii. They have access to preventive services and protective supplies
iii. They start sexual activity before they have experience and skills in self protection
iv. They have adequate information regarding STIs and how to avoid contracting these infections

Q.13 **Factors that hinder adolescents from seeking prompt STI treatment**

(Please tick three of the most important reasons)

i. STIs are often asymptomatic
ii. They do not have information about existing services
iii. They do not have money to pay for services
iv. Concerns about confidentiality
v. Fear of stigma and embarrassment
vi. Afraid of being scolded by health-care workers