



Youth.now

# **PREPARING CARE PROVIDERS IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH**

**A Resource Guide for Trainers,  
Educators and Facilitators**

**The Futures Group International  
GOJ / USAID**



**JAMAICA ADOLESCENT  
SEXUAL  
&  
REPRODUCTIVE HEALTH**

**TRAINER RESOURCE BOOK (TRB)**

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Youth.now is implemented on behalf of the Ministry of Health (Jamaica) by the Futures Group International in collaboration with Margaret Sanger Centre International (MSCI) and Dunlop Corbin Communications (DCC).

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We can only ask that as the manual and resource guide are used, you, the users, will share your comments and recommendations for improving their subsequent versions.

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# Abbreviations and Acronyms

ABBREVIATION	MEANING	ABBREVIATION	MEANING
<b>A.I.D.S</b>	Acquired Immune Deficiency Syndrome	<b>N.G.Os</b>	Non-Governmental Organizations
<b>A.S.R.H</b>	Adolescent Sexual and Reproduction Health	<b>O.H.T</b>	Overhead Transparency
<b>C.O.R.A</b>	Center for the Orientation of Adolescents	<b>P.I.D.</b>	Pelvic Inflammatory Disease
<b>F.S.H</b>	Follicle Stimulating Hormone	<b>P.W.P</b>	Participatory Workshop Process
<b>G.A.T.H.E.R</b>	Greet Ask Tell Help Explain Return	<b>S.E.S</b>	Socio Economics Status
<b>G.O.J</b>	Government of Jamaica	<b>S.E.S.P</b>	Social and Economic Support Programme
<b>H.I</b>	Hearing Impaired	<b>S.T.Ds</b>	Sexually Transmitted Diseases
<b>H.I.V</b>	Human Immune Deficiency Virus	<b>S.T.Is</b>	Sexually Transmitted Infections
<b>I.C.P.D</b>	International Conference on Population Development	<b>TFGI</b>	The Futures Group International
<b>L.H</b>	Luteinising Hormone	<b>T.M</b>	Trainers' Manual
<b>M.O.E.Y.C</b>	Ministry of Education Youth and Culture	<b>T.R.B</b>	Trainers' Resource Book
<b>M.O.H</b>	Ministry of Health	<b>T.S.S</b>	Toxic Shock Syndrome
<b>M.R.</b>	Mental Retarded	<b>U.S.A.I.D</b>	United States Agency for International Development
<b>M.S.C.I</b>	Margaret Sanger Centre International	<b>V.I.P.P</b>	Visualization In Participatory Planning

# Overview of the ASRH Training Programme

**The Futures Group International**, with funding from the USAID, and in collaboration with the Ministry of Health (MOH) in Jamaica, the Margaret Sanger Centre International (MSCI), Dunlop Corbin Communications (DCC) and JHPIEGO launched an Adolescent Reproductive Health (ARH) Project called **Youth.now**.

**Youth.now** supports the ongoing efforts of government and non-government organizations to address the health and social issues associated with early unintended pregnancy and sexually transmitted infections including HIV among adolescents 10-19 years. Youth.now endeavours to improve access to quality reproductive health and preventative services and to combat improve adolescents' and providers of care to adolescents' knowledge and skills related to reproductive health.

In order to bring about the needed changes in knowledge, attitudes and practices of adolescent service providers and care givers, which will support improved health- ASRH and positive life choices, an Adolescent Sexual and Reproductive Health (ASRH) Training Programme was developed to train trainers in the first instance. Trainers are expected to use this material to train adolescent care providers. To facilitate training, a Trainer Manual (TM) and a related Trainer Resource Book (TRB) were developed. Materials were developed through consultations with educators, service providers and facilitators.

During consultative workshops, participants identify topics in six areas deemed essential to training trainers in adolescent sexual and reproductive health. The suggested topics are:

1. Sexuality
2. Reduction of sexual risk taking behaviours
3. Sexually transmitted infections (STIs)
4. Unplanned pregnancy
5. Abortion
6. Sexual abuse
7. Encouraging healthy lifestyles and positive health-seeking behaviours.  
(Youth. Now Report, p.1).

The Trainer Manual was developed from materials compiled and written by the Advanced Training and Research in Fertility Unit, UWI, Mona. The manual outlines the aim of the training programme, suggested organization of workshops, content materials, methodologies for training participants, references to additional material support and presentation tips. The manual covers the following topics:

- 1. Introduction to Adolescent Sexual and Reproductive Health**
- 2. ‘Youth-Friendly’ Health Services**
- 3. Introduction to Adolescence**
- 4. Reproductive Anatomy & Physiology**
- 5. Contraceptive Technology In Adolescence**
- 6. Promoting Healthy Lifestyles During Adolescence**
- 7. Nutrition, Eating Disorders and Personal Health Care**
- 8. Introduction to Sexuality**
- 9. Sexuality and Gender Issues**
- 10. Counselling Adolescents**
- 11. Sexually Transmitted Infections**
- 12. Substance Abuse**
- 13. Crisis Issues**
- 14. Care of Adolescent During Pregnancy and Childbirth**

## **15. Abortion**

## **16. Homosexuality, Bisexuality, Lesbianism and Heterosexuality**

## **17. Evaluation of Training Programme, Trainer Manual and Trainer Resource Book**

Each topic is addressed within the following format:

**Session Topic**

**Recommended Time**

**Session Objectives**

**Materials**

**Advance Preparation**

**Activities , with References to TRB pages**

**Session Review/ Evaluation**

**Reference**

*NB. In some cases there are additional resource materials.*

The training manual begins with an Introductory Session (Session One) where the **Visualization in Participatory Planning** (VIPP) is introduced as a part of the workshop process. VIPP Principles and rules are introduced and their use is recommended to ensure an atmosphere of warmth and to encourage the highest level of participation. Emphasis is placed on evaluation which is informal and qualitative, using the Mood & Feeling and Matters Arising Charts at the end of each session and Plus (+) Delta (-) at the end of the programme. Instruments for the evaluating the TM and TRB are included in the respective document. Facilitators are requested to complete these instruments and submit to Youth.now for analysis. The data/ information gathered will be used to improve the content and presentation and develop a revised TM and TRB.

The Trainer Manual and Trainer Resource Book have been developed as a guide for the trainer/ facilitator and are intended to be used with much flexibility. The trainer/

facilitator can, and should, modify activities, tips and suggestions and also use others, which may be more relevant to participants and the training objectives, to stimulate discussion and participation.

It is recommended that the manual is implemented in its entirety. The 18 sessions should take approximately 54 hours, or nine days with two sessions per day. The following table gives a recommended outline for scheduling the entire training programme:

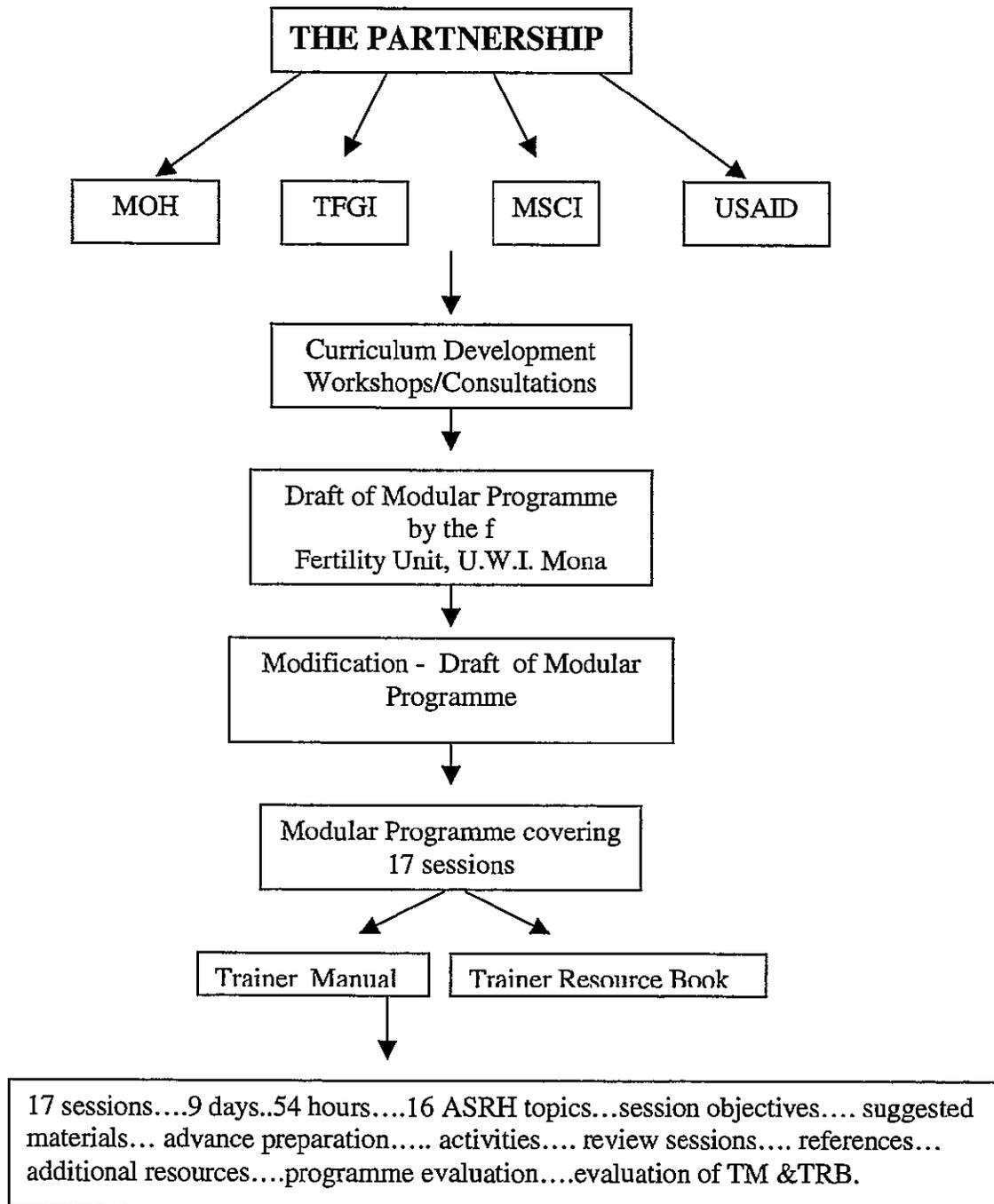
<b>Session/ Day</b>	<b>Hours</b>	<b>Session</b>	<b>Hours</b>	<b>TOTAL</b>
<b>One: Day 1</b> Introductory Session	2	<b>Two: Day 1</b> 'Youth Friendly' Health Services	4	<b>6</b>
<b>Three: Day 2</b> Introduction to Adolescence	4	<b>Four: Day 2</b> Reproductive Anatomy and Physiology	2	<b>6</b>
<b>Five: Day 3</b> Contraceptive Technology in Adolescence	3	<b>Six: Day 3</b> Promoting Healthy Lifestyles in Adolescence	3	<b>6</b>
<b>Seven: Day 4</b> Nutrition, Eating Disorders and Personal Health Care	3	<b>Eight: Day 4</b> Introduction to Sexuality	3	<b>6</b>
<b>Nine: Day 5</b> Sexuality and Gender	2	<b>Ten: Day 5</b> Counselling Adolescents	4	<b>6</b>
<b>Eleven: Day 6</b> Sexually Transmitted Infections (STIs)	3	<b>Twelve: Day 6</b> Substance Abuse Among Adolescents	3	<b>6</b>
<b>Thirteen: Day 7</b> Crisis Issues	4	<b>Fourteen: Day 7</b> Care of Adolescent Pregnancy & Childbirth	4	<b>8</b>
<b>Fifteen: Day 8</b> Abortion	2	<b>Sixteen : Day 8</b> Homosexuality, Bisexuality, Lesbianism, Heterosexuality	4	<b>6</b>
<b>Seventeen: Day 9</b> Evaluation of Training Programme, Trainer Manual and Trainer Resource Book	3	<b>Closing Session</b>	1	<b>4</b>
<b>GRAND TOTAL</b>				<b>54</b>

# Aims of the Adolescent Sexual and Reproductive Health Programme

There are four (4) aims:

1. To **improve the Sexual and Reproductive Health** of youths in Jamaica.
2. To **increase** young people's **access** and use of **quality** adolescent sexual and reproductive health services and **preventative practices** in nine parishes in Jamaica.
3. To improve the adolescents' sexual and reproductive health **knowledge** and **skills** as well as that of the health service providers.
4. To implement **National Policies and Guidelines** in support of Adolescents Sexual and Reproductive Health.

# Curriculum Development Process



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# SESSION One

## Introductory Session

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**A. Recommended Time:** 2 hours

### **B. Overview**

This is the Introductory Session of our training programme on Adolescent Sexual and Reproductive Health (ASRH). It covers the introduction of participants and facilitators; familiarization with the Participatory Workshop Process (PWP), the background of the ASRH Project and the aim of the ASRH Project. The issues emanating from the International Conference on Population and Development (ICPD) 1994, which relate to ASRH Responsibilities and Rights will be discussed. All key words, terms and abbreviations relevant to the session will be clarified.

### **C. Session Objectives**

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

- C. 1 Describe an ice-breaker to acquaint participants and facilitators.
- C. 2 Explain the Participatory Workshop Process.
- C. 3 Explain the background of the ASRH Project
- C. 4 Explain the aims of the ASRH Project

- C. 5 Discuss the issues emanating from the International Conference on Population and Development (ICPD) 1994, which relate to Adolescent Sexual and Reproductive Health (ASRH) responsibilities and rights.
- C. 6 Define “key words”, terms and abbreviations relating to the Introductory Session.

## **D. Recommended Materials/ Equipment**

Overhead Projector, Transparencies, Assorted Colours Cartridge Paper And Markers, Flip Charts, Masking Tape, Index Cards (Optional), Pens.

## **E. Advance Preparation- (See Relevant TRBs under Activities in Section F)**

### **E. 1 Charts, Cards and Handouts**

- Cards and pens for each participant
- Chart with Session Objectives
- Feedback Mood Chart
- Chart with VIPP Principles
- Chart with rules for writing VIPP cards
- Chart with VIPP definition
- Handout - Key words, terms, abbreviations
- Handout -The background, Aims of the ASRH Project and Issues of the of ICPD Conference
- Chart with the quote: What I hear, I forget etc.
- Evaluation Chart (Pictogram) – How do you feel about this module?
- Matters Arising Chart

## E. 2 Key Words, Terms, and Abbreviations

Adolescent	Youth	Health	Sexual Health
Reproductive Health	Rights	Gender	Service Providers
Age Range for: Adolescents, Youth and Young People		Abbreviations: PWP, VIPP, ICPD, ASRH, TRB	

## F. Activities

The facilitator will do the following in sequence:

**F. 1 Thank** participants for attending and use icebreaker for introduction (**TRB pp.1-3, Suggested Ice-Breakers**). Pin up the Session Objectives Chart. Read aloud, chart contents to the participants.

**F. 2 Distribute** handouts on Key Words, Terms and Abbreviations.

*(Point out the importance of understanding what these mean and that they will be referred to from time to time – TRB pp.4-5, Key Words, Terms and Abbreviations)*

**F. 3 Introduce** the Participatory Workshop Process (PWP). Ask for opinions on PWP and list key elements/ definitions.

**F. 4 Display** prepared VIPP chart (**TRB p.6, VIPP Chart**): Point out definition and discuss each area. Point out also the following- *importance of the Participatory Approach* - every idea counts, it is not a waste of time to allow as many as possible to share ideas, telling retards thinking.

*Pin up the following quote:*

**“What I hear, I forget  
What I see, I remember  
What I do, I understand”  
Confucius, 551-479 B.C.**

*(Stress that this quote is 1,500 years old and is still in use today as an element of learning and that the **participatory method** will require participants to do a lot of things – share their views with each other. In this way, everyone including the facilitators and participants will be equally involved in the activities of the sessions).*

- F. 5 Display** the prepared VIPP Principle Chart (TRB p.6, VIPP Principle Chart). Discuss each principle, placing emphasis on numbers 3 and 4.
- F. 6 Display** the prepared VIPP Rules Chart (TRB p.6, VIPP Rules Chart). **Discuss** each principle (*point out that these rules should be followed during all VIPP activities*).
- F. 7 Distribute** handouts on ASRH and Rights/Issues of the ICPD Conference (TRB pp.7 - 12, ASRH and Rights/Issues of the ICPD Conference). **Divide** participants in groups to discuss handout for 15 minutes, bring participants together for the report. The following guidelines for reporting may be used – **WHO, WHAT, WHY, WHEN and WHERE?**
- F. 8 Introduce** the method of evaluation.  
*(Point out that the sessions will not be formally evaluated, but it is important to record the participants' moods and feelings about the session, as well as to record their expectations of the*

sessions and carry out a review. For each session, this will be done in a non-intimidating/ non-threatening way).

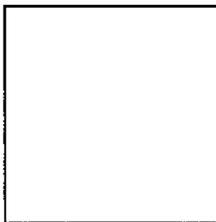
### F.8-1 Expectations of Session

**F.8-1-1 Solicit** answers from participants on their expectations/ hopes, concerns/ fears for the workshop now and expectations in the next six months after the workshop.

**Distribute** 3 different colour cards to participants to record their feelings.

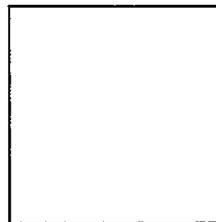
*(Point out what colour cards should record particular answers, e.g. red for fears/ concerns, blue for expectations/ hopes and white for expectations in the next six months. Remind them of the VIPP Rules)*

EXPECTATIONS/HOPES  
EXPECTATIONS



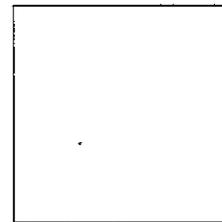
RED

CONCERNS/FEARS



BLUE

6 MONTHS



WHITE

*(While participants are writing up their cards, place three separate flip chart sheets on wall, write up the titles to record responses as participants share their recordings; their individual cards may be displayed as well).*

**F. 8-1-2 Record** brief statements after clarifying points of view and indicate areas of expectation etc. outside the scope of the workshop.

**F. 8-2 Introduce Evaluation Chart (Pictogram TRB p.12) – How do you feel about this module?**

Explain that each person can place a tick on the line beside each face that most closely matches his/her mood and feeling about the session.

*(Point out that over time it gives everyone an easy-to-see record of how the feelings change from session to session. Stress that participants can do this anytime in privacy).*

**F. 9 Session Review**

**Explain** that you are about to conclude the **Introductory Session**.

**Display** the Session Objectives and read them again.

**Display** the Matters Arising Chart (Explain that matters arising from each session will be listed at the end of each day/ start of new day, solicit matters arising from this session and fill in).

**MATTERS ARISING CHART**

Date	Session	Matter	Decision

**Remind** participants to fill in the Mood and Feeling Chart (*point out that reading will be taken in the next session*).

**F.10 Distribute** handout on “What are the sexual and reproductive health needs, which blind adolescents face in preparation for Session Two- ‘Youth Friendly’ Health Services.

## **G. References**

The Daily Gleaner, Tuesday, November 7, 2000 p. B5 : article by  
Maureen Campbell (**TRB p.13, Excerpt from the Gleaner**)

The Caribbean Youth Summit Final Report 1998. (**TRB pp.7 - 12, Final  
Report**)

**END OF SESSION ONE**

# **SESSION** **TWO**

## **'Youth Friendly' Health Services**

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**A. Recommended Time:** 4 hours

### **B. Overview**

This is Session Two of our training programme on Adolescent Sexual and Reproductive Health (ASRH). It covers the four types of health centres in actuality, and also perspectives on how they should operate in serving adolescents. Models in developing and developed countries are discussed in detail for effective comparisons with our situation in Jamaica. All key words, terms and abbreviations relevant to the session will be clarified.

### **C. Session Objectives**

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

- C. 1** Describe how adolescents typically view health care provisions.
- C. 2** Identify what help adolescents typically seek from a health service.
- C. 3** Describe adult perspectives on 'Adolescent Friendly' health services.
- C. 4** List important institutional barriers to adolescents' use of health services.

- C. 5 Discuss personal fears and concerns of service providers, which prevent them from offering 'Adolescent Friendly' health services.
- C. 6 Discuss value issues that service providers have that prevent them from offering 'adolescent friendly' health services.
- C. 7 Identify different models for providing 'Youth Friendly' ASRH services.
- C. 8 Discuss different models for providing 'Youth Friendly' ASRH services.

#### **D. Recommended Materials:**

Overhead Projectors, Transparencies, Flip Charts, Assorted Colour Markers

#### **E. Advance Preparation**

**E.1 Handouts – Values and Attitudes Questionnaire**

**E.2 Flip Chart or Transparencies for the following:**

**E. 2- 1** Barriers that prevent available health services from being provided.

**Restrictive Laws & Policies**  
**Judgmental Health Workers**

**E. 2- 2** Barriers that make it difficult for adolescents to reach/ use health services

**Locations**  
**Timing**

## Cost

### E. 2- 3 Barriers which make adolescents reluctant to seek help.

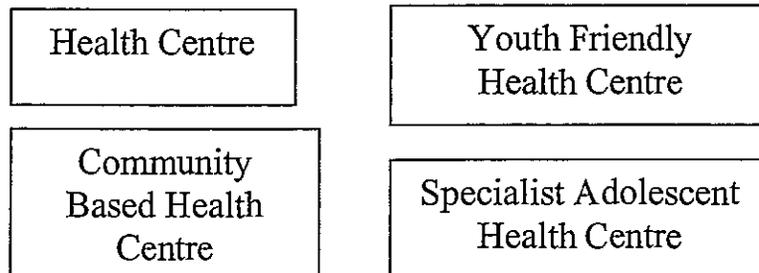
Fear/ knowledge that health workers may:

- **Humiliate their parents/guardians**
- **Ask difficult questions**
- **Be of the opposite sex**
- **Conduct unpleasant procedures**
- **Contact parents or otherwise violate confidentiality**

Fear that the health service may:

- **Be of poor quality**
- **Not be confidential**
- **Be lacking privacy**
- **Take an unreasonably long time/ long waiting time**
- **Require parental consent**
- **Be a cumbersome/ bureaucratic procedure**
- **Have certain boundaries or be insecure if located in a troubled environment, which features gangs, violence, drugs etc.**

### E.3 Key words/Terms



## **F. Activities**

The facilitator will do the following in sequence:

- F. 1 Administer the Values and Attitudes Questionnaire (TRB p.14, Values and Attitudes Questionnaire)**
- F. 2 Ask participants to use the key to rate their values and attitudes towards ASRH. (TRB p.15, Values and Attitudes Questionnaire Key)**
- F. 3 Invite participants to discuss their relevant interpretation scores and discuss the items of concern.**
- F. 4 Introduce participants to key terms that will be used in the session:**
  - **‘Youth Friendly’ Health Centre (TRB p. 16)**
  - **A Community Based Health Centre (TRB p. 16)**
  - **A Specialist Adolescent Health Centre (TRB p. 16)**
- F. 5 Give participants handouts and discuss critical elements: (TRB p.17-18, Elements of Centre)**
  - F. 5- 1 Carry out discussion on Health Centres (TRB pp. 19 – 21)**
    - Types of Health Centres**
    - Who operates Health Centres?**
    - What are the services provided for adolescents in Health Centres?**
    - What are temporary Health Centres?**
  - F. 5-2 Focus discussion on ‘Youth Friendly’ Health Centre (TRB pp. 17 - 20)**

The ‘Youth Friendly’ Health Centre has certain elements (discuss these in details: **(TRB pp.20, Elements of a Youth Friendly)**)

### **F. 5-3 A Specialist Adolescent Health Centre**

This is a centre that can be linked to a Medical School. It provides clinical services to adolescents. It serves as a referral centre to other general health facilities.

It conducts training programs for youth-serving professionals from different disciplines, both pre-service and in-service training programmes.**(TRBp.21, Description of a Specialist Centre)**

### **F. 5- 4 Community Based Health Centre**

This facility strives to provide user-friendly clinical services to adolescents within the context of health service provision to all **(TRB p. 22)**

*(Ask participants to keep a diary of priority actions to improve the standards of Health Services provision for adolescents in their community).*

**F. 5- 5 Divide participants** into three (3) groups and issue the following for group discussion. Ask each group to appoint a group leader to present the group’s report. Give about 15 minutes for discussion and 5 minutes for each report. Each group should present a flip chart presentation:

1. How do adolescents typically view health care provisions? **(TRB p.22, Flip Chart Answers)**
2. What are the personal fears, concerns and values issues that Service Providers have that prevent them from operating “Adolescent Friendly” health centres?

3. What do adolescents typically seek from a health centre? (TRB p.23, Flip Chart Answers)

**F. 6 Models for providing 'Youth Friendly' ASRH Services**

- Developed Countries
- Developing Countries (TRB p.23, Outline of Model Countries)

**F. 7 Institutional Barriers To Adolescents' Use Of Health Services (TRB p.26, List of Barriers)**

**Display** the flip chart prepared on barriers that prevent available health services from being provided.

**Discuss** each barrier with participants. Add new ones. Modify existing ones as necessary.

**F. 8 Contributions that Service Sector Groups can make.**

**Divide** participants into Service Sector Groups. E.g.

- Health workers
- Social workers
- Educators
- Parents

*(Tell each group to choose a leader to report, and then give them 15 minutes for discussion. Ask each group to list on respective flip charts provided, their contributions to health and development of adolescents. Give about 5 minutes for each report; display all flip charts. Please see TRB p.27, for additional information).*

**F. 9 Identify commonalities and differences from the Values & Attitudes Questionnaire results.**

*(Ask participants to compare and contrast attitudinal concerns and issues that they had from the above questionnaire. Encourage them to keep a record of them and monitor their change in response from time to time).*

## **F. 10 Session Review**

**F.10 - 1 Explain** that you are **about** to conclude the session

**F.10 - 2 Display** the Session **Objectives**

**F.10 - 3 Display** the Matters **Arising** Chart

*(Ask participants to fill in at their convenience)*

**F.10 - 4 Remind** participants to fill in the Mood & Feeling Chart.

*(Ask them to do this, as well, at their convenience.)*

**F. 10– 5 Distribute** handout on “What are the sexual and reproductive health needs, which blind adolescents face in preparation for Session Three- Introduction to Adolescence.

## **G. References (TRB pp. 19-26)**

## **H. Additional Resources (TRB pp. 40-43)**

See Youth.now Document entitled “Jamaica Guidelines for Adolescent Reproductive Healthcare Service Delivery” pp. 6-8 & 31-39. Adapted from Guidelines for Adolescent Preventive Services—GAPS— of the American Medical Association (February 2002)

**END OF SESSION TWO**

# SESSION Three

## Introduction to Adolescence

---

**A. Recommended Time:** 4 hours

**B. Overview**

In this session the nature and sequence of changes during adolescence will be identified and what makes adolescence such a special phase in growth and development will be explored. The area of adolescents with disabilities will be discussed and focus will be placed on their special sexual and reproductive needs

**C. Session Objectives**

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

- C.1 Identify the nature and sequence of changes during adolescence.
- C.2 Describe what makes adolescence such a special phase in growth and development.
- C.3 Discuss the special needs of adolescents with disabilities.
- C.4 Define “key words” relevant to this session.
- C.5 Discuss the issues emanating from the **International Conference on Development (ICPD) 1994** which relate to **Adolescent Sexual and Reproductive Health (ASRH)** responsibilities and rights.

- C.6 Define “key words”, terms and abbreviations relating to the Introductory Session.

## D. Recommended Materials

Overhead Projector, Transparencies, Assorted Colours Cartridge Paper And Markers, Flip Charts, Masking Tape, Index Cards (Optional), Pens, Highlighters (Optional)

## E. Advance Preparation- (See Relevant TRBs under Activities-Section F)

### E. 1 Acquire recommended materials listed in Section D

Charts and Handouts

Chart with Session Objectives

Handout - Key words

Handouts:

- Adolescents with special needs
- Table showing adolescent growth and development [one special column for summarizing]

Flip Charts on:

- Reinforcement points on adolescents
- Definition of “Growth” and “Development” (underline the words physical in “growth” and non-physical in “development”)

Invitations to:

- Psychiatric social worker or psychiatrist, a special educator and a nurse/medical doctor to discuss ways in, which existing adolescent services can become user-friendlier for all adolescents with disabilities.
- An interpreter for deaf adolescents
- Selected parents of adolescents who will be invited to the forum panel.

*(Arrange refreshments and ask a participant to extend vote of thanks)*

## E. 2 Key Words, Terms, and Abbreviations

Adolescence	Growth	Blindness	Development
Reproductive Health	MR	Paraplegics	HI
Reproductive Health	Abbreviations: HIV, STD/STIs		

## F. Activities

The facilitator will do the following in sequence:

### F. 1 Distribute handouts on Key Words, Terms and Abbreviations.

*(Point out the importance of understanding what these mean and that they will be referred to from time to time – (TRB pp.44-45, Key Words, Terms and Abbreviations).* Ask participants to differentiate between “growth” and “development.” Write down responses, and then point out the key difference by underlining physical change in the definition of “growth” and non-physical in the definition of “development.”

### F. 2 Divide participants into small groups. Each group should have a mixture of disciplines and sexes. Distribute table showing adolescent growth and development (TRB p.46, Table Showing Adolescent Growth And Development). Explain that each task will be to identify three (3) examples of change in these categories over a period of 15-20 minutes. Identify the line/column that each group should do. Explain that all the activities in each column or line must be completed. Ask each group to prepare a flip-chart presentation for a group report. During the group- reporting, summarize the changes that are to be special note by underlining them on the flip chart or highlighting with special notes on each flip chart presented.

### **F. 3 What is special about adolescence?**

**F. 3- 1** Remind participants of the definition given in F.1.

**F. 3- 2** Tell participants to relax, close their eyes and try to return, mentally, to the age of 10 years old.

**F. 3- 3** Tell participants to try and carry out the following processes:

- Think about what you were like
- Think about what you might be wearing
- Think about the games you might have been playing on a typical Saturday evening.
- Can you hear your parent's or your guardian's voice?  
What is he/she saying?

*(Still keep your eyes closed)*

- Remind yourself of when you turned 13 years.
- How did it feel to be a teenager?
- What made this birthday extra special?
- What were your expectations?

*(Still keep your eyes closed)*

- Remind yourself when you turned 16 years
- What kind of clothes were you wearing?
- Did your relationship with your parents or guardians change?
- Did you have any special feelings for a particular boy or girl?
- What kinds of “fun” things did you do with friends?
- What kind of fears or concerns did you have?

*(Still with eyes closed, remember your first love)*

- Was your love returned?
- Were you heartbroken?
- What kinds of outdoor activities did you do with your loved one?

- Did you go for long walks together?
- Did you exchange notes?
- Did you daydream for hours?
- Did you listen and dance to your favourite pop song?
- Did you go swimming?
- Did you go to the movies?
- If you went for walks, can you still smell the leaves or flowers or feel the sun on your skin?  
*(Now slowly open your eyes and return to the present)*

**F. 3- 4** What made your adolescence a special time in your life?  
*Note as many responses as possible on a flip chart—include positive and negative*

**F. 3- 5** Display reinforcement points on adolescence (**TR B p.47, Reinforcement Points on Adolescents**) and read them.

#### **F. 4 Special needs of adolescents with disabilities**

**F. 4- 1** Remind participants of the definitions of blindness in F.1.

**F. 4- 2** Let participants know that in this session, a panel consisting of adolescents who are blind, deaf, paraplegic and mentally retarded/ or high functioning persons with autism will be their special guests. An interpreter for the deaf adolescents will also be present as well as parents of some of the adolescents on the panel. Additionally, there will be the following in the audience: a psychiatrist, social worker; a special educator, a nurse and a medical doctor

**F. 4- 3** Ask participants to direct questions to you as the moderator, and redirect them to the respective persons on the panel. You may influence the discussion by asking the following questions:

- What are some of the challenges that persons with disabilities have as they seek to cope during adolescence?
- What special services would they like to have?

- How might they want the existing providers to change so as to be more responsive to their needs?

*Questions to Parents*

- Please share your views on the kind of services that are needed to meet the needs of adolescents with disabilities?

**F. 4- 4** Refer participants to handouts (**TR B pp. 48-53, Specials Needs of Blind Adolescents**) on adolescents with special needs distributed at the end of session two and ask them to share some of their findings. (You might involve guests in the discussions)

**F. 4- 5** Invite the special educator, psychiatrist, nurse, medical doctor and social worker to discuss ways in which existing adolescent services can become more user friendly for all adolescents including those with disabilities. (Summarize and note points **on flip chart**)

**F. 4- 6** Invite a participant selected to extend vote of thanks to guests speakers and serve refreshments to them before they leave.

### **F. 5 Session Review**

**F. 5- 1** Bring session to a close by displaying the session objectives, and read them to participants

**F. 5- 2** Remind participants to fill in the following charts:

- Mood and Feeling
- Matters Arising

**F. 6 Distribute** handouts for next session (Session Four- Reproductive Anatomy and Physiology).

## **G. References**

The Sexual and Reproductive Health Issues of Adolescents with Hearing Impairment and Mental Retardation, Avril Daley, 1999. (**TRB pp.54-59**).

## **H. Additional Resources**

See Youth.now Document entitled “Jamaica Guidelines for Adolescent Reproductive Healthcare Service Delivery” pp. 11-24 & 40-43. Adapted from Guidelines for Adolescent Preventive Services— GAPS— of the American Medical Association (February 2002)

**END OF SESSION THREE**

# **SESSION** **FOUR**

## Reproductive Anatomy and Physiology

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**A. Recommended Time:** 2 hours

### **B. Overview**

This is the fourth session in training programme on ASRH. It covers the anatomy and physiology of the human reproductive system and the role of hormones in effecting changes. Some myths and misconceptions about sexual intercourse, reproduction and pregnancy will be discussed as well as the contribution of views.

### **C. Session Objectives**

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

- C. 1** Discuss the anatomy and physiology of the human reproductive system.
- C. 2** Discuss the role of hormones in effecting changes in the secondary sexual characteristics of the male and female, respectively.
- C. 3** Discuss the similarities between the male and female sex organs.
- C. 4** Discuss the role of hormones in menopause and andropause and the associated changes that accompany those phases.
- C. 5** Identify myths and misconceptions about sexual intercourse, reproduction and pregnancy.

**C.6** Identify ways of combating myths and misconceptions about sexual intercourse, reproduction and pregnancy .

## **D. Recommended Materials / Equipment**

Overhead Projector, Transparencies, Assorted Colours Cartridge Paper And Markers, Flip Charts, Masking Tape, Index Cards (Optional), Pens, Highlighters (Optional)

## **E. Advance Preparation** (See relevant TRBs under Activities in Section F)

- E. 1** Handouts for each participant on definition of words, terms, abbreviations and phrases.
- E. 2** Outlines of the male and female reproductive anatomy for each participant on a transparency for group discussion.
- E. 3** Diagrams showing male and female sex characteristics.
- E. 4** Handout of a glossary on Caribbean myths.
- E. 5** Questionnaire- Test yourself- “Reproductive Health Anatomy and Physiology”.
- E. 6** Handout on Mid-life.

## **F. Activities**

The facilitator will do the following in sequence:

- F. 1** **Distribute** handouts to all participants on words, terms and abbreviations. Discuss selected ones or all. (*Point out that it is*

*important to understand all areas throughout the entire session) – (TRB pp. 60-64).*

**F. 2 Distribute** outlines of both female and male reproductive anatomy. Project the transparency models and point out each area for discussion. **(TRB pp. 65-66).**

**F. 3 Discuss** similarities between male and female physiologies:

*(Point out that the male and female organs develop from the same tissue in the fetus during the first six weeks of fetal life).*

**F. 3- 1** The gland of the penis and the clitoris in the vagina.

**F. 3- 2** The penis and vagina.

**F. 3- 3** The testicles and ovaries.

**F. 3- 4** The vas deferens and the fallopian tubes.

**F. 3- 5** The outer lips of the vagina and the scrotum .

**F. 3- 6** The inner lips of the vagina and the bottom of the penis.

**F. 4 Discuss differences between the male and female anatomies and physiologies:**

**F. 4- 1** All the reproductive organs are located inside her body , while his are outside.

**F. 4- 2** The female produces an ovum monthly while the male produces sperms.

**F. 4- 3** The female reproductive system has a uterus while the male reproductive system doesn't.

**F. 4- 4** The males ejaculate while the females don't.

*(It is important to point out that both boys and girls should know about their bodies and how they function. Misinformation or lack of information is often responsible for a lot of the needless worry and can sometimes cause serious problems).*

## **F. 5 The role of hormones in effecting changes:**

**F. 5- 1 Review** “What is a hormone?”- the female hormones (*oestrogen and progesterone*) and the male hormone (*testosterone*).

**F. 5 - 2 Distribute** the flow diagrams on male and female secondary sexual characteristics. (**TRB pp. 67-68**). (*Point out the secondary characteristics, verbally*)

Write up a flip chart with additional secondary characteristics changes:

- **Gain in muscular strength for boys.**
- **Voice changes in both girls and boys.**
- **First ejaculation and often-nocturnal emissions (wet dreams) for boys.**

*(Points out that the changes for boys take approximately 5 years, beginning at the age of 12 or 13 years. For girls, the changes take approximately 6 years beginning at 11 or 12 years of age)*

**F. 6 Distribute** handouts on mid-life (**TRB pp. 69-71**). Discuss the phases for both men and women. Note the meaning for:

Pre-menopause

Climacteric

Menopause

*(Discuss the handout with participants)*

**F. 7 Distribute** handout on “Myths and Misconceptions about Sexual Intercourse, Reproduction and Pregnancy.”(TRB pp. 72-75). Discuss selected myths and misconceptions.

**F. 8 Divide** participants into two groups. Distribute the “Test Yourself Questionnaire” (TRB pp. 76-85). Ask participants to discuss information within their groups. Ask each group to modify, add or delete as far as the Jamaican situation is relevant. Give about 10 minutes for group discussions and approximately 5 minutes for reports. Summarize points made on the flip charts.

**F. 8- 1** Ask participants to make their corrections and make notes of the areas that they need to focus on.

### **F. 9 Session Review**

**F. 9- 1** Explain that the session is about to close.

**F. 9- 2** Display the Session Objectives, and read them to participants

**F. 9- 3** Ask participants to remember to fill out the following charts:

- **Mood and Feeling Chart**
- **Matters Arising Chart**

**F. 10 Distribute** handout on “Contraceptive Technology During Adolescence” for Session Five.

## **G. References**

Sex and Sexuality: The life cycle, family life education programme adapted from a publication of the parent Ed Programme of Planned Parenthood. NY USA.

The Adolescence Development Physical changes in boys and girls. Traditional gender prescription. Pre-development of the male and the female genitalia. Information about reproductive anatomy and physiology.

**END OF SESSION FOUR**

# **SESSION** **Five**

## **Contraceptive Technology In Adolescence**

---

**A. Recommended Time:** 3 hours

### **B. Overview**

The title of this session is Contraceptive Technology In Adolescence. The duration is about 3 hours. It covers factors that impact on the delivery of contraceptives to adolescents, abstinence as a method of contraceptive, the types of contraceptives that are available in Jamaica for adolescents, their side effects and how they can be managed. Additionally, focus is on counselling the adolescents with a view to facilitate informed consent to the use of contraceptives.

### **C. Session Objectives**

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

- C. 1 Discuss the factors that impact on the delivery of contraceptives to adolescents.
- C. 2 Discuss abstinence as a method of natural contraception, a traditional alternative to penetrative sex.
- C. 3 Discuss the contraceptives that are available in Jamaica, as prescribed by the MOH for use by adolescents.
- C. 4 Identify the mechanisms of action and side effects of contraceptives
- C. 5 Explain the management of side effects of contraceptives.

C. 6 Identify the use of hormonal contraceptives.

C. 7. Identify proper methods to counsel adolescents on the use of contraceptives.

#### **D. Recommended Materials/ Equipment**

Flip Chart, Assorted Fine Point And Felt-Tip Markers, Plain Paper, Pens, Cartridge Paper, Overhead Projector, Transparencies.

#### **E. Advance Preparation (See relevant TRBs under Activities in Section F)**

E. 1 Invitation letter to a health service provider to discuss Family Planning methods. (Ask for a practical demonstration).

E. 2 Flip chart presentation on “Provider Characteristics” relevant to providing contraceptive services to adolescents

E. 3 Moot on abstinence (pros and cons).

E. 4 Panel for debate and judges. (Use persons at the workshop or include when visitors come for presentation on Family Planning Methods).

E. 5 A cake should be ordered as prize for the winning team— to be presented and shared at the end of the workshop sessions (last day).

E. 6 Flip chart presentation on Contraceptive Methods (be method specific listing at least six methods outlined in section F.7-2 below)

E. 7 Discussion notes for group work.

- E. 8 Flip chart presentation on why counselling counts.
- E. 9 Large letters to spell GATHER and a display board with the GATHER METHOD
- E. 10 Comic strip dialogue.
- E. 11 Choose a participant to extend vote of thanks

## **F. Activities**

The facilitator will do the following in sequence:

- F. 1 Review** the definition of adolescence. Distribute plain paper and pens.
- F. 2 Ask** participants to list (individually ) some of the factors that affect the delivery of services to adolescents in their communities. Summarize and list on flip chart.
- F. 3 Display** flip charts made up from **(TRB p.86 , Considerations for Providing Contraceptive Services; adolescent characteristics)**

*(Point out that it is important to take characteristics of adolescents into consideration in weighing the factors).*

**F. 3- 1 Physically**

**F. 3- 2 Emotionally**

**F. 3- 3 Cognitively and;**

**F. 3- 4 Socially (TRB p. 87-88 , Adolescent Characteristics)**

- F. 4 Ask** participants to list (individually ) some of the characteristics that health care providers should have to provide

delivery of services to adolescents in their communities.  
Summarize and list on flip chart.

**F. 5 Display on flip chart made up from (TRB p. 89, Provider Characteristics and Clinical Characteristics)**

*(Point out that service providers should be prepared to adjust or change their approach from time to time, to improve their services to adolescents. Refer to the characteristics of adolescents from time to time TRB pp.94 - 95 , Pointers, & Quick Reminders; TRB pp.96 - 97 Gather Method; TRB pp.105-106 Helping to choose a method).*

**F. 6 Divide participants into two groups for a debate. Distribute moot on abstinence. Ask participants to debate the moot and prepare for debate. Choose a group leader to assign first, second and third speakers to represent respective positions give to the group. Flip a coin to assign pros to the group leader that chose head of coin.**

*(Point out that the importance of “waiting” as a means of contraception and ways in which abstinence and self-control can be encouraged. Additionally, point out the importance of not being judgmental, especially as far as masturbation is concerned).*

**F. 7 Contraceptives in Jamaica for use by adolescents.**

**F. 7- 1 Discuss** with participants the various contraceptive methods in Jamaica for use by adolescents. List them.

**F. 7- 2 Display** flip charts on method-specific considerations: (Discuss them and query overview of each)

- **OCS**
- **Implants**
- **Injectables**
- **Condoms**

- IUDs
- ECPs

**F. 7- 3 Divide** participants into four (4) groups to discuss side effects of each method, management of the side effects, hormonal effects, ethical considerations and outreach. The group assigned to discuss hormonal effects should consider the following questions:

Should we encourage one method?	<input type="checkbox"/> yes
Should we promote condom use only, hormonal method use or should we ask adolescents to always use both?	<input type="checkbox"/> yes

**F. 7- 4 Ask** each group to prepare a flip chart presentation. **TRB pp. 90-93 ) Handout on Side Effects (TRB p. 102)** has suggestions for each group)

*(Point out that one way to build community-based support for services is by having a speakers bureau in public institutions such as churches, youth clubs, schools etc. and by giving out flyers etc.).*

**F. 7- 5 Invite** a health service provider to do a talk and display methods. Ask for a hands-on session.

**F. 8 Counselling adolescents on proper contraceptive methods**

**F. 8- 1 Ask** participants to share what comes to mind when they think of counselling adolescents. List on flip chart summary of discussion points.

**F. 8- 2 Display** flip chart presentation (**TRB pp. 103**) and read and discuss “What is counselling?” as well as the pointers and quick reminders.

*(Point out that other counselling methods/models can be used, including non-contraceptive methods and these should be included appropriately in counselling session with adolescents).*

**F. 8- 3 Plan a skit**

**F. 8- 3 (i) Divide** participants in four (4) groups telling them that each group will be helping to choose a method (**TRB pp. 94-95, Good and bad dialogue**).

**F. 8 - 3 (ii) Ask** group to produce a simple three (3) minute skit with client and service provider.

Ask participant’s audience to rate the dialogue as follows:

- |                                  |
|----------------------------------|
| What is good about the dialogue? |
|----------------------------------|
  
- |                                   |
|-----------------------------------|
| What is wrong about the dialogue? |
|-----------------------------------|
  
- |                                   |
|-----------------------------------|
| How can the dialogue be improved? |
|-----------------------------------|

*(Point out that the presentations are guidance skits purely for training purposes and not to be judgmental of participants).*

**F. 9 Session Review**

**F. 9- 1 Explain** to participants that you are about to close the session

**F. 9- 2 Display** the Session Objectives and read them

**F. 9- 3 Remind** participants to fill out the following charts:

- **Mood and Feeling Chart**
- **Matters Arising Chart**

**F. 10 Distribute** handouts on “Promoting Healthy Lifestyles” for Session Six.

## **G. Reference**

Elements of Informed Choice (TRB pp. 104-105)

**H. Additional Resources** (TRB pp. 98-101. The GAP Method)

**END OF SESSION FIVE**

# **SESSION** **SIX**

## **Promoting Healthy Lifestyles In Adolescents**

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### **A. Recommended Time: 3 hours**

### **B. Overview**

The topic- Promoting Healthy Lifestyles In Adolescence is addressed in this session. It covers the identification of adolescents' health-related lifestyle concerns, perspectives of the service providers on health-related lifestyle concerns of adolescents and governmental legislations relevant to contraceptive use by adolescents.

### **C. Session Objectives**

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

- C. 1** Identify adolescents' health- related lifestyle concerns
- C. 2** Identify the perspectives of service providers on health – related lifestyle concerns of adolescents.
- C. 3** Acquaint participants with the government's proposed policy-statement on contraceptives to minors and get their perspective on same.

### **D. Recommended Materials**

Overhead Projector, Transparencies, Assorted Colour Markers, Flip Charts, Masking Tape, Index Cards (optional), Pens, Slips of Plain Paper and Container to hold same, Bell.

## E. Advance Preparation (See relevant TRBs under Activities in Section F)

- E. 1 Collection of letters written by adolescents to magazines, newspapers etc. for example, "Tell it to your doctor," or columns seeking guidance, for example, "Dear Pastor". Cut out the responses given in the print media as well.  
(Collect an assortment and acquaint yourself with all of them before the activity).
- E. 2 Handout on Summary: Promoting Healthy Lifestyles during adolescence.

## F. Activities

The facilitator will do the following in sequence:

- F. 1 **Divide** participants into groups and **distribute** one letter per group.
- F. 2 **Ask** participants to read and discuss each letter then record on a flip chart, their group reports under the following headings:

Health concerns	Lifestyle issues	Doctor's/Counsellor's Response

NB. Tell participants to record the group's overall comments on the letter.

- F. 3 Give each group 15 minutes for discussion and 5 minutes for presentation on each Flip Chart report.
- F. 4 Summarize and make a list of healthy lifestyle concerns.  
*N.B. You may add others from the discussion.*

- F. 5 Display a list of the health lifestyle concerns in F. 2.
- F. 6 Divide participants in service providers groups. For example, Social workers and Educators. Ask providers to give their perspectives from the specific service provider's group on the list of concerns in F. 2.
- F. 7 Additionally, ask them to give their perspectives on the following concerns if they were not raised in F.2:
- STDs/STIs
  - HIV/AIDS
  - Pregnancy
  - Pre-Marital Sex

F. 8 Brainstorm session on: Situational Issues.

Write the following information on plain slips of paper and place them into a container. Close the container and pass it around the room from participant to participant, to the tune of "How Green you are." You can give the command to stop by clapping your hands or ringing the bell. The person with the container in hand when you gave the "Stop" command should take out a slip of paper, read it and give a response.

*N.B. After the participant gives a response, all other participants can share in the discussion.*

Question 1

Mentally, put on the 'hat' of an adolescent. Pretend that you are a student of a co-ed high school class and that you are requested to respond to a proposal that condom vending machines should be installed in the school. What would be your reactions and concerns?

Question 2

You are the parent of a boy/girl in an upper class home, you are from the white race, your child is attending a private high school, 16 years of age. You are at a PTA meeting where a proposal was sent by the MOEYC that condom Vending Machines should be placed in all schools with children over 10 years of age to stop HIV/AIDS. What would be your reaction and concern?

Question 3

You are the parent of a boy/girl in a poor Inner City Jamaican neighbourhood, you are from the black race, and your child is attending a government Junior High School, 14 years of age. You are at a PTA meeting where a proposal was sent by the MOEYC that condom Vending Machines should be placed in all schools with children over 10 years of age to stop HIV/AIDS. What would be your reaction and concern?

**F. 9** Summarize by drawing attention to the following handout: (TRB pp. 108 & 110, **Promoting Healthy Lifestyles in adolescence and “What is Moral and Immoral?”**)

### **F. 10 Review Session**

**F. 10- 1 Explain** to participants that you are about to close the session

**F. 10- 2 Display** the Session Objectives and read them

**F. 10- 3 Remind** participants to fill out the following charts:

- **Mood and Feeling Chart**
- **Matters Arising Chart**

**F. 11 Distribute** handouts on “Nutrition and Personal Health Care” for Session Seven.

## **G. References**

MOEYC Statement of Policy: Providing Effective Contraceptives to Minors. **(TRB pp. 109-110)**

What is Moral and What is Immoral?: Source – Lester A. Kirkendall and Elizabeth Ogg: Sex and Our Society (New York, Public Affairs Committee, 1994 p. 4.)  
**(TRB pp. 110)**

**END OF SESSION SIX**

# **SESSION** **Seven**

## **Nutrition, Eating Disorders and Personal Health Care**

---

**A. Recommended Time:** 3 hours

### **B. Overview**

This session is on Nutrition and Personal Health Care. It covers the difference between healthy and unhealthy diets for adolescents, planning affordable/ balanced meals for adolescents and eating disorders. Mention is made of the role of the media in promoting body beauty. The session is supported by resource persons as guest presenters on Nutrition and Personal Health Care for adolescents and Stress Management, as well as, special care concerns of the disabled adolescents.

### **C. Session Objectives**

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

- C. 1** Differentiate between healthy and unhealthy diets for adolescents
- C. 2** Plan affordable and balanced meals for adolescents
- C. 3** Discuss the aetiology and symptoms of eating disorders in adolescents and ways of preventing, managing and caring them.
- C. 4** Identify the role of the media in promoting stereotypical body beauty, which impact on eating disorders.

- C. 5 Discuss pertinent personal health care concerns during adolescence.

## **D. Recommended Materials/Equipment**

Overhead Projector, Transparencies, Assorted Colour Markers, Flip Charts, Masking Tape.

## **E. Advance Preparation (See relevant TRBs under Activities in Section F)**

- E. 1 Invitation to Nutritionist to make a presentation on proper nutrition during adolescence. Enclose a guide sheet for the presentation to include:

- Reminder on the characteristics of adolescents.
- What adolescents like to eat and how it can be nutritionally prepared.
- Address the How, Where, When and Why on adolescent nutrition and Personal Health Care
- Eating disorders
- The use of Case studies in the presentation
- Request any prepared handouts that may be available on the topic as well as references.

- E. 2 Invitation to a medical doctor to make presentation on Stress Management in adolescence and other aspects of personal health care concerns in adolescence. Enclosed a guide sheet including:

- **What is stress**
- **How it is manifested in adolescents**
- **How to manage stress**
- **Concerns of:**
  - Breast examination
  - Prostrate examination
  - Pap smears
  - Self-mutilation
  - Suicide causes and prevention during adolescence
- **Budgeting - Money management according to nutritional requirements**
- **Make a request for handouts and references.**

*(Remember to select one of the participants to give the vote of thanks)*

### **E. 3 Handouts:**

- Assessing Diet, Nutrition and Obesity
- Additional Information on Nutrition (**TRB p.112**)

## **F. Activities**

The facilitator will do the following in sequence:

- F. 1** Ask the participants to discuss some of the nutritional characteristics of the adolescents. Summarize and list them on Flip Chart (**see TRB p.111 :Assessing Diet, Nutrition and Obesity- GATHER Information etc.**). Present this as a handout and discuss elements in flow diagram.
- F. 2** Tell participants that you have invited two guests (a nutritionist and a doctor) as their guest presenters. The first presenter will be the nutritionist, who will make a presentation on the Nutritional Needs of the adolescent.

*(Prompt participants to ask presenters questions on the topic. Tell them to be prepared to make notes and ask for references where appropriate).*

**F. 3 Introduce** the nutritionist formally, then invite him or her to make the presentation. After the presentation by the nutritionist conduct a question and answer session.

**F. 4 Ask** participants to identify advertisements in the Print and Electronic media, which promote body beauty. Summarize and write down the key elements on Flip Chart.

**F. 5 Tell** participants that their next guest will be a doctor to address them on Stress Management during adolescence and other aspects of personal health care concerns to adolescents such as:

- **Breast examination**
- **Prostrate examination**
- **Pap smears**
- **Self-mutilation**
- **Suicide causes and prevention**

*(Tell participants that they should be prepared to make notes and ask questions)*

**F. 6 Introduce** the doctor formally then invite him/ her to make the presentation. At the end of the presentation, conduct a question and answer session.

### **F. 7 Session Review**

**F. 7- 1** Explain to participants that you are about to close this session

**F. 7- 2** Display the Session Objectives, read them to participants

**F. 7- 3** Remind participants to fill in the following charts:

- **Mood and Feeling Chart**
- **Matters Arising**

## **G. References**

Refer to the details stated on the handouts used by guest presenters  
(Nutritionist and Doctor)

## **H. Additional Resources**

See Youth.now Document entitled “Jamaica Guidelines for Adolescent Reproductive Healthcare Service Delivery” pp. 26-27. Adapted from Guidelines for Adolescent Preventive Services— GAPS— of the American Medical Association (February 2002)

**END OF SESSION SEVEN**

## SESSION

# Eight

## Introduction To Sexuality

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**A. Recommended Time:** 3 hours

### **B. Overview**

The topic – Introduction to Sexuality is addressed in this session. It covers clarification of terms relevant to the session, messages about sexuality, gender and sexual behaviour from media and other sources. The impact of media and other messages are analyzed and the implications for Counselling adolescents are identified.

### **C. Session Objectives**

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

- C. 1** Define words/terms relevant to the session.
- C. 2** Critically evaluate messages about sexuality, gender, and sexual behaviour from media and other sources.
- C. 3** Analyze the impact of media and other messages on adolescents.
- C. 4** Identify the implications of media, other sources and their messages for counselling adolescents on sexuality.

## **D. Recommended Materials/Equipment**

Overhead Projector, Transparencies, Assorted Colour Markers, Flip Charts, Masking Tape, Index Cards (Optional), Pens, Video – Vibes In A World Of Sexuality, Equipment To Show Video.

## **E. Advance Preparation (See relevant TRBs under Activities in Section F)**

### **E. 1 Handouts:**

Clarification of words/terms  
Group identification number and questions

### **E. 2 Flips chart:**

Titles of Flip Charts to summarize discussions

### **E. 3 Preview:**

Preview video, prepare notes and questions. Acquire VCR and monitor

## **F. Activities**

The facilitator will do the following in sequence:

**F. 1** Distribute the handout on the clarification of words/terms (TRB pp. 113-114). Discuss each with participants:

Sex	Sexuality	Self- esteem
Gender Identity	Gender Roles	

**F. 2** Divide participants into four groups to discuss the following: (TRB p. 115 )

**Group 1-** Messages they have heard about sexuality from the Electronic and Print Media.

**Group 2-** Messages they have heard about sexuality from general friends, associates in various work-study settings and public settings.

**Group 3-** Messages they have heard about sexuality from the church, school, parents, older relatives and private home settings.

**Group 4-** Messages they have heard on sexuality from direct experience in relationships with romantic partners or significant other.

*(Point out that they can record whatever they have heard or learnt directly. There are no right/ wrong answers- rather it is experience sharing.)*

- F. 3** Let each group report after about 15 minutes of group discussion. Give about 5 minutes for each group report.

Write up the following flip chart to record responses (**TR B pp. 116-117**).

- F. 4** Tell participants that they will now watch a video- “Vibes in the World of Sexuality.” Read the background to the video, the duration and let them know that they should listen for the messages about sexuality .
- F. 5** After the showing of the video, discuss the messages on sexuality that they have previously listed, compare them with some of those from the video.
- F. 6** Discuss the implications of these messages for counselling the adolescent about sexuality and sexual experimentation. Write

up the two titles as follows on flip charts and summarize and record the responses.

### Counselling Issues

Sexuality	Sexual Experimentation

**F. 7** Refer participants to **TRB p. 118 , Children Live What They Learn.** Let one participant read for all to hear.

#### **F. 8 Session Review**

**F. 8- 1** Explain to participants that you are about to close this session.

**F. 8- 2** Display the Session Objectives, read them to participants.

**F. 8- 3** Remind participants to fill out the following charts:

- **Mood and Feeling Chart**
- **Matters Arising Chart**

**G. References:**

Introduction to Human Sexuality. (TRB pp. 119-122)

Self-esteem and Decision-making. Planned Parenthood Association of South Africa, Family Life Education

**END OF SESSION EIGHT**

# **SESSION** **Nine**

## **Sexuality and Gender Issues**

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### **A. Recommended Time: 2 Hours**

### **B. Overview**

This is the ninth session in the training programme on ASRH. Session 8 (the precursor session) focused on the introduction to sexuality. In this session sexuality will be discussed in relationship to gender. It covers the differentiation between the sex, sexuality and gender, development throughout the life cycle, the impact of gender on sexuality and the counselling issues relevant to sexuality, as they apply to the young Jamaican adolescent.

### **C. Session Objectives:**

- C. 1** Differentiate between sex, sexuality and gender.
- C. 2** Discuss the sexual development throughout the life cycle.
- C. 3** Analyze the interconnections of sex, sexuality and gender to assess their impact on the power and self-esteem of the male and female.
- C. 4** Discuss aspects of sexuality and the implications for counselling the Jamaican adolescent about sexuality.

## **D. Recommended Materials**

Flip Chart, Assorted Color Markers, Overhead Projector and Transparencies.

## **E. Advance Preparation (See relevant TRBs under Activities in Section F)**

### **E. 1 Handouts:**

- Clarifications of words/terms
- Outline for brainstorming on sexuality
- Why gender is important
- Sexual development throughout the life cycle
- Venn Diagram on sexuality
- Circles of sexuality
- Circles of sexuality explanations
- Questions for group work in Section F.3 - 4

### **Invitations:**

- A letters to persons in non-traditional areas of work to discuss their experience as far as gender roles, discrimination, etc in the world of work, education etc.

### **Flip Chart:**

- Phases in Sexual Development

*(Remember to choose a participant to give a vote of thanks to guests).*

## **F. Activities**

**F. 1 Distribute** the handout on the clarification of words/terms (TRB. pp. 123-124)

**F. 1– 1 Discuss** handout with participants.

**F. 1– 2 Display** Venn diagram on sex, sexuality and gender (TRB p. 125)

**F. 1– 3 Discuss** each area of the diagram. Explain that the common area is both sex and sexuality, which both genders share.

**F. 1– 4 Distribute** handout – Why gender is important (TRB pp. 126-128) Focus on education, employment and sexual activity.

**F. 2 Distribute** handout – Sexual development throughout the life cycle (TRB pp. 129-131)

**F. 2– 1 Divide** participants into two groups to read and discuss the handout for about 20 minutes.

*(Ask them to take note of each phase of development)*

**F. 2– 2 Discuss** with participants, as a unit the handout. **Display** the Flip Chart on Phases of Sexual Development (TRB pp.132)

**F. 3 Review the clarification of the following words/terms:**

- Gender roles
- Gender responsibilities
- Gender stereotypes
- Gender scripts
- Gender equalities
- Gender discrimination

**F. 3- 1 Distribute** handout on Circles of Sexuality (TRB pp. 133-140)

**F. 3- 2 Explain** the meaning of the 4 terms surrounding the circles:

- **Intimacy**
- **Sexual Identity**
- **Sexual health and reproduction**
- **Sexualization**

**F. 3- 3 Explain** that in discussing the circles you will focus on body image of the Jamaican adolescent, intimacy and gender.

**F. 3- 4 Divide** participants in 3 groups to discuss the three areas of focus. (TRB pp. 140-141)

**F. 3- 5 Bring** groups together, discuss and summarize discussion on a Flip Chart.

#### **F. 4 The role of service providers.**

**F. 4- 1 Ask** participants what service providers can do to encourage adolescents to place value on themselves.

*(Include in the responses the following: become economically self-sufficient, regain control of their bodies– make up a list on flip chart)*

- **Medical concerns**
- **Psychosocial concerns**
- **Legal & ethical concerns**

Allow 15 minutes for discussion and 5 minutes for each group to report.

**F. 4- 2** Summarize these discussions and write them on Flip Chart

**F. 5** List some of the aspects of sexuality that have implications for counselling the adolescent. E.g. STIs and HIV/AIDS (TRB pp. 142-146)

**F. 5- 1** Summarize the discussions and write them on a Flip Chart. Use the following format:

<u>Aspects of sexuality</u>	<u>Implications for counselling</u>

*(Ask participants to consider the effects of gender roles and responsibilities, expectation and relationships between both genders, Aspects having to do with favouritisms, scripts, double standards, mixed messages and gender discrimination should be discussed).*

**F. 6 Session Review**

**F. 6- 1** Tell participants that you are about to close this session

**F. 6- 2** Display the Session Objectives and read them

**F. 6- 3** Ask them to fill out the following charts at their convenience

- **Mood & Feeling Chart**
- **Matters Arising Chart.**

## **G. References:**

1. Evans, Hyacinth (November, 1998) **Gender Differences in Participation, Opportunities to Learn and Achievement in Jamaica**, Mona, Jamaica: UWI.
2. National Family Planning Board (1997) **Jamaica: Summary Chartbook of Main Findings of the Reproductive Health Survey**, Kingston, Jamaica: NFPB
3. NFPB. (August, 1998) **Reproductive Health Survey 1997 Jamaica, Draft Final Report**, Kingston, Jamaica: NFPB.
4. Pfannenschmidt, Susan, McKay, Arlene and McNeill, Erin, Family Health International for The Gender Group, Population, Health and Nutrition Centre, USAID (October, 1997) **Through Agenda Lens**, New York: USAID.
5. The Planning Institute of Jamaica, (April, 1998) **Economic and Social Survey, Jamaica, 1997** Kingston, Jamaica.

**END OF SESSION NINE.**

# SESSION Ten

## Counselling Adolescents on Reproductive Health Issues

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### A. Recommended Time: 4 hours

### B. Overview

Our training programme on ASRH consists of 16 sessions. We have completed 9 sessions and are advancing to the tenth session. We hope that the sessions, so far, have made you more aware of the knowledge, skills, values and attitudes required to work successfully with this special group – adolescents. This session will deal with Counselling adolescents on Reproductive Health Issues. It covers definitions of communication, non-verbal communication, barriers to communication and strategies to overcome some of these barriers as far as adolescents' Reproductive Health issues are concern.

### C. Session Objectives

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

- C. 1 Define communication and other words/terms relevant to the session.
- C. 2 Identify examples of non-verbal communication of adolescents on reproductive health issues.
- C. 3 Identify barriers in communicating with adolescents on reproductive health issues.
- C. 4 Develop strategies to overcome barriers to effective communication on reproductive health issues.

## **D. Recommended Materials / Equipment**

Overhead Projector, Transparencies, Assorted Colour Markers, Flip Charts, Masking Tape.

## **E. Advance Preparation** (See relevant **TRBs** under Activities in section F)

**E. 1** Clarification of words/terms

**E. 2** Flip Chart with list of emotions

**E. 3** Collection of letters from “Dear Pastor” (in the Gleaner’s Star) / “Tell Dr. Mary” (on radio).

*{You may write letters of your own or ask a group of adolescents to write letters on reproductive health issues and keep them for this session}.*

**E. 4** Suggested statements for activity in **F.10**

## **F. Activities**

The facilitator will do the following in sequence:

**F. 1** **Distribute** handouts on the Clarification of Words/Terms (**TRB p.147**)

**F. 2** **Point** out the importance of knowing the characteristics of adolescence– **Physically, Emotionally, Educationally and Socially**. These will be useful in communication decisions with the adolescents.

**F. 3** **Read** through the Clarification of Terms and invite participants to give input to elaborate or modify words/terms.

**F. 4** **Ask** participants to identify reproductive health issues of adolescents.

**Summarize** and write them on Flip Chart. For example: Choosing a Family planning method, Abstinence, Multiple sex partners, Myths on sexuality, Sex, and pregnancy, STDs/STIs concerns and Sexual abuse.

**F. 5** **Distribute** handout on the GATHER method (**Session 5: TRB pp. 96-97**). **Discuss** and summarize and Flip Chart.

**F. 6** **Divide** participants into pairs and ask them to list different ways in which people communicate. Possible responses:

- **Touch**
- **Body movements**
- **Voice (tone of voice)**
- **Words/ Codes**
- **Facial expression**
- **Eye contact**
- **Drums/ Abeng**
- **Whistles**

**F. 7** From their list of responses ask them to identify which are verbal and non-verbal ways of communicating.

*(Explain that a person's tone of voice also communicates different emotions; display Flip chart on different emotions – TRB p.148).*

**F. 8** **Distribute** letters collected from “Dear Pastor”, “Tell Dr. Mary” etc., and divide participants to form four (4) groups to identify the issues and how they are communicated, what emotions are evident and why, what are the non-verbal communication messages?

*(Give 10 minutes for discussion, 5 minutes per group to report)*

**F. 9 Summarize** the reports on Flip chart.

**F. 10 Display** the list of Adolescent Reproductive Health Issues in *F.4.*

**Ask** half of the participants to develop a short skit on any two areas for presentation (5 minutes) involving Counselling, verbal/non-verbal communication.

**Ask** the other half to develop non-verbal communication to the following statements by adolescent:

- **Do not keep me waiting another minute**
- **I do not want that family planning method**
- **I am having abdominal pains**
- **I do not understand your instructions**
- **I love it**
- **Let me go, its unsuitable**
- **I am afraid of a vaginal examination**
- **It is comfortable**
- **I am not interested in this health talk**

*(Participants can say whether the expression is from a male/female adolescent).*

**F. 11 Ask** participants to share their presentations in a unit session:

- **Skits**
- **Miming**

*(Let participants identify – positive, negative communication and barriers). Write these up on 3 different Flip Charts. Ask participants to add to the 3 lists, based on experience – TRB p.149).*

**F. 12 Discuss** some barriers to adolescent communication.

**F. 13 Do** a unit brainstorm session on some strategies that can be used to overcome barriers. Summarize and record on Flip Chart.

**F. 14 Display** flip chart on communication- verbal, non-verbal, positive, negative feedback. Discuss and fill-out accordingly. Use the flip chart format for barriers in (TRB p.149), and list the strategies under Health Provider, Message, Channel, Adolescent and Feedback.

### **F. 15 Review Session**

**F. 15- 1 Bring** session to a close by displaying the session objectives, and read them to participants

**F. 15- 2 Remind** participants to fill in the following charts:

- **Mood and Feeling**
- **Matters Arising**

## **G. References**

IPCC Training Manual, Malawi, 1998.

## **H. Additional Resources (TRB p.150-151, Abortion Policy)**

See Youth.now Document entitled “Jamaica Guidelines for Adolescent Reproductive Healthcare Service Delivery” pp. 3-5. Adapted from Guidelines for Adolescent Preventive Services— GAPS— of the American Medical Association (February 2002)

**END OF SESSION TEN.**

# **SESSION** **Eleven**

## **Sexually Transmitted Infections (STIs)**

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**A. Recommended Time:** 3 hours

### **B. Overview**

In this session the topic STIs, traditionally called STDs is covered, over a period of about three hours. It covers the identification of those infections frequently encountered by Jamaican adolescents, the aetiology, signs and symptoms, management and treatment including HIV/AIDS. The psychosocial impact of these infections on the adolescent and his/her family is discussed and ways of reducing the incidence among Jamaican adolescents.

### **C. Session Objectives**

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

- C. 1 Identify the issues that place Jamaican adolescents at risk for STIs/HIV/AIDS.
- C. 2 Discuss strategies to be used to empower Jamaican adolescents to break the cycle of STIs.
- C. 3 Identify the common STIs affecting Jamaican adolescents
- C. 4 Discuss the aetiology, signs, symptoms, management and treatment of STIs commonly affecting Jamaican adolescents.

- C. 5 Discuss methods that can be used by Jamaican adolescents to promote safer sex.
- C. 6 Identify the types of services available to Jamaican adolescents for information and treatment of STIs.
- C. 7 Identify various negotiating skills and methods of community with disabled adolescents on STI issues.
- C. 8 Discuss ways that the disabled adolescents can cope with sexual urges.

#### **D. Recommended Materials /Equipment**

Overhead Projector, Transparencies, Assorted Colour Markers, Flip Charts, Masking Tape, Video On STDs/STIs.

#### **E. Advance Preparation (See relevant TRBs under Activities in section F)**

- E. 1 Charts, Handouts, Invitations, Pens for each participant, Chart with Session Objectives

##### **Flip Chart Headings:**

Self- Esteem, Power and Gender

List of STDs/STIs: Issues and Strategies

##### **Video:**

Secure video on STDs/STIs and relevant equipment. Preview the video and prepare discussion questions.

Outline on aetiology, signs, symptoms, treatment and management of STDs/STIs

Invitation letter to at least one person living with HIV/AIDS or contact an investigator for STI/HIV/AIDS; and or a health provider from an STI clinic to visit and share experiences on STI/HIV/AIDS occurrences (data, treatment, management etc.)

## F. Activities

The facilitator will do the following in sequence:

- F. 1 **Ask** participants to suggest some of the issues that place adolescents at risk for STIs. Summarize the responses or flip charts under three broad headings (**TR B p.152**):
- F. 2 **Ask** participants to suggest some of the strategies that could be used to empower adolescents to break the cycle of STIs. Summarize responses on a Flip Chart under the headings (**TR B p.153**):

Issues	Strategies
e.g. Self-esteem	
Lack of a job	Learn a skill in the short-term e.g. data entry
Multiple sex partners	Limit to one/fidelity/abstinence/condom use.

*(Point out that some of the issues may overlap as well as some of the strategies).*

- F. 3 **Display** the list of STIs (**TRB p.154**). Ask participants to identify the ones commonly found in Jamaican adolescents (*tick these on the list*).
- F. 4 **Ask** the participants watch to the video on STIs (*prepare them based on your preview of the video and allow them to watch it undisturbed.*)

**F. 5 Distribute** the outline (TRB p.154) on the aetiology (origin), signs, symptoms, treatment and management. **Distribute** also the handout on STIs (TRB pp.155-162). **Ask** participants to divide into three groups and have group one working through the outline on the first three, group two on the next three and so on. (*Allow fifteen minutes for this exercise and five minutes for the groups to report. At the end of the exercise all infectious diseases should be covered*).

**F. 6 Invite** the health service providers or clients to share their experiences on the occurrence (percentage), care and management of persons with STIs/HIV/AIDS. After the presentation, have participants ask questions. (Be sure to ask questions relevant to strategies and tips for counselling, heterosexual/ abused/ homosexual/prostitutes/mentally and physically challenged adolescents, Male/female and their families).

**F. 7 Form** a panel from the guests and participants. Place strips of paper with questions in a container on the following issues, and ask participants to choose one, attempt an answer, and redirect to relevant members of the panel for additional information/ clarification:

- What are some of the methods that can be used to promote safer sex practices among Jamaican adolescents?
- What are the services available to adolescents for information and treatment of STIs/HIV/AIDS, especially for adolescents in the vulnerable groups such as those with disabilities; such as, the deaf, dumb, blind and minors?

**F. 8 Divide** participants into two (2) groups after the panelists are dismissed. Ask participants to role-play one negotiating skill and methods of communicating with a disabled adolescent. (*After this role play, ask other participants to suggest other*

*negotiating and communication skills, summarize and write them on a flip chart).*

- F. 9** Ask participants to share their ideas on how disabled adolescents can cope with their sexual urges. Are there ways peculiar to this group, depending on the type of disability?
- F. 10 Distribute STDs-Quiz (TRB p.163-164).** Ask participants to respond to the items. After they are finished, distribute the Answer Key (TRB p.164-165) and ask them to make their corrections (*Discuss areas of concern to participants*)
- F. 11 Distribute** handout on myths and facts about HIV (TRB p.166). Discuss them.

**F. 12 Session Review**

- F. 12- 1** Bring session to a close by displaying the session objectives, and read them to participants
- F. 12- 2** Remind participants to fill in the following charts:

- **Mood and Feeling**
- **Matters Arising**

**G. References : (see TRB pp.151)**

**END OF SESSION ELEVEN.**

# **SESSION** **Twelve**

## **Substance Abuse Among Adolescents**

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**A. Recommended Time:** 3 hours

### **B. Overview**

This session is about substance abuse among adolescents. It introduces health care providers to a serious health issue among adolescents that is all too often little understood: their use of psychoactive substances. The different types of substances, the contributing factors and consequences of their use, how to prevent substance abuse among adolescents and the reason for adolescents' use of drugs are all explored in this session.

### **C. Session Objectives**

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

- C. 1** Identify the most common psychoactive substances used by adolescents.
- C. 2** Identify risk and protective factors for adolescents' substance abuse.
- C. 3** Describe the most common problems associated with substance abuse by adolescents.
- C. 4** Discuss reasons for adolescents' use of drugs.
- C. 5** Describe the ways in which adolescents can be assessed about their levels of substance abuse during routine visits to health services.

## **D. Recommended Materials /Equipment**

Overhead Projector, Transparencies, Assorted Colour Markers, Flip Charts, Masking Tape, Video On Drugs/Substance Abuse.

## **E. Advance Preparation**

- E. 1** Charts, Handouts, Invitations, Cards and pens for each participant, Chart with Session Objectives

**Flip Chart (s) headings:**

Psychoactive Substances - Jamaica

**Handouts on:** Clarification of words/ terms on substance abuse  
Power and Control Wheel  
Sample Assessment Questions

**Video:**

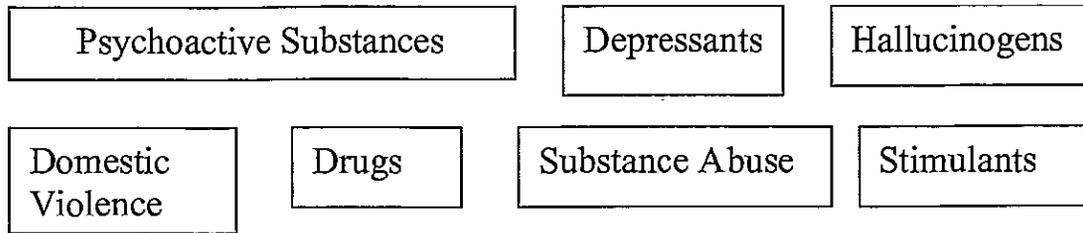
Secure video on Drugs/Substance Abuse and relevant equipment. Preview the video and prepare discussion questions.

Invitation letter to self-confessed drug abusers who have been rehabilitated to share experiences (invitees with different substance abuses).

## **F. Activities**

The facilitator will do the following in sequence:

- F. 1** Distribute handouts on the clarification of words/terms on Substance Abuse (**TRB p. 167-172 Myths/ Facts on Domestic Violence**).



- F. 2** Read the definitions and discuss with participants.  
*(You may modify the definitions based on your discussion).*
- F. 3** Discuss with participants the psychoactive substances commonly used by adolescents.  
*(Use a flip chart to record both their names and examples, TRB p.172)*
- F. 4 Explore the risks and protective factors:**
- F. 4- 1** **Divide** participants into groups to discuss the effects of alcohol and substance abuse on:
- Family
  - Work
  - School
  - Community
  - Finances
  - Personal Interaction
  - Goals/Dreams
- (see also TRB p.173-176)*
- F. 4- 2** **Ask** participants to report after fifteen minutes of discussion. Give five minutes for each report. Ask participants to share some protective factors in each area.
- F. 5** **Display** prepared charts on the following and discuss them with participants:
- Why do adolescents use substances? **(TRB- OHT SU3, p.177-183)**

- Factors influencing adolescents' use of substances (protective and risk) (TRB- OHT SU4, p.184)
- Types of substances used by adolescents (TRB- OHT SU6, p.184)
- Motivation for use (TRB- OHT SU7, p.184)
- Consequences of use – general (TRB- OHT SU8, p.184)
- Consequences of use – interpersonal and social problems, mental health problems. (TRB- OHT SU9, p.185, *see Power and Control Wheel* [TRB p.186])
- Controlling Behaviour (TRB pp.187, Behaviour Checklist)

**F. 6 Prepare** participants to view video. Invite self-confessed substance abusers who have been rehabilitated to watch the video with participants. Ask them to share their experiences similar/different to video. Prepare participants to ask questions relevant to abusers screening, experiences and ultimate recovery.

*(Remember to have a participant extend a vote of thanks. Provide light refreshments).*

**F. 7 Distribute** handout on Sample Assessment Questions. Discuss the handout with participants (TRB p.188-190).

*(Summarize and write them on flip chart).*

**F. 8 Summarize** discussions on the topic by using OHT. (TRB p.188)

**F. 9 Introduce** participants to Drug Card. (TRB p. 188)

**F. 10 Session Review**

**F. 10- 1** Bring session to a close by displaying the session objectives, and read them to participants

**F. 10- 2** Remind participants to fill in the following charts:

- **Mood and Feeling**
- **Matters Arising**

**G. References:**

WHO/CMA/UNICEF Field Test 1999

Module: Substance use among adolescents: Facilitators' Notes

Patterns of Substance Abuse Among Jamaican Adolescents in 1997-1998 (**TRB pp. 177-182**)

**H. Additional Resources**

See Youth.now Document entitled "Jamaica Guidelines for Adolescent Reproductive Healthcare Service Delivery" pp. 28-29. Adapted from Guidelines for Adolescent Preventive Services—GAPS— of the American Medical Association (February 2002)

**END OF SESSION TWELVE.**

# **SESSION** **Thirteen**

## **Crisis Situation: Rape and Sexual Abuse, Incest, Domestic Violence, Adolescent Pregnancy**

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**A. Recommended Time:** 4 hours

### **B. Overview**

The title of this session is Crisis Issues: Rape, Sexual Abuse, Incest, Domestic Violence, and Adolescent Pregnancy. The duration is about four (4) hours. It comes immediately after the session on Substance Abuse, which can be considered as one of the contributing factors to the crisis issues in the life of an adolescent. It covers discussion of these issues as crisis issues, the identification of factors in society, which contribute to the existence of the issues, highlights myths about the issues, the consequences and the strategies to avoid compromising situations. The participants are supported in their discussions by appropriate handouts and scenarios; the facilitators will engage the participants in summarizing their discussion for future reference.

### **C. Session Objectives**

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

- C. 1 Identify the various crisis issues.
- C. 2 Identify factors in society, which contribute to the existence of these issues.
- C. 3 Discuss myths about rape and the other crisis issues.

- C. 4 Identify the consequences/effects of crisis issues on the adolescent, their family members and the wider society
- C. 5 Demonstrate skills to respond to these and similar crisis issues.

## **D. Recommended Materials /Equipment**

Flip Chart, Assorted Fine Point And Felt-Tip Markers, Plain Paper, Pens, Video On Human Sexuality, Highlighting “Touches, VCR and Monitor

## **E. Advance Preparation (See relevant TRBs under activities in Section F)**

### **E. 1 Handouts:**

- Clarification of words/terms
- Quiz on Facts about rape
- Scenarios on rape
- Touch Continuum
- Ori & Kori: Help adults and children
- Highlights on an education programme

### **E. 2 Flip charts:**

- Crisis Issues Facing Adolescents
- Consequences of Crisis Issues
- Solutions: Prevention of Sexual abuse.

### **E. 3 Preview Video and prepare questions.**

## **F. Activities**

The facilitator will do the following in sequence:

**F. 1** Ask participants to name some of the crisis issues affecting adolescents. List them on Flip chart:

- **Sexual abuse**
- **Physical/Emotional/Economic Abuses (see TRB p.194)**
- **Rape (see TRB p.193-195)**
- **Domestic violence (see TRB p.191-192, Domestic Violence Myth/ Fact Sheet)**
- **Alcohol and drug abuse**
- **Commercial sex**
- **Child maintenance**
- **Adolescent pregnancy**
- **Incest**
- **Child abuse (see TRB p.195)**

**F. 2** Distribute handout on clarification of words/terms. (TRB p.191-192). Discuss these with participants and modify if necessary.

*(Explain to participants that it is important to bear this information in mind as the session progresses).*

**F. 3** Display the list of crisis issues again. Read them through, state that they are all important issues, however for this session focus will be on:

- **Rape and Sexual abuse**
- **Adolescent pregnancy**
- **Incest**
- **Domestic violence**

**F. 4** Divide participants into 4 groups to identify the following in regard to the 4 issues above:

- **Factors in society which contribute to each**
- **Myths**

- Consequences/Effects

*(See TRB p.196, for outline for making summary)*

**F. 5 Distribute** handout on Facts About Rape (**TRB p.197**). Allow participants about 15 minutes to complete quiz. Discuss quiz. Give correct answers. Have participants cross out the words “quiz on” and leave just “Facts about rape.”, because all the statements on the sheet are true. Ask participants the following questions:

- Are you surprised by some of the facts?
- How prevalent are these myths about rape?
- Do you consider rape to be a problem in your community?
- Are these facts true for the other three (3) areas you have identified?
- Discuss any myths/facts peculiar to the area discussed in your group.

**F. 5- 1** Discuss these facts relevant to the other crisis issues, such as incest.

**F. 6 Distribute** scenario on rape (**TRB p.198**). Ask participants to read them and decide if each situation is a rape or not. Ask them to give reaction to the following:

- How does each situation differ?
- Are women enticing naturally?
- Are men entitled to sex?
- Is rape natural?
- Are men biologically aggressors?
- Do men have a role to play in rape? (Positive/negative roles)? Explain.

Can you think of one scenario (true to life/made up to depict the other areas discussed, such as incest, domestic violence and adolescent pregnancy)?

**F. 7** Discuss some situations that can lead to these crisis issues and some strategies to prevent them. Summarize the discussion as follows:

<b>Crisis Issues</b>	<b>Situations</b>	<b>Prevention strategies</b>
Rape		

**F. 8** Ask participants to share their understanding on: “Be careful of strangers!”

**F. 9** Ask participants to react to the following questions:

- Are all perpetrators strangers?
- Is sexual abuse clear to young people?
- Are parents specific in their explanations?
- If much sexual abuse includes coercion or threat, how can children speak up if they are being abused?

**F. 9- 1** Distribute handout on Touch Continuum (TRB p.199)

Discuss the following:

- What is the touch continuum ?
- What is lack of touch?

- What is Nurturing Touch?
- What is Confusing Touch?
- What is Exploitative Touch?

**F. 9- 2 Show** excerpt from Video on Human Sexuality, on Good and Bad Touches. (*Discuss after viewing*).

**F. 9- 3 Distribute** handout on Ori and Kori: Help Adults and Children Learn (**TRB p.200**). Ask participants to read and share reactions.

*(Explain that touching can be a gray and confusing area for adults. When we were children no one told us about different types of touches.)*

**F. 9- 4 Discuss** handout on Highlights of an Education Programme to Prevent Sexual Abuse (**TRB pp.201-203**). Ask participants to list the key elements for each crisis issue on plain paper (**TRB p.204-205, Crises Issues: Key Elements for Education Programme**).

*(You may use TRB p.188 OHT, to summarize participants' discussion)*

## **F. 10 Session Review**

**F. 10- 1 Explain** to participants that you are about to close the session

**F. 10- 2 Display** the Session Objectives, and read them

**F. 10- 3 Ask** the participants to fill out the following charts in their own time:

- Mood & Feeling Chart

- Matters Arising Chart

## **G. References:**

**Touch Continuum (TRB p.199)**

Highlights of and Educational Programme to Prevent Sexual Abuse,  
**(TRB pp. 189-191)**

Rape and Child Abuse In Jamaica, **(TRB p.195)**

## **H. Additional Resources (TRB p. 206)**

See Youth.now Document entitled “Jamaica Guidelines for Adolescent Reproductive Healthcare Service Delivery” p.30. Adapted from Guidelines for Adolescent Preventive Services— GAPS— of the American Medical Association (February 2002)

**END OF SESSION THIRTEEN.**

# **SESSION** **Fourteen**

## Care of Adolescent Pregnancy and Childbirth

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**A. Recommended Time:** 4 hours

### **B. Overview**

This is the fourteenth session in the training programme on ASRH. It covers the impact of pregnancy on the adolescent, factors that influence care, the risk factors, how to care, the impact of the birth of a mentally/physically challenged child on the adolescent-mother/adolescent-father and available resources and the application of some adolescent issues to pregnancy and care.

### **C. Session Objectives**

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

- C. 1** Discuss the psychosocial and economic impact of adolescent pregnancy on the adolescent-mother, family members and the wider society.
- C. 2.** Identify the risks associated with adolescent pregnancy and childbirth.
- C. 3.** Discuss issues relating to care of the adolescent during pregnancy, delivery and post partum.
- C. 4.** Identify ways to apply some issues of adolescent pregnancy care.

## **D. Recommended Materials/Equipment:**

Flip Chart, Assorted Colour Markers, Overhead Projector And  
Transparencies

## **E. Advance Preparation (See relevant TRBs under Activities in section F)**

### **E. 1 Handouts:**

- The case of Janet
- Factors that influence adolescent pregnancy and childbirth.
- Population and development in the Caribbean
- Transparency notes
- Care of the adolescents: Some important factors
- Data on how common adolescent pregnancy and childbirth are in Jamaica (latest figures)
- Some global figures on adolescent pregnancy and childbirth.

### **E. 2 Flip Charts**

- Risk factors
- Summary

## F. Activities

**F. 1** Distribute the handout: Case of Janet, an adolescent-m other of a child with multiple disabilities: (TR B pp.207-208)

**F. 1- 1** Ask participants to read the story individually

**F. 1- 2** Ask for individual reactions relevant to the adolescent-mother/ adolescent-father, grandm other and the wider society.

*(Point out that both adolescent-m other, and grandmother had their hopes dashed. Point out also, that few adolescents ever imagine that they might give birth to a disabled child, hence, they are ill-prepared to cope with the demands of the child).*

**F. 1- 3** Ask participants, what compounded the problems?

- The grandmother being trapped
- The flight of the boyfriend

**F. 1- 4** Ask participants to think of the story with the birth of a normal child. How would the situation pertaining to the adolescent, grandmother and the wider society differ? Summarize and write on a Flip Chart.

*(You may want to use the following outline form at:)*

Types of Birth	Adolescent	Grandmother	Wider Society
Normal Child			
Disabled Child			

## F. 2 Factors that influence adolescent pregnancy and childbirth

**F. 2- 1** Distribute handout on factors (TR B p.209-211), also Population and Developments in the Caribbean (TR B p.211)

**F. 2- 2 Identify** the following types of factors:

- Biological
- Sociological
- Changing circumstances of young people
- Vulnerability of young people
- Service related factors

**F. 2- 3 Divide** participants into 5 groups to discuss each Factor identified. Ask each group to produce a Flip Chart presentation.

*(Tell them that they can use handouts as a guide)*

**F. 2- 4 Give** each group 20 minutes for discussion and 5 minutes to report.

### **F. 3 Risk Factors**

*(You may want to make the point that it is accepted as a fact – that adolescent pregnancy is risky or problematic).*

**F. 3- 1 Ask** participants why this is so? List their suggestions.

**F. 3- 2 Distribute** handout on: Why complications are worse in adolescents (**TRB pp.212-213**). Discuss the handout and summarize on Flip Chart

**F. 3- 3 Display** Flip Chart on Risk factors (**TR B p.218**)

*(Point out also the social cost of risk factors):*

- More future births
- Poverty (cycle of poverty)
- Lower levels of education

#### **F. 4 Care For Adolescent Pregnancy and Childbirth: Some Important Factors**

**F. 4- 1** Ask participants to list the important factors. Four (4) important factors are identified:

- Early diagnosis of pregnancy
- Quality antenatal care
- Management of labour and delivery
- Postpartum care

*(Display these on Flip Chart)*

**F. 4- 2** Distribute the seven (7) scenarios (TRB p.213-217)

**F. 4- 3** Ask participants to choose one of the scenarios and prepare a short skit as a group.

*(Tell participants to think of the aspects of care by the service provider, please take note that each group has a different scenario).*

**F. 4 –4** Ask all groups to perform their skits and use the rest of the participants who are not performing to evaluate for clarity, message and effectiveness.

*(You may want to ask them to rate each area out of a total of 10 marks).*

#### **F. 5 Application of issues to adolescent pregnancy care.**

**F. 5- 1** Ask participants to suggest some of the issues relating to care.

**F. 5- 2** Display chart on Important Factors In Adolescent Pregnancy (TRB p.218)

**F. 5- 3** Discuss in particular the message to:

- Providers
- Over-all – typical care

*(You may ask participants to share particular experiences relating to the issues of care).*

**F. 6 Ask participants to give views on how common are adolescents pregnancy and childbirth in their communities.**

- F. 6- 1** Distribute: How Common Is Adolescent Pregnancy and Childbirth- Some Global Data handout (**TRB p.219**).  
Discuss the data and compare accordingly.

*(Be sure to have the most up-to-date data on the Jamaica)*

- F. 6- 2** Display Summary on Flip Chart (**TRB p.220, Summary Notes**)

**F. 7 Session Review**

- F. 7- 1** Tell participants that you are about to close this session
- F. 7- 2** Display the Session Objectives and read them
- F. 7- 3** Ask them to fill out the following charts at their convenience

- **Mood & Feeling Chart**
- **Matters Arising Chart**

**G. References:**

Population and Development in the Caribbean- A Demographic Survey  
by Jean-Pierre Guengant, 1985, p.9 (**TRB p.211**)

How Common is Adolescent Child Pregnancy and Childbirth (TRB  
pp.218-219)

**END OF SESSION FOURTEEN.**

# **SESSION** **Fifteen**

## **Abortion**

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### **A. Recommended Time: 2 hours**

### **B. Overview**

This is the fifteenth session in the training programme on ASRH. It covers contributing factors to abortions in Jamaica, the consequences of unsafe abortions, the psychological and physical impact of abortion, induced abortions, examination of the process, medical techniques, complications, treatment and management of abortions. The session ends with the identification of ways to reduce the incident of abortions in Jamaica, among adolescents, in particular.

### **C. Session Objectives**

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

- C. 1** List the factors that contribute to abortions in Jamaica.
- C. 2.** Discuss the consequences of unsafe abortions in Jamaica.
- C. 3.** Evaluate the psychological and physical impacts of abortion on the couple, the Family in general, and the adolescent in particular.
- C. 4.** Discuss the medical, legal, ethical and social considerations with regard to induced abortions.

- C. 5 Examine the process of abortion and the medical techniques of conducting abortions.
- C. 6 Examine the complications, treatment and management of abortions.
- C. 7 Identify ways of reducing the incidence of abortion in Jamaica.

#### **D. Recommended Materials/Equipment:**

Flip Chart, Assorted Colour Markers, Overhead Projector and Transparencies

#### **E. Advance Preparation (See relevant TRBs under Activities in section F)**

##### **E. 1 Flip Charts Headings**

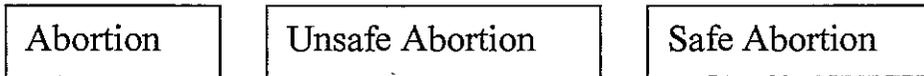
- Safe and unsafe abortion factors: The Jamaican experience (see F. 2 below)
- Consequences of abortions in Jamaica

##### **E. 2 Invitation letters**

- A letter to a doctor to speak on the medical process, techniques, complications and management of abortions in adolescent situations.
- A letter to a lawyer to speak on the legal, social and ethical issues of abortions in Jamaica.
- (Ask the guests to take relevant handouts and references)

#### **F. Activities**

- F. 1 Clarification of words/ terms. Write up the following words/terms on Flip Chart. Discuss and summarize:



**F. 2** Conduct a brainstorming session on the factors that contribute to safe and unsafe abortions in Jamaica. List summary on Flip Chart:

**SAFE & UNSAFE ABORTIONS/ FACTORS: The Jamaican Experience**

Safe	Unsafe
------	--------

**F. 3** Divide participants into small groups to identify the:

- Medical consequences of unsafe abortions
- Psychological and Physical consequences of unsafe abortions
- Economic consequences of unsafe abortions

*(Ask participants to relate their discussions to the couple, Service providers and the wider society. You may want to use the format outline below)*

Consequences	The Couple	Service Provider	Wider society

**F. 4** Invite a medical doctor to give a presentation on the following aspects of abortion in Jamaica:

- **The process**
- **Complications**
- **Treatment**
- **Management**

*(Remember to do some research and obtain the data relevant to Jamaica. Also get the most up-to-date figures).*

**F. 5** Summarize and fill out the outline in F. 3.

*(Remember to prepare this outline in Advance Preparation)*

**F. 6** Invite a lawyer to speak on the legal, ethical and social considerations of abortions in Jamaica, especially as they relate to adolescents.

*(If possible, form a panel/forum with the doctor, lawyer, a nurse and a social worker to answer questions after the two presentations. You may want to ask participants to ask questions from an adolescent perspective.)*

**F. 7** Ask participants to share some of the things they learnt in the sessions with the medical doctor and the lawyer in an open discussion forum.

**F. 8** Ask participants to carry out research on the following topics in preparation for Session 16:

- Lesbianism
- Homosexuality
- Bisexuality
- Heterosexuality

**F. 9 Session Review**

**F. 9- 1** Tell participants that you are about to close this session.

**F. 9- 2** Display the Session Objectives and read them.

**F. 9- 3** Ask them to fill out the following charts at their convenience.

- **Mood & Feeling Chart**
- **Matters Arising Chart**

## **G. References:**

1. Please see TRB Session 15 for an extract from the “Population Policy Data Bank” maintained by the Population Division of the Department for Economic and Social Affairs of the United Nations Secretariat: **Background to the Abortion Policy in Jamaica** (refer: [www.un.org/esa/population/publications/abortion/doc/djibou1.doc](http://www.un.org/esa/population/publications/abortion/doc/djibou1.doc))
2. Offences Against the Persons Act- Jamaica
4. Additional References may be provided by the guest presenters.
5. Abortion and Pre-natal Care (**TRB p.221**)

**END OF SESSION FIFTEEN.**

# **SESSION** **Sixteen**

## **Homosexuality, Lesbianism, Bisexuality and Heterosexuality**

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**A. Recommended Time:** 4 hours

### **B. Overview**

This is the sixteenth session in the training program me on ASRH. It covers four (4) areas, namely: homosexuality, lesbianism, bisexuality and heterosexuality. Participants are encouraged to carry out research on each area to define specific words and terms, and share knowledge in group sessions. Specifically, participants will describe the impact in each area on the Jamaican adolescent. Mention will also be made of sexual dysfunction, which should not be confused with the areas in the topic under study- homosexuality, bisexuality, lesbianism and heterosexuality.

### **C. Session Objectives:**

- C. 1** To identify factors that contribute to homosexuality, lesbianism, bisexuality and heterosexuality.
- C. 2.** To discuss the impact of homosexuality, lesbianism, bisexuality and heterosexuality on the adolescent, service providers and the wider society.
- C. 3** To discuss the reproductive health challenges presented by homosexuality, lesbianism, bisexuality and heterosexuality and their implication for the adolescent and service providers.
- C. 4** To define sexual dysfunctions.

- C. 5 To identify the biological, physiological/social factors and interpersonal factors of sexual dysfunctions.

## **D. Recommended Materials/Equipment**

Flip Chart, Assorted Colour Markers, Overhead Projector and Transparencies.

## **E. Advance Preparation (See relevant TRBs under Activities in section F)**

### **E. 1 Handouts:**

- Definition of words/terms.

### **E. 2 Four Flip Charts Headings with the captions:- *Consequences of:***

- Homosexuality
- Lesbianism
- Bisexuality
- Heterosexuality

**E. 3** Invitation letters to a medical doctor and a lawyer to share their experience and expertise on homosexuality, lesbianism, bisexuality and heterosexuality. Ask the medical doctor to speak on the medical and the psychosocial aspect, and the lawyer on the legal and ethical aspects. Ask them also to answer questions from participants. Ask the medical doctor, in particular, to speak also on sexual dysfunctions.

## F. Activities

- F. 1** Distribute sheets with the definition of words/terms. (TRB pp. 222-224)
- F. 2** Discuss each definition and modify if necessary.
- F. 3** Display prepared flip charts and ask participant to list factors (from their research) that contribute these activities in Jamaica.
- F. 4** Ask participants to divide into four groups to discuss the consequences of homosexuality, lesbianism, bisexuality and heterosexuality in Jamaica using the following table. Develop a table for each area— this activity should take about 10 minutes.

**Area: e.g. Homosexuality**

<b>Consequences</b>	<b>Adolescents</b>	<b>Service Provider</b>	<b>Wider Society</b>
Medical			
Psychosocial			
Ethical			
Legal			

- F. 5** Ask participants to prepare a flip chart for a reporting session.
- F. 6** Ask participants to come together as a unit to present reports. Give about five (5) minutes for each report.

**F. 7** Tell participants that they will have two guests— a medical doctor and lawyer to share their experience and expertise on homosexuality, lesbianism, bisexuality and heterosexuality. The medical doctor will address the area of sexual dysfunctions (**TRB pp.225**) –for causes of sexual dysfunctions: Biological factors, Psychological/Social factors, Interpersonal factors.

**F. 8** Invite the guest to make a short presentation of 10 to 15 minutes and then invite participants to ask questions.

### **F. 9 Session Review**

**F. 9- 1** Tell participants that you are about to close this session

**F. 9- 2** Display the Session Objectives and read them

**F. 9- 3** Ask them to fill out the following charts at their convenience

- **Mood & Feeling Chart**
- **Matters Arising Chart**

## **G. References**

1. Sexual Behaviours (**TRB p.222-224**)
2. A Message To ... Adolescent Girls And Women (**TRB p.226-227**)

**END OF SESSION SIXTEEN**

# **SESSION** **Seventeen**

## Evaluation of Training Programme, Trainer Manual and Trainer Resource Book

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**A. Recommended Time:** 3 hours

**B. Overview**

This is the final session in the training programme on ASRH. The programme covered sixteen sessions on very important areas of Adolescent Sexual and Reproductive Health, listed as follows, (place on transparency):

1. **Introduction to Adolescent Sexual and Reproductive Health**
2. **'Youth-Friendly' Health Services**
3. **Introduction to Adolescence**
4. **Reproductive Anatomy & Physiology**
5. **Contraceptive Technology During Adolescence**
6. **Promoting Healthy Lifestyles During Adolescence**
7. **Nutrition, Eating Disorders and Personal Health Care**
8. **Introduction to Sexuality**
9. **Sexuality and Gender Issues**
10. **Counselling Adolescents**
11. **Sexually Transmitted Infections**

**12. Substance Abuse**

**13. Crisis Issues**

**14. Care of Adolescent Pregnancy and Childbirth**

**15. Abortions**

**16. Homosexuality, Bisexuality, Lesbianism and  
Heterosexuality**

**17. Evaluation of the Training Programme, Trainer Manual  
and Trainer Resource Book**

In this session you will be required to evaluate the training programme, and make recommendations for improvement. You will also be required to submit your personal diaries and plans for training others.

### **C. Session Objectives:**

- C. 1 Evaluate the sixteen (16) sessions on A SRH by using the PLUS (+) DELTA (-) informal method.
- C. 2. Recommend in writing, ways in which the sessions could be improved.
- C. 3 Submit a written diary and work plan for training others.

### **D. Recommended Materials**

PLUS (+) DELTA (-) Charts, Pens, Diaries

## **E. Advance Preparation**

- E. 1** Preparation of PLUS (+) DELTA Charts
- E. 2** Tips for developing work plan and writing up diary.
- E. 3** Arrangements for prize cake to be delivered as planned earlier during debating competition.

## **F. Activities**

- F. 1** **Display** the PLUS (+) DELTA (-) Charts. PLUS (+) will record things that participants liked most about the training programme, and DELTA (-) will record things that participants liked least... see example below and (TRB pp.228-229).

<b>PLUS (+) : THINGS PARTICIPANTS LIKED MOST</b>
1. 2. etc.

<b>DELTA (-): THINGS PARTICIPANTS LIKED LEAST</b>
1.... 2..... etc

**F. 2 Distribute** diaries (plain) and ask participants to develop their work plan and diary.

**F. 3 Request** participants to hand in the completed Evaluation Questionnaire, but to keep their diaries.

**F. 4 Session Review/ Close of Training Programme**

**F. 4- 1 Tell** participants that you are about to close training programme

**F. 4- 2 Display** the Session Objectives and read them

**F. 4- 3 Make** final announcements and distribute certificates.

*NB.* The facilitators are required to fill out the questionnaire to evaluate the Trainer Manual and Trainer Resource Book. These questionnaires are in Appendices (i - ii) (**TRB pp.230-235**) at the back of the Trainer Resource Book.





# SESSION **One**

## Introductory Session

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### **Introductory Activities: Suggested Ice Breakers**

#### **A. Ready Body Drawing**

**Specific Objective:** To have each participant focus on and present one part of their body

**Time:** 10 to 15 minutes

**Materials:** Paper and pens or pencils, tape for mounting drawings

**Process:**

1. Tell each participant draw one part of their body that is ready. To those who protest that they “can’t draw,” tell them that any three-year-old can draw.
2. Have them mount the drawings on the wall.
3. View the Ready Body gallery together asking each “artist” to identify his or her work, the “body part” depicted, and say what makes that part “ready”, and “ready” for what.
4. Have the group pay attention to how the space on the sheet of paper was used. Was the drawing expansive...taking over the whole sheet? Was it tiny, tucked away in a corner? Or centred in the space? What parts predominate? Were there more outer than inner parts? What can we learn about individuals and the group from what they drew, where they placed it? What can we learn from what participants said when talking about their drawings?

## **References:**

### **SEXUAL AND REPRODUCTIVE HEALTH ISSUES OF ADOLESCENTS WITH HEARING**

**Impairment And Mental Retardation**  
Avril Daley, 1999

#### **SOCIETY'S VIEW ON DISABILITY**

Disability deviates from the norm. Disability is seen as a "deviance."

Society tends to value persons based on wholeness. This is, society is prejudiced against anything that is not typical.

A person is judged on:

- body type
- personality
- age
- gender
- race/nationality
- attributes

SOCIETY MORE THAN THE DISABILITY/CONDITION,  
DETERMINED WHAT A PERSON WILL BE PERMITTED TO DO OR  
HOW HE/SHE WILL BEHAVE.

The individual may be devalued because of the lack of particular skills,  
sense or body part.

Children with disability, as a group usually has more psychological  
problems adjusting to his/her environment. This is due more to the society's  
response to the child rather than the disability itself.

The child may accept the devaluation of society and perceive him/herself as  
less worthy and engage in self-devaluation.

However, each disabled individual formulates his own responses to his  
disability in accordance with his lifestyle.

The greater the restriction on the child's ability to assimilate and  
accommodate the environment, as well as limitation in cognitive growth, the  
greater the strain on the child's resources for successful adaptation.

## **SEXUALITY AND DISABILITY**

Common beliefs about sexuality and person with disability:

- Deny that the person has any interest in sexual relations.

5. Tell them that the drawing skill is not the important issue at hand but what they expressed- during the drawing and during the taking of the drawing.
6. Return to the group circle after the view and commentary.
7. Introduce your session.

### *Note to Trainer*

- This exercise is very useful for handling late coming because participants can start working on their drawings as soon as they arrive.
- Drawing is a leveling exercise. Except for the one or two gifted members of the group (this also makes it an opportunity for talent-spotting) most participants will have disabilities in the form of this expression.

## **B. "If I were not a human being"**

Specific Objective: To have each participant learn and share something new about the self.

Time: 10 minutes

Process:

1. Ask participant to imagine that they were created something other than a human being...something from the natural environment. How do they see themselves, and why? Tell them to see themselves as something specific. For example, if they see themselves as a bird or flower, it should be a particular bird. If, a flower, they should share the name and the color as well. After all, a white hibiscus is not the same as the red one!
2. Ask persons to stand when they have made their decisions.
3. When the whole group is standing, have each person share (a) how she/ he sees her in another form; and (b) Why.

4. Ask persons who come up with similar thing to move next to each other so, for example, all the birds will be in a flock, with the kisskadees forming a pair or small group.
5. Point out the exercise as intended to help persons discover something new about themselves and others in the group. They can also learn how they differ and what they have in common with others. Encourage them to try it out with pairs, friends and family members.
6. Close by telling the group that this exercise can serve to remind us that we are fortunate to have been created human, with all the powers human beings have been given. Like nothing else on the earth, we can consciously shape and reshape our lives and our environment- for our personal good and the good of all.

*Note to Trainer*

After you have used this exercise with a group it may be varied with the same group by having them choose from one "nature family," for example, "if you were a bird what do you see yourself being?" (And so on, for tree, plant, fish, animal, insect, colors, things in the sky, and things underneath the earth. You can also experiment with manufactured environment: furniture, thing made of plastic, paper, steel, agricultural implements, kitchen utensils, musical instruments, and construction tools.)

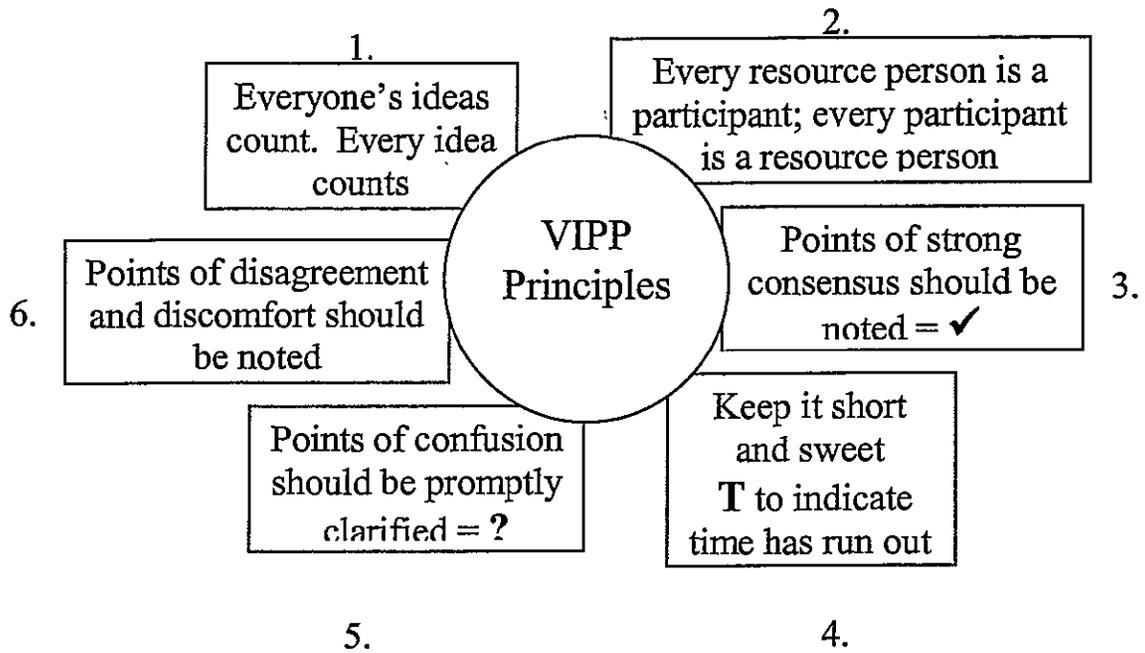
"It is a great event to be born a human being!" [the Dhammapada, Buddhist scripture] Are you living your life as though you are aware of this?

## Definitions of Words, Terms, Abbreviations:

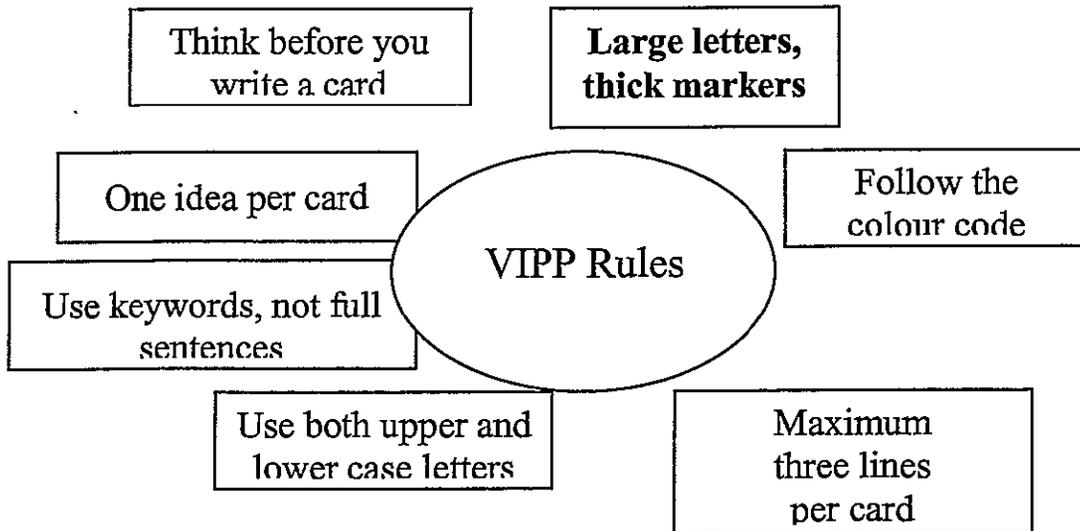
<b>Adolescent</b>	Covers young persons ages 10 to 19.
<b>ASRH</b>	Adolescent Sexual and Reproductive Health
<b>Gender</b>	The culturally defined aspects of being male or female
<b>Health</b>	State of wellness of the entire human body or in reference to a part of the human body.
<b>ICPD</b>	International Conference on Population Development
<b>Reproductive Health</b>	Those aspects of sexual health, which pertain to the male and female opportunity to conceive children.
<b>Responsibilities</b>	A duty that a person has to perform for his or her own benefit and/or the benefit of others.
<b>Rights</b>	The benefit that a person is entitled to either because the law states this or it is the just thing to do based on accepted ideas of right and wrong.

<b>Service Provider</b>	Anyone in the field of health, education, social services, or community development who provides services to adolescents
<b>Sexual Health</b>	The integration of the physical, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.
<b>VIPP</b>	Visualization In Participatory Planning
<b>Youth</b>	Covers young persons ages 15 to 24.

## VIPP Principles Chart



## VIPP Rules Chart



## **Declaration On Adolescent Sexual And Reproductive Health & Rights**

### **What is a right?**

“A right is a benefit that a person is entitled to because the law states this or because it is the just thing to do based on accepted ideas of right and wrong.”

We therefore, in the presence of and with the support of representatives from our **national governments and the NGO community participating in this UNFPA sponsored Caribbean Youth Summit on Adolescent Reproductive Health and Rights** commit ourselves, affirm and declare as follows:

1. That all adolescents and young persons are entitled to the right to life, integrity of person and protection from arbitrary deprivation of life.
2. That no adolescent or young person's life shall be put at risk or endangered whatever their sex/gender, race, colour, ethnic group, language, religion, political or any other opinion, sexual orientation, national or social origin, economic position, birth, disability or other status.
3. That no adolescent or young persons should be subject to any sexual or reproductive health care programme which is discriminatory against particular population groups on the basis of gender, sexual orientation, age, race, mental or physical disability.
4. That in full recognition of the right to liberty and security, all adolescents and young persons have the right to clean, health custodial facilities devoid of sexual intimidation or harassment, separate and apart from adult detainees and in an environment that takes account of their sex/gender and age; that government provides facilities for rehabilitation and counseling for the first time and young

- offenders and that all existing legislation relating to the above are enforced.
5. That all adolescents and young persons should have access to effective, confidential health care services, results of research, medical technology and various types of medical treatment especially when the withholding of such access would have harmful effects on their health and well-being.
  6. The adolescents and young persons should have access commensurate with their individual level of development, to proper information and education on their rights and responsibilities including:
    7.
      - Sexuality and reproductive health;
      - Fertility regulation;
      - Health, developmental and life threatening risks of early and unprotected sexual behaviour;
      - Responsibilities for self as well as for their partners;
      - Other options including the exercise of discipline, self-esteem and self control through and including abstinence and non-sexual expression of affection to one another
    8. That adolescents and young persons seeking assistance from health and social services on reproductive health and rights issues should be given proper, professional and non-judgmental information on these issues and be educated on options available to them including abstinence, the latest scientific knowledge on fertility regulation, health, development and life threatening risks of early and unprotected sexual behaviour, responsibilities to themselves and their partners as well as other options including the exercise of discipline, self-esteem and self-control and non-sexual expression of affection to one another.
    9. That adolescents and young persons are providing needed services and /or given necessary referrals in an environment which non-judgmental, that ensures their sense of dignity, privacy and confidentiality with respect to their persons, personal and health data,

types of services accessed or provided on any aspect of sexual and reproductive needs and which takes account of their gender /sex and age.

10. That adolescents and young persons, including those physically impaired, are assured the right to sexual and reproductive health services as part of primary health which are comprehensive, accessible financially, physically and geographically, private and confidential, which pay due regard to the dignity and comfort of the person.
11. That all adolescents and young persons should be protected by all means including legislation and effective law enforcement, from coercion into marriage/conjugal unions, unplanned pregnancy or sexual exploitation, forced sterilization and/ or forced abortion and genital mutilation and is entitled to free independent legal representation.
12. That all adolescents and young persons should have the right protected by
13. Legislation, to have a given name and parental surname and to acquire a nationality from either parent.
14. That all adolescents and young persons are ensured the right to have appropriate nutrition, basic and vocational education and other skills training to ensure their healthy and complete development into productive members of the society
15. That all adolescents and young persons above the age of consent as established by law, should enjoy the full range of rights and responsibilities required to manage their sexual and reproductive life, and that those under the age of consent should be provided with medical health services and information required to assist them in their decision.

16. That all adolescents and young persons have the right to choose abstinence as a an option and that this choice be respected as part of their right to make informed choices about controlling their sexuality

17. That we move to ensure the passage of legislation enabling health professionals to provide sexual and reproductive health services to sexually active adolescents under the age of consent without their parents' consent if:

- The adolescent, although under 16 years of age, will understand the doctor's advice;
  - The adolescent cannot be persuaded to inform her parents or allow the doctor to inform them
- 
- The adolescent is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment;
  - The adolescent's physical or mental health or both are likely to suffer if he or she does not receive treatment;
  - The adolescent's best interests require the doctor to proceed without parental consent.

18. That all adolescents and young persons should be assured, by legislation and effective law enforcement, the right to be free from any medical interventions especially related to their sexual and reproductive organs and health.

19. That no adolescent or young person below the age of majority shall be subjected to medical trials or experimentation related to sexuality or fertility regulation methods except with their full, free, informed and written consent of their parents.

20. That all adolescents and young persons should be assured, by legislation and effective law enforcement, the right to be free from all forms of violence and abuse, incest, rape, sexual exploitation and harassment, trafficking and abduction, or in pornographic performances and materials, torture, cruel and inhuman and degrading

treatment and from coercion to engage in any unlawful sexual activity or use I prostitution or other unlawful sexual practices

21. That measures should be promulgated to protect the right of all adolescents and young persons to be free from externally imposed fear, shame guilt, beliefs based on myths and other psychological factors calculated to inhibit their overall
22. Development but in particular their present or future sexual and reproductive development or relationships.
23. That all adolescents and young persons be assured freedom from all forms of discrimination based on customary, culture, religious and social practices base on the concept of the inferiority or superiority of, or stereotyped roles for either of the sexes.
24. That the right of all adolescents and young persons to equal access to education and information, to ensure their health and well-being, including access to services relating to their sexual and reproductive health and rights, be protected by legal regulations and any other means.
25. That all adolescents and young persons are assured by legislation and effective law enforcement, the right to protection from discrimination in educational, social, domestic or employment spheres of reason of pregnancy, maternity and paternity.
26. That all pregnant adolescents and young females are assured access to appropriate healthcare, educational, social and financial services, prenatal, confinement and post-natal health care with inadequate nutrition during pregnancy and lactation.
27. That all adolescents and young mothers and fathers are assured of empowerment in parenting, and family life education and appreciation, general development and skills training.
28. That all adolescents and young persons are assured enjoyment (within existing legal restrictions for the protection for the rights of others) of

freedom of thought, conscience, association, religion, expression and opinion on all issues including those related to their sexual reproductive lives, rights and health

Nothing contained in this Declaration or the absence of any provision thereof may be interpreted as granting to any state, groups or persons the right to do any act which results in the derogation of any of the international and regional rights and freedoms stated herein and as contained in international instruments.

## Mood and Feelings Chart

How do you feel about this <u>        </u> session? 1 <sup>st</sup> , 2 <sup>nd</sup> , etc	
	<hr/> <hr/>
	<hr/> <hr/>
	<hr/> <hr/>

## References:

Maureen Campbell, **The Daily Gleaner**, Tuesday, November 7, 2000 p.B8

In May 1995, Jamaica signed the Rights of Children Convention. There are ten rights set out in the convention. Every child has the right to:

1. Equality, regardless of race, colour, religion, sex, nationality
2. Healthy mental and physical development
3. Sufficient food, housing and medical care;
4. Free education, play and recreation
5. Special care of the handicapped;
6. Love, understanding and care;
7. Immediate aid in the event of disasters and emergencies
8. Protection from cruelty, neglect and exploitation;
9. Protection from prostitution and
10. A right to have an upbringing in the spirit of worldwide brotherhood and peace.

Browne W. and Dunn-Smith, (1999) **Jamaica: Living Together in Society**, p.253. Carlong Publishers

**The Caribbean Youth Summit Final Report 1998 (TRB p.7-10)**

# SESSION TWO

## 'Youth Friendly' Health Services

### Values and Attitudes Questionnaire

**Instructions:**

Please place a tick inside the appropriate column that most closely matches how you feel about each of the following statements:

	I agree	I am undecided	I disagree
1. I believe that adolescents should not be having sex if they are not married.			
2. I feel comfortable about providing counseling services for adolescents.			
3. I have no objections to providing information about contraceptives to adolescents.			
4. I am willing to provide contraceptives to adolescents who request them.			
5. I am concerned that I will be condoning adolescent sexual experimentation if I give them contraceptives.			
6. I am concerned that I will be breaking the law if I give an adolescent below age 16 condoms.			
7. I believe that it is immoral and against God's commandments to provide contraceptives to unmarried adolescents.			
8. If I had a daughter below 16 years I would not like her to be given contraceptives without my knowledge.			
9. If I had a son below age 16 years I would not like him to be given contraceptives without my knowledge.			
10. I would approve of my son or daughter over 16 years obtaining contraceptives.			

Question	Ratings			
	AGREE	UNDECIDED	DISAGREE	
1	3	1	2	
2	3	1	2	
3	3	1	2	
4	3	1	2	
5	3	1	2	
6	3	1	2	
7	3	1	2	
8	3	1	2	
9	3	1	2	
10	3	1	2	
<b>TOTAL SCORE (30)</b>	+	+	=	

**Scores**

1 - 13

14 - 27

28+

**Interpretation**

**NOT AT ALL** in touch with the required values, attitudes and issues regarding ASRH

**SOMEWHAT** in touch with the required values, attitudes and issues regarding ASRH

**FULLY** in touch with the required values, attitudes and issues regarding ASRH

## Definitions of Terms:

<b>Health Centre</b>	Any recognized institution that provides health services, e.g. small clinics to large hospitals.
<b>'Youth Friendly' Health Centre</b>	A health centre that has been transformed into a welcoming user-friendly setting for young people. <i>(see next two page)</i>
<b>Specialist Adolescent Health Centre</b>	A centre linked to other health facilities, e.g. a medical school, providing clinical services to adolescents and serves as a referral centre to other general health facilities.
<b>Community-Based Health Centre</b>	A centre that provides user-friendly clinical services to adolescents within the context of health service provision to all segments of the population.

# Critical Elements for 'Youth Friendly' Services for Jamaica

## *Provider characteristics*

### 1. Specially Trained Staff

Training for staff should include building the following qualities:

- Friendliness
  - Caring
  - Respect for youth
  - Flexibility in providing services/ openness to new ways of doing things (e.g. such as seen youth outside of regular service hours, willingness to be flexible in collecting medical history/ data, etc.)
  - Good listening skills
  - Non-judgmental attitudes
- ### 2. Privacy and confidentiality honoured
- ### 3. Ensuring adequate time for client/ provider interaction

## *Facility Characteristics*

1. Convenient hours
2. Comfortable surrounding (e.g. friendly tone, youth involvement in designing surroundings, cleanliness)
3. Uncomplicated layout
4. Convenient location
5. Adequate space and sufficient privacy
6. Confidentiality honoured

## *Service Design Characteristics*

1. Client-centered approach
2. Youth involvement in design of service
3. Mechanism for continuing youth feedback
4. Local data collected on youth analyzed and used for planning.
5. Frequency of services:
  - Drop-ins

- Appointment arranged within two weeks
- Adequate staffing
- 6. No gender discrimination in services provided
- 7. Educational materials available (type of materials available, standard package of print materials available).
- 8. Minimum packages of services available per facility type
  - Necessary referrals/ referral network
  - Mechanism for clinical follow-up
- 9. Links to other community services available in health centre (e.g. other community agencies can provide services in centre such as counselling, etc.)
- 10. Fees in keeping with gazette fees set by government/ regional authority
- 11. Publicity of services
- 12. Mechanism to recruit youth

*Other things to considered*

- Training does not guarantee that staff will become 'youth friendly.'
- Need to select providers that already demonstrate positive qualities and interest in youth.
- Design questionnaire to assess attitudes
- Finite pool of providers nurses are already pressed
- Important to assess before and after training
- Government clinics are closed on Saturdays
- Many nurses do not live in the communities where they work, so working extra hours maybe difficult.
- Medical records- youth may be reluctant to disclose 'private information' about themselves, important to work with nurses, etc. to encourage alternatives/ flexible ways of collecting vital information.

*(Compiled by Youth Friendly Services Working Group November 3, 2000)*

## **Health Centers**

### **What are the types of health centers?**

- Community-Based Health Center,
- Specialist Adolescent Health Center and;
- ‘Youth Friendly’ Health Center.

### **Who operates these health centers?**

Health centers may be operated by the public sector, the private (profit seeking) sector or by charitable (non-profit seeking sector).

They may exist as independent entities or may be located within institutions providing other services to adolescents, such as:

- Educational Institutions (e.g. schools)
- Correctional Institutions (e.g. remand homes)
- Residential Institutions (e.g. youth hostels)

### **What are the services provided for adolescents in health centers?**

- Clinical Services
- Referral Services
- Counseling Services

### **What are temporary health centers?**

They are health centers established on a temporary basis in sites where large numbers of people are forced to live in camp-like conditions, for example, in the aftermath of a natural disaster, civil strife or war.

*(Additional information on health centers TRB pp19-22)*

## **Elements of a 'Youth Friendly' Health Centre**

### **13. Community Support:**

- well informed of its existence
- acknowledges its value
- supportive of its work

### **14. Youth Participation:**

- well informed about available health services and their utilization
- active participation

### **15. Youth friendly policies:**

- guarantee confidentiality
- do not require parental consent
- do not withhold provision of services and products

### **4. Youth friendly procedures:**

- easy-registration/ retrieval procedure
- short waiting time
- 'drop ins' with prior appointment possible
- strong linkages to other health and social services providers
- not expensive and flexible about payment

### **5. Youth friendly staff:**

- technically competent, interested and concerned, understanding and considerate, easy to relate to and trustworthy.
- able and willing to devote adequate time
- can be contacted at repeat visits

### **6. Youth friendly environment:**

- no stigma
- appealing milieu
- good facilities
- convenient working hours

- convenient location
- information/education materials available
- privacy in the examination/consultation/waiting rooms, and in the entrance/exit.

*Note:* These elements need to be considered not just in relation to adolescents as a population segment, but also in relation to groups within the population segment: such as male and female adolescents, older and younger, physically handicapped adolescents, and so on.

A great deal of good work has been - and is being – done in many developing countries as well, and there are many useful lessons that we draw from these initiatives. Detailed descriptions of these initiatives are available, however what follows is an attempt to represent the different models that are in place.

## **A ‘Specialist’ Adolescent Health Center Linked To A Medical School**

This centre provides clinical services to adolescents, serves as a referral center to other (general) health facilities and conducts training programmes for youth-serving professionals from different disciplines (both pre-service and in-service training programmes).

Two excellent examples are:

- The Unidad Clinica de Adolescentes, UCA, (Adolescent Health Unit), Rio de Janeiro, Brazil and
- The Centro de Medicina y Desarrollo Integral de Adolescente, CEMERA, (center for Adolescent Reproductive Health), Santiago, Chile.

## **A Community-Based Health Centre**

This facility strives to provide user-friendly clinical services to adolescents within the context of health service provision to all segments of the population. This model includes two categories:

- *Stand-alone units*, almost always operated by NGOs, such as:

- The Marie Stopes International (MSI) in Uganda and elsewhere
  - The African Medical and research Foundation, AMRE in Tanzania
  - District or municipal level health systems, almost always run by the government, which are working to reorient the delivery of their services to meet the needs of adolescents more effectively.
- *The District level, 'Youth Friendly' Health services project in Lusaka, Zambia (which is being run in partnership with a consortium of NGOs), and the nationwide chain of primary level adolescent clinics which are closely tied into secondary and tertiary level health facilities, through functional referral systems in Costa Rica.*

## **Possible Responses to Questions for Discussion Groups**

### **How do adolescents typically view health care provisions?**

In many parts of the world, adolescents are reluctant to go to places where health care provisions are available for a host of reasons. Some of them are:

- Long waiting period
- Overpopulated areas with people they might know
- Long and tedious bureaucratic procedures
- Humiliation by health care providers
- Examination by a health care provider of the opposite sex
- Consent of parents might be required for accessing certain services
- Lack of confidentiality by health care providers
- Unable to afford services
- Poor quality service, which could possibly cause harm.

### **What do adolescents typically seek from a health center?**

- STDs diagnosis
- Health products (such as condoms and contraceptive pills)

**What are the personal fears, concerns and values issues that Service Providers have that prevent them from operating 'Adolescent Friendly' health centers?**

- Laws and regulations forbid –or are believed to forbid – the provision of services to people below a certain age or to unmarried people
- Unknown level of sexual activity
- Suspicion of substance abuse.

## **Models for Providing ‘Youth Friendly’ ASRH Services**

What approaches have been and are being used to make health services user-friendly to adolescents? Below we offer experiences from more developed and developing countries.

### **Experiences from more developed countries**

Over the past two to three decades, adolescent medicine has emerged as a specialty in its own rights in many developing countries.

1. In the United States for instance, a national society for adolescent medicine has been established, textbooks on adolescent health have been published.
2. Training programmes for different cadres of youth-serving professionals are available, guidelines for health care providers have been developed.
3. Concerted efforts are underway to examine and address the crucial issue of improving the access of adolescents to health services.

There are useful lessons to draw from initiatives in these countries to make services widely available and accessible to young people. An interesting model that has emerged from experiments in the USA in the 1970s is that of the *integrated, comprehensive approach* to providing adolescents with the health and social services they need. In this model, the presenting complaint is merely seen as a ‘ticket entry’ to an array of services provided by professionals drawn from different disciplines. This ‘one-stop’ shopping approach means that the different needs of adolescents can be met under one

roof, by a team of professionals who understand their needs and are trained to address them effectively.

The integrated, comprehensive model has inspired the development of similar models in other developed countries as well as in some developing countries (notably in Latin America).

Another interesting model that has emerged from early experiments in Sweden is that of youth clinics. These clinics provide information and advice, counseling and clinical services relating to sexual and reproductive health. Their informal and friendly atmosphere appears to be very popular with young people. Over the years, youth clinics have been set up all over the country; a national network of these clinics is now in place. Swedish model has also been widely emulated in other parts of the world.

### **A Community-Based Center (which is not a health facility)**

This center is dedicated to providing adolescents with some or all of the services they need. The model also includes two categories:

- Centers which provide health information, counseling and clinical services only, such as:
  - the youth counseling centers run by the Family Planning Association of Kenya in Nairobi and Mombasa, and;
  - the Naguru Teenage Information and Health Centre in Kampala, Uganda.
- Centers which provide a wider array of services (of which health information, counseling and clinical services are only a small part). One of the pioneering initiatives of this kind is that of the Centro de Orientacion para Adolescentes, CORA (Centre for the Orientation of Adolescents), Mexico City, Mexico. CORA's multi-service center model has been widely replicated within Mexico and elsewhere in Latin America.

Another example is that of the Under Twenties Club in Grenada. A variation of this model is organizations working primarily to address

the non-health-related needs of special groups of adolescents (such as pregnant and parenting adolescents). In addition to providing some health services themselves, these organizations often have functional linkages with health facilities nearby.

Example of such initiatives include:

- The renowned Women's Centre in Kingston, Jamaica
- The Educational Center for Adolescent Women run by the Young Women's Christian Association in Gaborone, Botswana.

Such centers tend to be operated by NGOs (in some instances with funding from government bodies).

### **Organizations that improve adolescents' access to health services that are available in their community**

The activities of these organizations (almost always NGOs) are aimed at preventing one or more specific public health problems, among adolescents in general or among especially vulnerable sub-groups of adolescents. Their main emphasis is on outreach work, in order to provide information and to educate their target group. Many of these organizations do not provide more

than the most rudimentary clinical services (if at all) but have strong linkages with health facilities in the areas in which they operate.

Examples of such initiatives are:

- The Dar es Salaam wing of the Youth Family Planning Through Peers Project of UMATI (the Family Planning Association of Tanzania)
- Proyecto Alternativa (the Alternatives Project) in Tegucigalpa, Honduras.

To sum up, there is a tremendous wealth of experience and expertise available around the world, in making health services user-friendly to adolescents in very different settings.

Note: This paper is an extract from the document: Programming for adolescent health and development. Report of a WHO/UNFPA/UNICEF

study group on programming for adolescent health, WHO technical report series: 886, WHO, Geneva...

### **Institutional Barriers to Adolescents' Use of Health Services**

Based on their own experiences or the experiences of their peers, they may fear that:

- they have to go to a place or wait in a public setting where they could be seen by people who know them.
- they have to go through a long and tedious bureaucratic procedure before they get to see a health care provider.
- they have to wait for a long time, seems like a full day, to see a health care provider and to get the health services they need.
- health care providers could humiliate them, ask them difficult questions and put them through unpleasant and painful procedures.
- health care providers will not maintain confidentiality (and that people around them will learn about their condition).
- the quality of health services they get is poor, services are unlikely to be helpful and could even be harmful.
  
- they cannot afford to pay for the services they need.
- health care workers cannot provide them with the services they need without the consent of parents or guardians.
- they will be examined by a health care provider of the opposite sex

- health care workers cannot provide them with the services they need without consent of parents or guardians
- they cannot afford to pay for the services they need

There is growing recognition among clinicians and public health workers alike of the pressing need to:

- overcome the many existing barriers that hinder the provision and utilization of health services to adolescents
- transform the image of health centres from the prevailing one of depressing and forbidding places that are best avoided, to an image of a welcoming user-friendly setting— a youth friendly health centre.

### **Contributions that Service Sector Groups Can Make**

#### **Health workers could make valuable contributions to the health and development of adolescents**

They can do this by promoting healthy development, preventing health problems and responding to health problems when they arise.

#### **In promoting health development:**

- advocating with gate-keepers for supportive policies and strong programmes
- engaging and supporting other sectors to contribute to programming
- contribute directly to the delivery of activities such as information provision and skills building outside health facilities.

#### **In preventing health problems:**

- monitoring growth and development, and checking on the state and function of the organ system of adolescents (such as the teeth, hearing and vision)
- providing information and advice to their adolescent patients
- providing an opportunity for their adolescent patients to ask questions and to clarify any doubts they have

- providing health products (such as vaccines, nutritional supplements, contraceptives and condoms)
- being alert to the possibility of the presence of health problems (such as sexually transmitted diseases or depression) and/or unhealthy practices (such as injecting drug use), and detecting them early (if and when they arise)
- linking up with, and drawing upon, the support of organizations who provide appropriate non-health services when required (such as legal and social support for adolescents who are being abused).

**In responding to the health problems if and when they arise:**

- detecting/diagnosing problems and/or unhealthy practices if and when they arise
- appropriately managing these conditions (this includes treating diseases and disorders, rehabilitating disabilities, responding to psychological needs, and helping adolescent patients with the social implications of their conditions)
- linking up with, and referring their adolescent patients to the next 'level' of health service delivery and/or to organizations which provide non-health services (if and when available)

Clearly there is much that health workers could and should do to promote healthy development, prevent health problems and respond to them when they arise. However, a central function of the health sector is the provision of health services, which at the barest minimum should include:

- the management of emergencies (such as obstructed labour)
- the routine treatment of commonly occurring diseases (such as malaria)
- ensuring regular access to health products (such as nutritional supplements).

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(Choose relevant ones from list)

# SESSION Three

## Introduction to Adolescence

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### Clarification Of Words/Terms /Abbreviations

<b>Adolescence</b>	The teen years. Adolescence is expressed differently in different cultures and there are variations even among subgroups in the same culture system.. It is the period between childhood and adulthood when the body undergoes remarkable hormonal and physical changes.
<b>Growth</b>	Growth refers to the physical changes that occur during adolescence.
<b>Development</b>	Development refers to the non-physical changes that characterize the maturation of the individual
<b>Blindness</b>	This is the complete or partial lack of sight, which can be caused by diseases, accidents, violence, or be congenital. There are two stages of blindness commonly referred to visual impaired or total blindness.
<b>Sexual Health</b>	Sexual health means having a responsible satisfying and safe sex life. Achieving sexual health requires a positive approach to human sexuality and mutual respect between partners.
<b>Reproductive Health</b>	Reproductive health suggests the right to have children and to safe guard your own health

<b>AIDS</b>	Acquired Immune Deficiency Syndrome. AIDS attack the body's immune system, destroying the ability to fight off infections.
<b>HI</b>	Hearing Impaired.
<b>MR</b>	Mental Retardation
<b>STIs</b>	Sexual transmitted Infections
<b>HIV</b>	Human Immune Deficiency Virus. This is the virus that causes AIDS. HIV can be in the body for years without producing signs of active infection.

**Table showing adolescents Growth and Development**

	<b>Early (10 – 13) Adolescence</b>	<b>Middle (14 – 16) Adolescence</b>	<b>Late (17 – 19) Adolescence</b>
<b>Changes that occur</b>			
<b>Physical</b>			
<b>Psychological</b> <b>Cognitive</b> <b>Emotional</b>			
<b>Social</b>			

## **REINFORCEMENT POINTS ON ADOLESCENTS**

- They are developing a sense of identity
- Their peer group become more important and more influential to them than it was in the past
- They are not easily controlled.
- Service providers need to be more aware of these changes and begin to treat the growing adolescent with respect and dignity.

# WHAT ARE THE SEXUAL AND REPRODUCTIVE HEALTH ISSUES THAT BLIND ADOLESCENTS FACE

*Written by Gloria Goffe*

The New Standard Encyclopedia defines "blindness" as "the partial or complete lack of sight which can be caused by diseases, accidents, violence or be congenital. These two stages of blindness are commonly referred to as visual impairment or total blindness. The latter situation is usually the cause of much discussion in the context of being the worst thing that could ever happen to anyone. How many times have we, as persons who are blind heard that comment when someone is supposed to be sympathizing with us. S. Finstone in his book "Social Casework on Blindness" states that blindness usually infers negative connotations, and because of this persons who are blind tend to experience a number of social and psychological problems due to stigmatizing, stereotyping, isolation and categorization.

Most young blind persons can relate to this statement as being true. People expect us to achieve a certain level, maybe secondary, of education. They expect us to be able to sing as well as Adinah Edwards, Stevie Wonder or Ray Charles; able to play musical instruments like the members of the Unique Vision band, and all are expected to exhibit Christian-like behaviour.

But blind persons are not expected to be involved in sexual and reproductive activities.

When a young blind man purchases condoms from a pharmacy, the salesperson is at a loss as to what he intends to do with it, and the same thing applies to a blind woman who buys birth control pills or seeks other forms of contraceptive devices from a clinic. These persons are made to feel that the issue of sexuality is not a part of their business. Some therefore become intimidated and end-up in unplanned-for situations like pregnancy, or are exposed to sexually transmitted diseases. Whether pregnancy is planned for or not, if and when it happens to a blind woman it is seen as a case of rape or some man's folly.

Dating, sex, grooming, child-rearing, are not seen as issues with which blind persons have to contend. We are therefore not seen as normal. In institutions such as children's homes and boarding schools, as well as in nuclear families, blind persons are not given the same level of exposure to these issues as their sighted peers as the perception of the care-givers is that they should not be involved. Even if they experience the sexual urges and the need for companionship, love and intimacy, these should be suppressed.

We are, however, very much aware that blindness is what is stated - simply the partial or complete lack of sight which does not prevent us from experiencing all the biological changes and emotions that are a part of human's development. We also have the same aims and objectives for employment, recognition, owning a home, having a family and self-actualization. We also recognize that many of the myths which are held by society are due to ignorance and a reluctance to accept the fact that blind persons have demonstrated over the years that we are no different. We are however cognizant that our socialization has been different to some extent due to our disability and the way our caregivers, service providers and the society at large view us. The barriers created by the society compel us to deal with our sexuality sometimes in ways that have proven detrimental to some. For example, by experimenting, and being less careful about our involvement.

The majority though, has been able to improvise ways of dealing with the ~~various issues stemming from~~ the broad topic, and achieving the satisfactory results as the rest of the society.

As the blind person develops they too ~~want to~~ <sup>want to</sup> dress attractively and take pride in their grooming and deportment, not only to make them feel good,

but also to attract the opposite sex. They get involved in putting on make-up, and some have developed the technique for doing this very well. But how does a blind person know what is fashionable? This is done by listening to the radio and in discussions with their partially blind schoolmates, or sighted relatives and friends. The more adult blind persons tend to select dressmakers and tailors who are fashionable and can advise them on colour combinations as well as hairdos and styles of shoes.

They are made aware of how successful their advisors have been by the comments made by people on the streets, although normally giving commendations to "those that dress us". This again shows that ignorance of the society, as they think the blind person is incapable of dressing himself or combing their hair.

Forming relationships with the opposite sex usually comes about by our interaction with them, and blind persons have no inhibitions about this especially with other blind persons. However, this interaction has been curtailed, and sometimes out-rightly prohibited by caregivers with the aim of protecting us from abuse. At the School for the Bland for example, while interaction was allowed, it did not extend beyond holding hands and sitting

beside each other, and again it would be a question of how long the hand is held, and how close you sit. Meeting in common areas such as the amphitheatre, music room or library was constantly supervised. However, intimate friendships were built on verbal and written expressions of love and appreciation, holding hands, and a stolen kiss or hug in the classroom after school or in the library behind a bookshelf. In most cases the sexual urges were controlled because of the fear of pregnancy and the constant reminders of the uncertainty of the future for blind persons from an economic and relationship standpoint. Dating therefore, included these planned moments, or on a Saturday when we all were allowed to go for walks.

After leaving school or the safety of your family comes along the real test as we are not fully prepared for the outside world. Many blind persons have ended up in relationships with persons with similar disability because of their mis-trust of sighted persons of the opposite sex, and also because these persons tend not to want an open relationship with a blind person. There have been healthy relationships and loving families emanating from relationships between both blind and sighted persons, but these are mainly among persons of higher educational standing. The relationships that have lasted are those in which the sighted parties have been able to recognize that

a sideways glance, a look of love or a playful smile means nothing to the blind person, and have therefore been able to express their feelings through verbal and physical communication such as a hug, a touch or a word of admonition or appreciation. They have also had to adjust their own methods of doing things in order to make the blind person more comfortable. For example, developing the art of walking with the blind in unfamiliar territory without the blind seeming clumsy because of wrong directions or gestures. Blind men tend to be less successful in getting into relationships with sighted women, as our culture dictates that men should make the initial move therefore the fear of these men of rejection by these women. This fear being born out of the knowledge of society's perception of us.

However, those who dared have done so after long-term social relationships with these women.

Peer pressure is another issue with which blind adolescents have to contend. Persons who have been integrated into mainstream high schools speak of their exclusion from this type of pressure as students of the opposite sex see them as being only a part of the academic activities of the school, and therefore most times ignore them. Invitations to students' homes or weekend parties are not extended to these blind students. The real pressure

then is how you cope with your self-esteem despite this exclusion, and this tends to lead them back to their own blind friends. The pressure there does include some of the pressures experienced by sighted students, such as sex, drugs and certain behaviour patterns. In the home the pressure usually comes from relatives and close friends, and while there is no record as to the extent to incest and rape, it is known that these do happen. In the case of rape, there is often very little redress as blind persons are unable to identify their aggressors, and even when they are, once it is denied, their care-givers tend to either doubt the report of the blind person because of their inability to see, or feel that to report it is an admission to their own inability to protect the blind child or adolescent. Care-givers are aware of the vulnerability of these persons, and because of this they become over-protective to the extent of stifling the sexuality of those in their charge and refuse to allow these persons freedom to decide on what they wear and with whom they interact. Persons who are blind are also aware of their vulnerability, and therefore take precautions such as being extra careful about whom they date, and try not to be alone at home, and, if they are, ensure the institution of security measures.

For those who have been raped, however, they react just as sighted persons who have had this experience, and suffer severe mental and emotional trauma. The blind person is, however, at a greater disadvantage because they are not able to see and therefore find it even more difficult to trust anyone.

Sexually transmitted diseases are another issue, which has not been discussed openly with young blind persons. They again have to rely on the radio and their peers how to prevent and/or deal with these diseases. Many young persons, who are sexually active without the knowledge of their caregivers, face the same problems as young sighted persons when they become pregnant or contract diseases because they are fearful of the wrath of their parents/caregivers or being ridiculed by persons in the health service. There is usually a delay in getting cure for the STDs. The more adult blind person, however, is not so fearful to get help because of his/her independence. Some have however, expressed their dissatisfaction with the reaction to service-providers, but are able to deal with the issue in a more mature way than the adolescents.

The majority of known pregnancies among blind persons are wanted even if not planned, and the question that normally follows is how can a blind

person safely carry a pregnancy, and then take care of the child. To this person, motherhood comes naturally, and because they are very much aware of the changes in their body, attend anti-natal clinics and receive advice from their doctors, parents and friends, they normally have an incident-free pregnancy, and are very much involved in the growth and development of their children. It is true to say that many of these persons live away from families and personally look after their children, dealing with all the delicate issues of early childhood, the confusion of the teenagers and adolescents.

Relationships involving persons who are blind tend to be more lasting, as for them it cannot be love at first sight which is based on outward appearance, the persons dress, walk, hair or colour, but is more based on a gradual getting-to-know-you, and therefore deal more with the inner person. This is not to say that there is not concern for the outward appearance. But someone who is gentle, loving, caring, understanding and mature, becomes much more important to the blind person than his/her Tommy Hilfiger or Moschino brand outfit, brown eyes or long black hair.

Things are changing, and persons who are blind are part of the change in that they are now more exposed and very much more aware of their sexuality and

how to deal with all the issues associated with it. However, there are those who are still uninformed, and who are not sure as to how to deal with these issues. The hardest part of the equation is how to change the perception of the society. For example, it is impossible for a beautiful young woman who is blind to be entered in the Miss Jamaica beauty pageant. It will be also the day when a blind person advertises a hairdo or dress in the media.

There is need for the caregivers in children's homes, boarding schools and even parents and family members to accept the fact that although blind children, and especially females are vulnerable, over-protectiveness can also be detrimental. They should therefore be open about sexual and reproductive issues, and expose them in the same way they expose their sighted children.

When a condom is found in a garbage bin, do not punish a whole dorm or class. Instead counsel them about the lack of wisdom in being engaged prematurely in sex, and also encourage them that if they must, using a condom is the way to go.

House mothers need to recognize the changes in those under their care, and rather than stifling their expressions by coercive means, they should speak openly with the young adults and inform them truthfully of the dangers

associated with sex, and the responsibilities that go with it. They should not feel that the need for sex and family life is wrong because they are blind.

Instead they must be taught the necessary skills to deal with homemaking, family development, taking their place in the society as workers, parents and teach them to value themselves and not feel that because they are blind they should look or feel different. Give them the chance to feel free to discuss whatever confusions or turmoil they might be going through.

Health workers need to be more sensitive in their questions and comments when a person who is blind requests information or seeks medical care in sex related matters.

Finally, seminars like this should be conducted for all service providers, and education on disability should be included in the training of all service providers to make them more aware of the impact negativity has on persons who are disabled, since sometimes the damage is irreparable.

In your demonstrations ensure that you consult with persons with special needs in order to develop more practical means of illustrations, as many of these are done by pictures and films which a blind person will not see.

Guidance counsellors in schools, especially mainstream schools where blind persons are integrated, should be aware of the culture of the society

regarding disabled people and therefore must be more sensitive to the needs of the blind students, ensuring that they are able to handle the sometimes unkind remarks of their fellow students, and also that they are not put through undue pressures.

Sexuality and reproductive health are national issues. It is not different for the person who is blind and therefore they must be included in the programme. Persons who are blind are part of the society and must be made to feel this way; they should be given the same level of guidance and allowed the same level of freedom to express themselves and take on the responsibilities of normal life.

The fact that we are seen to be more vulnerable is every reason why we should be more knowledgeable. We are normal and we value our independence, give us a chance to achieve both.

## **References:**

### **SEXUAL AND REPRODUCTIVE HEALTH ISSUES OF ADOLESCENTS WITH HEARING**

#### **Impairment And Mental Retardation**

Avril Daley, 1999

#### **SOCIETY'S VIEW ON DISABILITY**

Disability deviates from the norm. Disability is seen as a "deviance."

Society tends to value persons based on wholeness. This is, society is prejudiced against anything that is not typical.

A person is judged on:

- body type
- personality
- age
- gender
- race/nationality
- attributes

SOCIETY MORE THAN THE DISABILITY/CONDITION,  
DETERMINED WHAT A PERSON WILL BE PERMITTED TO DO OR  
HOW HE/SHE WILL BEHAVE.

The individual may be devalued because of the lack of particular skills,  
sense or body part.

Children with disability, as a group usually has more psychological  
problems adjusting to his/her environment. This is due more to the society's  
response to the child rather than the disability itself.

The child may accept the devaluation of society and perceive him/herself as  
less worthy and engage in self-devaluation.

However, each disabled individual formulates his own responses to his  
disability in accordance with his lifestyle.

The greater the restriction on the child's ability to assimilate and  
accommodate the environment, as well as limitation in cognitive growth, the  
greater the strain on the child's resources for successful adaptation.

## **SEXUALITY AND DISABILITY**

Common beliefs about sexuality and person with disability:

- Deny that the person has any interest in sexual relations.

- Believe that persons with disability are more highly sexually charged than non-disabled persons.
- Treat persons with disability as if they were younger and more immature than their age peers.
- Deny sexual information, because they believe that by giving information that the individual may not have received otherwise.

The two disabilities on focus are:

**Hearing Impairment:** Any hearing loss from mild to severe/profound, which may or may not preclude the understanding of speech with or without the use of a hearing aid.

**Mental Retardation:** Significant impairment in an individual's mental development which manifests itself in difficulty in learning and performing certain daily living skills.

The more severe the disability the more complicated issues will become and the reactions and adaptations will be for the individual as well as the society.

## **ADOLESCENTS WITH DISABILITY**

The Adolescent period is usually a very difficult period.

Adolescence: Psychological changes which occur between puberty and adulthood. Psychological changes result from increased interest in the opposite sex; marked by participation in activities, which are sexual in nature, such as kissing, petting, premarital sex, masturbation etc.

## **EFFECTS OF DISABILITY OF SEXUALITY**

Personal views on disability and sexuality will colour our views and interaction with persons with disability.

## **Question: DO PERSONS WITH DISABILITY HAVE THE RIGHT TO FULL PHYSICAL INTIMACY?**

Some of the effects that a disability may have on sexual and reproductive health are:

1. Level of **INVOLVEMENT OF THE DISABILITY**.
  - Usually affects sexual behaviours but not the ability to reproduce.
2. The manner in which **SEXUAL INFORMATION** is given.

It is the right of all persons to receive education, including sexual education. This education will assist persons with disability to be protected from abuse, exploitation, unwanted pregnancy, and sexually transmitted diseases.

Hearing Impairment (H):

- Many of the avenues open to hearing persons may not be available to the HI.
- Limited communication skills of persons in charge of providing the information.

Mental Retardation (MR):

- Limitation in understanding the standard information package available to non-related persons.

Much of the information that a non-disabled person takes for granted may have to be taught to persons HI and MR:

This information may include, how to handle:

- interpersonal relationship
- sexual urges
- public and private behaviours
- myths and facts about sexual and reproductive health issues

It may be easier to provide this information to the teen with HI, after the communication barrier has been overcome.

### 3. Level of **SELF-CONCEPT AND SELF-ESTEEM**

- Low or negative self-concept or self-esteem may lead to promiscuity.
- More positive self-esteem, less likely that the individual will be taken advantage of.
- More susceptible to negative peer influence.

### 4. Dealing with **PREGNANCY, STD'S AND SEXUAL ABUSE.**

- Parents or caregivers often assume the responsibility for making choices for persons with disability, especially the MR, such as the right to have children.
- Persons with disability are more open to sexual exploitation than persons without disability.

## **DEVELOPING POSITIVE ATTITUDE TOWARD SEXUAL & REPRODUCTIVE HEALTH**

- Establish a positive relationship based on trust
- Develop friendship with the child/teenager
- Treat child/teenager with respect and understanding
- Be open about Sexuality
- Teach child/teenager about sexual responsibility
- Foster positive attitude toward the body
- Impart positive self-concept and self-confidence
- Provide sexual and reproductive education
- Allow individuals to make informed decision about their lives.

# SESSION **Four**

## Reproductive Anatomy and Physiology

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### Clarification of words/terms:

<b>Adolescence</b>	It is also called puberty, is the period between childhood, when peoples; bodies undergo remarkable hormonal and physical changes.
<b>Clitoris</b>	Is the organ located in the soft folds of the skin in the front of a woman's vagina. It is very sensitive, about the size of a pea. Its function is to help a woman have sexual pleasure.
<b>Urethra</b>	Is the passageway for urine from the bladder to the outside of the woman's body
<b>Vagina</b>	An orifice approximated 3-5" long extending from the outer opening at the vulva to the cervix. Is the muscular passage extending from the woman's outer sexual organ (the vulva) to the uterus. It is also called the birth canal, the passage through which a baby is born.
<b>Hymen</b>	A membrane structure that

	partially covers the entrance to the vagina. Often, but not always, a small web of skin, which covers the opening of the vagina.
<b>Labia Minora</b>	The inner lips of the vagina
<b>Labia Majora</b>	The outer lips of the vagina
<b>Fallopian Tubes</b>	Two thin tubes approximately 4" long, which convey eggs (ova) from the ovaries into the uterus
<b>Cervix</b>	The neck of the uterus, which protrudes down into the back of the vagina
<b>Uterus</b>	Also known as the womb. It is the place where the fertilized egg grows and develops into a foetus
<b>Menstruation</b>	Commonly called a period. Comes about once per month for most women. It is the shedding of the uterus if the egg of the uterus is not fertilized. It is a cycle ranging from 26-34 days in length.
<b>TSS</b>	Toxic Shock Syndrome- it has been associated with the use of tampons. It is believed to cause byatoxin (poison) released by staphloeoceas aurens bacteria
<b>Ovaries</b>	The female gonad. Two sexual glands located on each side of

	the uterus. They produce the female hormones- oestrogen and progesterone
<b>Hormones</b>	Chemical messengers that travel through the blood-stream
<b>Embryo</b>	A fertilized egg 3-8 weeks inside a sac filled with amniotic fluid connected by the umbilical cord to the placenta to nourish the baby.
<b>F.S.H</b>	A hormone produced by the pituitary gland in the brain called Follicle Stimulating Hormone. It stimulates an ovary to develop a number of follicles. As the follicles develop, they secrete an increasing amount of oestrogen into the blood stream.
<b>Foetus</b>	A developing baby from 7-8 weeks after fertilization until birth.
<b>LH</b>	When the amount of oestrogen reaches the peak level, the pituitary gland responds by sending out another hormone called Luteinising Hormone (LH). LH acts on the ovary by causing one follicle (rarely, too) to develop fully and burst from one ovary, <u>a process called ovulation</u>
<b>Ovulation</b>	Marks the beginning of the

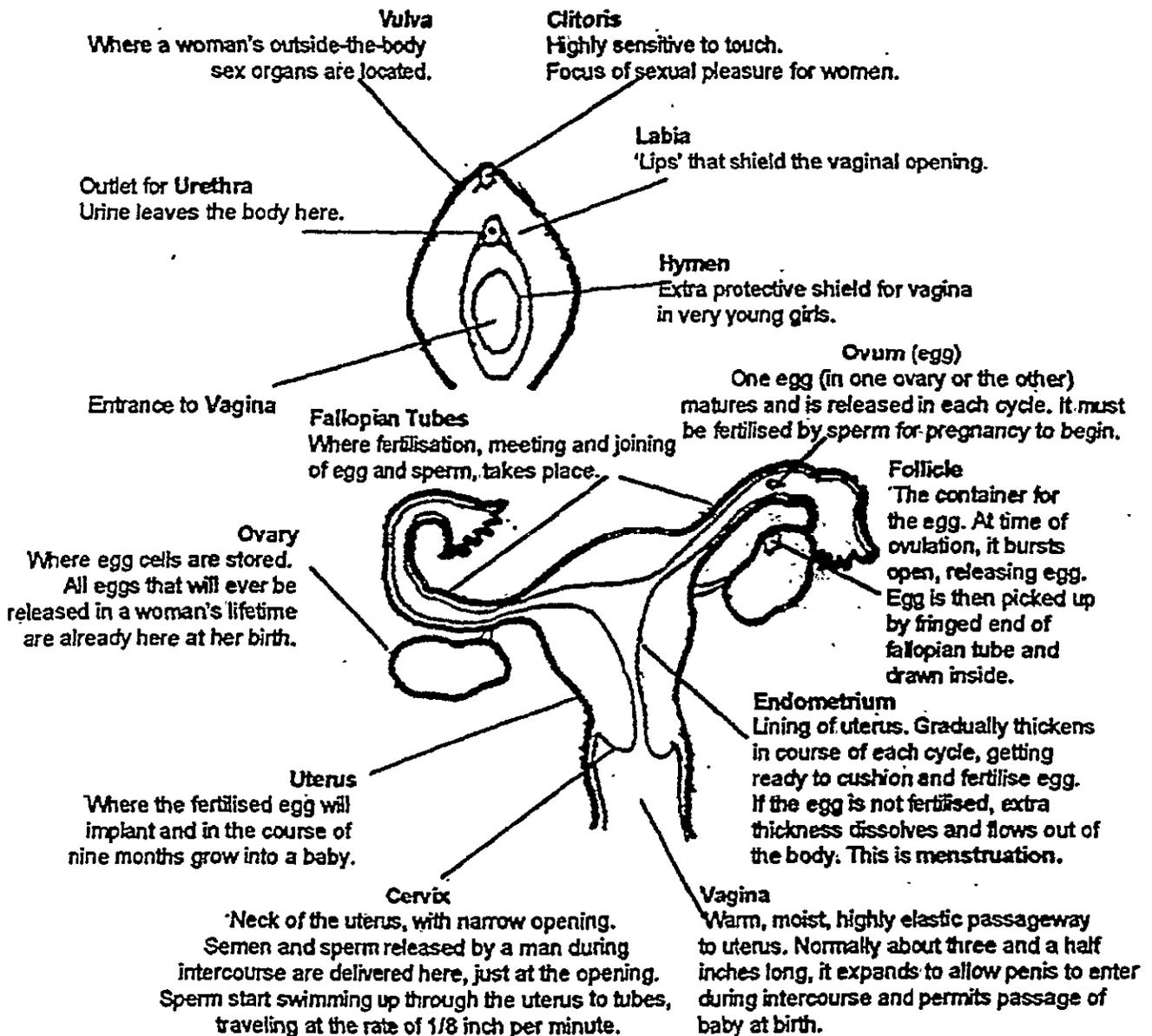
	second phase of the menstrual cycle. It occurs 12-16 days before the next menstrual cycle.
<b>Progesterone</b>	Is the secretion of the ovary after ovulation, along with more oestrogen it maintains

## Male Anatomy

<b>Penis</b>	Made up of a spongy erectile tissue. It is an external sex organ of the male. The eutive penis is highly sensitive, particularly the glans or head. An erect penis is about 7 ½ inches long and 1 ½ inches in diameter. (normal flaccid state).
<b>Testicles</b>	Two small balls in the scrotum produce sperm and the male hormone called testosterone.
<b>Scrotum</b>	The soft muscular pouch, containing the testicle to the abdominal cavity. Controls the temperature of the testicles. The adult man has two testicles about the shape of plums.
<b>Vas Deferens</b>	Two fine tubes though which sperms pass through to the seminal vesicles, where they mix with semen.
<b>Semen</b>	Seminal fluid, is the whitish fluid that carries the sperm,

	which is about a teaspoon of fluid. Each ejaculation contains from 100 to 600 million sperms in about a teaspoon of fluid.
<b>Sperms</b>	Microscopic male reproductive cells, made up less than two percent of the total ejaculate. Each has a head and a tail, like a tadpole. They each live 6-8 hours in the vagina. They reach the fallopian tubes within an hour to one and a half hours after ejaculation
<b>Circumcision</b>	The removal of the head skin call foreskin, which covers the end of the penis
<b>Wet Dreams</b>	Also known as, seminal or nocturnal emissions makes females also have erotic dreams that can lead to an orgasm. It is also common not to have wet or erotic dreams.
<b>Testosterone</b>	The most important male androgen or male hormone in the testicles.
<b>Ejaculation</b>	The release of semen from the penis
<b>Erection</b>	The process whereby the penis is filled with blood to enlarge and stiffen

# Female Reproductive Anatomy



# Male Reproductive Anatomy

Tube through which semen and sperm are released from body is the **URETHRA**.

Urine coming from **BLADDER** leaves body through same tube. But never at same time as semen.

## **PENIS.**

Tip especially sensitive to touch. Sexual stimulation (physical or mental) causes erection—increase of blood supply to penis, making it bigger and harder, standing out from body. Penis has to be erect to enter woman's vagina easily in intercourse.

Climax of sexual intercourse brings on **EJACULATION** here. Semen is released in explosive spurts, not under the man's control. Each ejaculation releases about a teaspoonful of semen, containing 100 million to 500 million sperm. (The longer since the last ejaculation, the higher the count.)

**SEMEN PRODUCING GLANDS.** Semen, the fluid in which sperm cells travel, is product of three different glands located here. The most important is the largest, the **PROSTATE** gland.

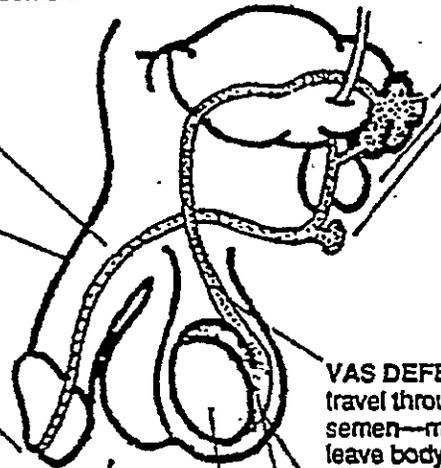
**VAS DEFERENS.** Tube sperm travel through to merge into semen—milky fluid in which they leave body.

**EPIDIDYMIS.** Where sperm cells are stored.

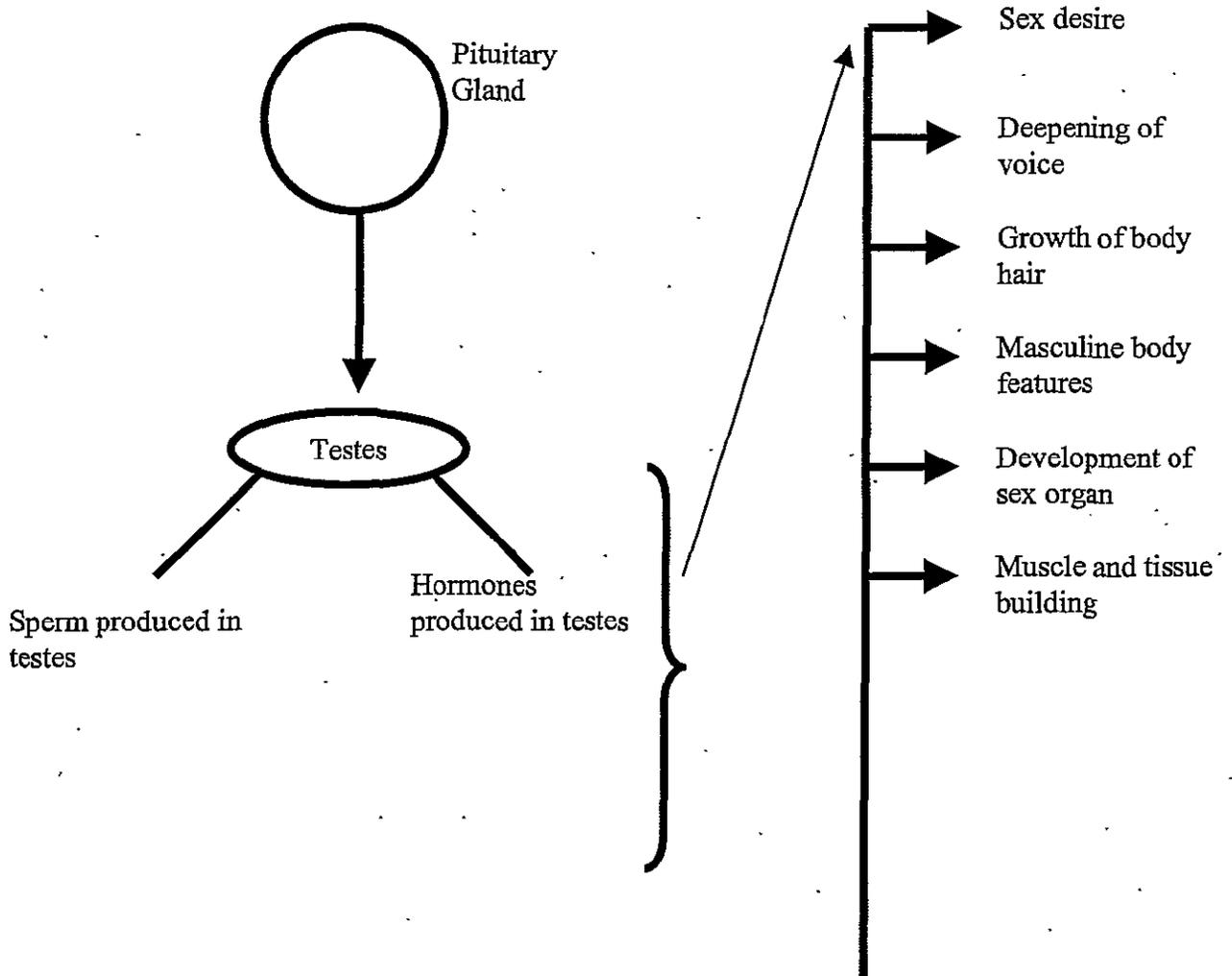
**SPERM CELLS.** One of these must meet and join with a woman's egg cell to start a pregnancy.

**TESTICLE.** Where male-sex hormone, testosterone, is produced. This chemical, circulating in the blood, is what chiefly makes a man 'male.' Testicles are also where sperm cells are made. Sperm production, stimulated by testosterone, starts when boy is between 12 and 15, then goes on for rest of his life.

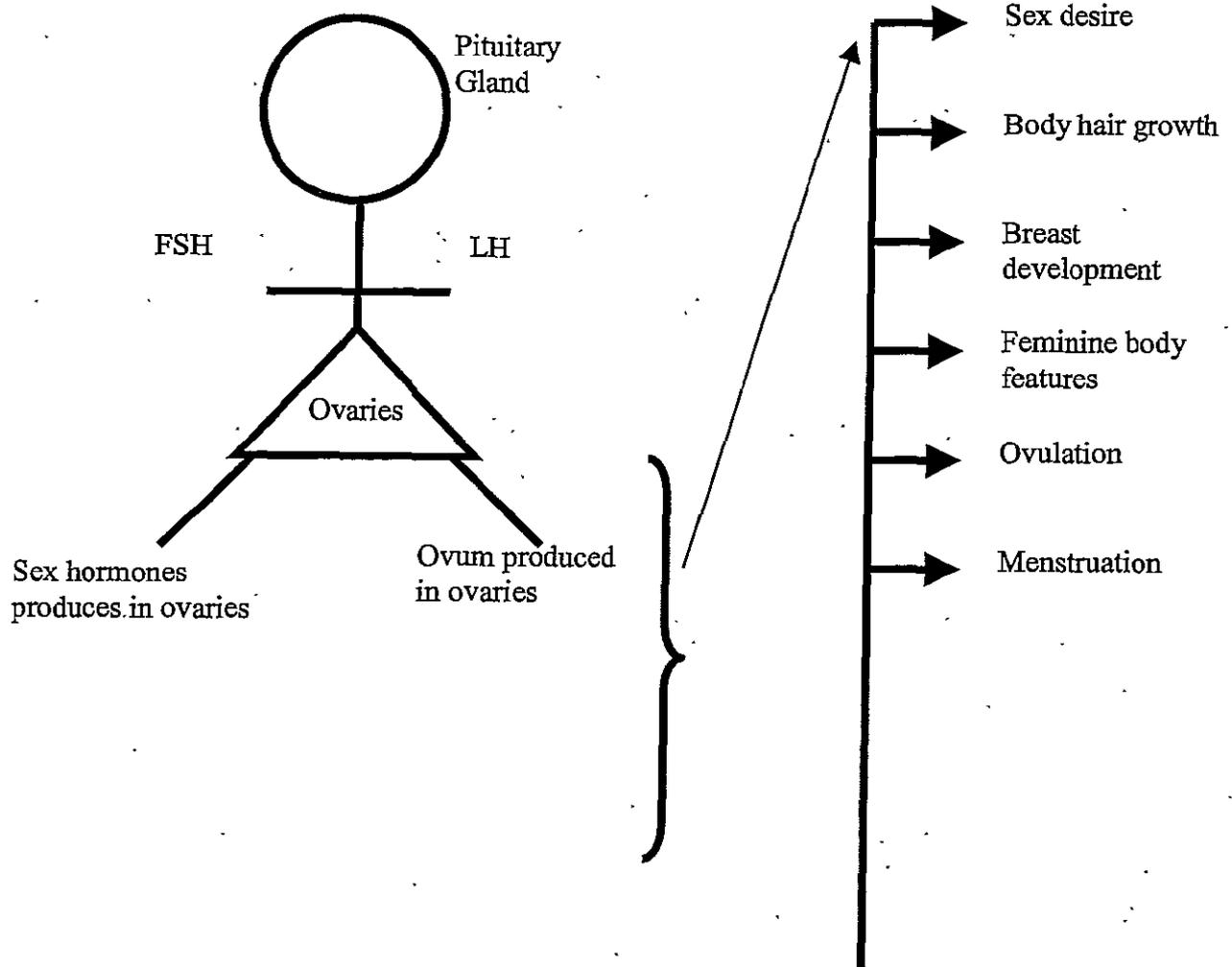
**SCROTUM.** Sack of thin loose skin that holds the two testicles. Temperature is lower here than inside the body itself. This is better for sperm production.



# Flow Chart Males Secondary Sex Characteristics



# Flow Chart Female Secondary Sex Characteristics



## Handout: Mid-life

The years between 40 and 55, including a difficult psychological phase called the climacteric in men and menopause in women. There are essentially four stages of reproductive maturity in woman:

1. Pre-menopause when a woman has regular menstrual cycles.
2. Climacteric, when the ovaries start to produce less estrogen. This is usually when the woman is about 35. As time goes on, she may have such symptoms such as breast tenderness, premenstrual syndrome (PMS), night sweats, or other signs of imbalance in estrogen and progesterone.
3. Pre-menopause, when the woman's periods become irregular. Some women experience hot flushes, lasting 30 seconds to 15 minutes. These usually occur between 6 and 8 in the morning or 8 and 10 at nights

Menopause, when a woman has not menstruated for a full year. This signals the end of the reproductive years. The average age at which this happens is 51.4 years.

Before birth, a female foetus has about 7 million eggs in her ovaries. Five million are lost before she is born. By the time she reaches puberty, she has approximately 300,000 undeveloped eggs. By the time she reaches menopause most – though not all – have disintegrated. At one time, menopause was believed to be estrogen deficiency disease. Today, some women are given estrogen/progesterone supplements to lessen bothersome symptoms, but there is much debate over the advisability of this kind of therapy.

The signs and symptoms of approaching menopause include vaginal dryness, overall tingling sensations, more frequent urinary tract infections, less strength in the hands, insomnia, hot flushes, less secure sense of balance, osteoporosis (brittle or soft bones), fornication,(itching under the

skin) and psychological symptoms (which may be physiological changes going on.

Some alternatives to hormone replacement therapy are maintaining a healthy attitude about aging, eating a well-balanced diet, getting appropriate exercise, joining self-help and support groups, having sex regularly, using vaginal lubricants or saliva to counteract vaginal dryness during sex, increasing intake of calcium, vitamin E, ginseng or bee pollen, herb teas, and cranberry juice, and equally important, understanding the physiological changes going on.

Many women sail through menopause without any problems. Studies suggest that if a woman has a healthy attitude towards life and the life cycle, she will probably not have any difficulties. If she does experience them, she should maintain a positive attitude, and the symptoms will eventually subside. Positive thinking is powerful.

The male climacteric is a better term than 'male menopause' for the kind of emotional and psychological crisis that overtake some men in mid-life. Since men do not menstruate, 'menopause' is inappropriate. Some men experience no crisis at all, some experience it mildly. Perhaps, 25% of men are profoundly affected. Just as estrogen production diminishes in women in mid-life, testosterone levels are also reduced in men. The physical consequences are taking longer to achieve an erection, ejaculations that are less strongly felt and a longer refractory period- the time it takes a man to recover from one ejaculation and ready for another. On the other hand, ejaculatory control is likely to be greater: desire and pleasure are in no way impaired, and the man remains as able as every to make a woman pregnant.

Apart from a slight slowing down, a man need not suffer any adverse consequences of aging in the mid-life period nor any anxiety. Some men, however, who are perhaps insecure in their masculinity react with something near panic. They may question virility and seek to prove they are as "good" as ever by pursuing the maximum possible number of sexual encounters. It is this group that has given rise to the myth that middle aged men look for younger women as sex partners.

Some men have a similar reaction to their gradually declining levels of non-sexual strength and endurance. Instead of accepting that these changes are natural and understandable. A minority of men will rebel and try to prove that they are still young strong men, which they cannot be. They may associate muscular strength with virility and indulge with all sorts of excessive behaviour to prove that there is no diminution of their manhood.

When a man experiences the psychological/ emotional crisis of the male climacteric, the indicators are likely to be vague and hard to assess.

They are likely to be something more than the natural reflections of a mid-age man on the direction his life has taken and on what the future holds: often he feels a profound depression for no obvious reason and he may show some personality changes that put a strain on his relationships. The duration of this period is highly variable. It may be concentrated in a few months, or it may last for several years, on and off, during a mans 40's, 50's or early 60's.

## Handout: Caribbean Myths

Source:

By: Allison Y Lewis, Selwyn Ragoonanan, Rosalind Saint-Victor

Pub.: IPPF (1984) St. John's, Antigua

### *A. Myths about Menstruation*

1. If a girl or woman picks fruit while she is menstruating, the fruit will get sour.
2. If a girl/woman touches a fruit tree when she is menstruating, the fruit on the tree will become sour.
3. Having sex with a girl/woman when she is menstruating will be harmful to the man.
4. A girl/woman will get sick if she bathes during menstruation.
5. If menstruation does not occur in a girl by the time she is 13, the blood would go up in her head.
6. A girl/woman is absolutely safe from getting pregnant if she has sex during menstruation.

### *B. Myths about Masturbation*

1. Masturbation causes hair to grow on the palm of a boys/man/s hand.
2. Frequent masturbation causes baldness.
3. Masturbation causes pimples.
4. Masturbation causes blindness.

### *C. Myths about Virginity*

1. If there is no blood from the hymen when a girl has sex on her wedding night, it means that she is not a virgin.
2. If a man who has V.D. has sex with a virgin, he will be cured.

### *D. Myths about Venereal Disease*

1. If a man finds himself impotent (cannot attain an erection) when he attempts to have sex with a woman, this is a sign that the woman has V.D.
2. If a man who has V.D. has sex with a virgin, he will be cured.

*E. Myths about Male and Female Sexuality*

1. If a person does not become sexually active by a certain age, he/she will become ill.
2. No woman is raped who doesn't want to be raped.
3. When a girl/woman says "No" to sex, she doesn't really mean it.
4. Men with large penises make better lovers than men with small penises.
5. The general size of a man can tell you the size of his penis.
6. Woman with large breasts make better sexual partners than women with small breasts.
7. Men need to have sex more often than women.
8. A woman who enjoys having sex often is nymphomaniac.
9. For a man to be sexually fulfilled, he needs to have sex with more than one woman.
10. Handicapped or disabled people cannot have sex.
11. When people cross a certain age, and become old, they can no longer have sex.
12. If a pregnant woman has sex, the baby will be harmed.
13. You can tell all homosexuals by the way they behave/speak and/or dress.

14. Women who are strong and muscular, and are generally built like men, are lesbians.

*F. Myths about Pregnancy and Childbirth*

1. A girl/woman is absolutely safe from getting pregnant if she has sex during menstruation.
2. If a woman is sexually active but finds that she cannot get pregnant, it is a sure sign she is a mule.
3. If a pregnant woman has sex, the baby will be harmed.
4. If a woman looks upon a handicapped person during pregnancy, she will have a handicapped baby.
5. A woman has her 'lot' of babies to make, and if she doesn't have them out, she will get sick.
6. If a girl does not have a baby by the time she is 19, she is a mule.
7. Having sex in a standing position will not result in pregnancy.
8. Having sex in the sea will not result in pregnancy.

# Questionnaire Test-Yourself

**Direction:** You have come to the end of the fault session in the programme on ASRH. Please respond to the following items accordingly and check your responses with the key that the facilitators will give to you. This is not a pass/fail questionnaire; the aim is for you to check your knowledge on this area and give you an idea of what you need to focus as you prepare to embark on your training in the field.

## A. Female Anatomy

**Underline as appropriate**

1. Give another name for the birth canal *clitoris, labia, vagina*
2. Give another name for the passage way for urine *vagina, urethra, labia*
3. Give another name for the neck of the womb *uterus vagina, cervix*
4. Give another name for menstruation *ovum, labia, period*
5. It's function is to help to give sexual pleasure *Vagina, clitoris, labia*
6. It conveys the ovum from the ovaries *Tube, Hymen, Fallopian Tubes*
7. These are chemical messages in the blood stream *ovaries, foetus, hormones*
8. Give another name for a fertilized egg *ovum, ovary, embryo*
9. What does the abbreviation TSS stand for?  

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10. What does the abbreviation FSH stand for?

\_\_\_\_\_

11. What does the abbreviation LH stand for?

\_\_\_\_\_

12. Ovulation begins

\_\_\_\_\_

13. Name two (2) female hormones involved in the hormonal changes at adolescence

\_\_\_\_\_ *and*

\_\_\_\_\_

14. The foetus is a developing baby from

\_\_\_\_\_

15. True or false- The pituitary gland is located in the brain and produces all the hormones in our body

*T / F*

**TOTAL SCORE** /15 = \_\_\_\_\_ %

## Questionnaire Test-Yourself

**Direction:** You have come to the end of the fault session in the programme on ASRH. Please respond to the following items accordingly and check your responses with the key that the facilitators will give to you. This is not a pass/fail questionnaire; the aim is for you to check your knowledge on this area and give you an idea of what you need to focus as you prepare to embark on your training in the field.

### B. Female Anatomy (with answers)

**Underline as appropriate**

1. Give another name for the birth canal *clitoris, labia, vagina*
2. Give another name for the passage way for urine *vagina, urethra, labia*
3. Give another name for the neck of the womb *uterus vagina, cervix*
4. Give another name for menstruation *ovum, labia, period*
5. It's function is to help to give sexual pleasure *vagina, clitoris, labia*
6. It conveys the ovum from the ovaries *Tube, hymen, fallopian tubes*
7. These are chemical messages in the blood stream *ovaries, foetus, hormones*
8. Give another name for a fertilized egg *ovum, ovary, embryo*
9. What does the abbreviation TSS stand for? *Toxic Shock Syndrome*

10. What does the abbreviation FSH stand for? *Follicle Stimulation Hormone*
11. What does the abbreviation LH stand for? *Luteinising Hormone*
12. Ovulation begins *12 – 16 days before the next menstrual cycle*
13. Name two (2) female hormones involved in the hormonal changes at adolescence *Oestrogen and Progesterone*
14. The foetus is a developing baby from *4 – 6 weeks*
15. True or false- The pituitary gland is located in the brain and produces all the hormones in our body *T / F*

**TOTAL SCORE** /15 = \_\_\_\_\_ %

## C. Male Anatomy

Here is a list of words. Choose the correct one and write in the appropriate box. You may use one word more than once if necessary.

Sperm, testicles, semen, penis, scrotum, vas deferens, nocturnal emission, 100 – 500 million, testosterone, 100 – 300 million.

1. Spongy erectile tissue \_\_\_\_\_
2. Produces testosterone \_\_\_\_\_
3. Have heads and tails like a tadpole \_\_\_\_\_
4. Controls the temperature of the testicles \_\_\_\_\_
5. Another name for wet dreams \_\_\_\_\_
6. Whitish fluid, carries sperm \_\_\_\_\_
7. The release of semen \_\_\_\_\_
8. An enlarged and stiff penis \_\_\_\_\_
9. A male hormone \_\_\_\_\_
10. Carriers of sperms to mix with semen \_\_\_\_\_
11. Each ejaculation has how many sperms \_\_\_\_\_
12. Microscopic male cells \_\_\_\_\_

**TOTAL SCORE**          /12 =

## Male Anatomy (with answers)

### D. Male Anatomy

Here is a list of words. Choose the correct one and write in the appropriate box. You may use one word more than once if necessary

Sperm, testicles, semen, penis, scrotum, vasdeferens, nocturnal emission, 100 – 500 million, testosterone, 100 – 300 million.

- |  |                               |
|--|-------------------------------|
| 1. Spongy erectile tissue                    | <i>penis</i>                  |
| 2. Produces testosterone                     | <i>testicles</i>              |
| 3. Have heads and tails like a tadpole       | <i>sperm</i>                  |
| 4. Controls the temperature of the testicles | <i>scrotum</i>                |
| 5. Another name for wet dreams               | <i>nocturnal emissions</i>    |
| 6. Whitish fluid, carries sperm              | <i>seamen</i>                 |
| 7. The release of semen                      | <i>ejaculation.</i>           |
| 8. An enlarged and stiff penis               | <i>erection</i>               |
| 9. A male hormone                            | <i>Testosterone</i>           |
| 10. Carriers of sperms to mix with semen     | <i>Vas deferens</i>           |
| 11. Each ejaculation has how many sperms     | <i>100-600 million sperms</i> |
| 12. Microscopic male cells                   | <i>sperms.</i>                |

TOTAL SCORE /12 = \_\_\_\_\_ %

## E. Secondary Sexual Characteristics

Write **T** for true and **F** for false for the corresponding organs in female for the male organs.

1. Scrotum is clitoris ( )
2. Ovaries is testes ( )
3. Gland of clitoris is glands of penis ( )
4. Outer labia is scrotum ( )
5. Inner labia is a bulb of penis ( )

Fill in appropriately

6. The onset of adolescence \_\_\_\_\_

7. Name one skin problem associated with adolescence \_\_\_\_\_

Name the four (4) female secondary sex characteristics

8. \_\_\_\_\_ 9. \_\_\_\_\_

10. \_\_\_\_\_ 11. \_\_\_\_\_

Name four (4) male secondary sex characteristics

12. \_\_\_\_\_ 13. \_\_\_\_\_

14. \_\_\_\_\_ 15. \_\_\_\_\_

**TOTAL SCORE.**      /15= \_\_\_\_\_ %

## **F. General**

16. What is the difference between Pre-menopause and menopause?

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17. What are the consequences of lower testosterone levels in men in midlife?

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### **KEY**

1 → 50

### **INTERPRETATION**

1. Each section A – D has its own mastery of 60%
2. The overall mastery 76%  $\phi$  38/50
3. Please check your marks and make your corrections.

## G. Secondary Sexual Characteristics

Write T for True and F for False for the corresponding organs in female for the male organs.

1. Scrotum is clitoris ( F )
2. Ovaries is testes ( T )
3. Gland of clitoris is glands of penis ( T )
4. Outer labia is scrotum ( T )
5. Inner labia is a bulb of penis ( F )

Fill in appropriately

6. The onset of adolescence **puberty**
7. Name one skin problem associated with adolescence **acne**

Name the four (4) female secondary sex characteristics

8. \_\_\_\_\_
9. \_\_\_\_\_
10. \_\_\_\_\_
11. \_\_\_\_\_ (your selection)

Name four (4) male secondary sex characteristics

12. \_\_\_\_\_
13. \_\_\_\_\_
14. \_\_\_\_\_
15. \_\_\_\_\_ (your selection)

**TOTAL SCORE**      /15= \_\_\_\_\_ %

## H. General

18. What is the difference between Pre-menopause and menopause?

*(Pre-menopause- woman's period becomes irregular; menopause- woman's period has not menstruated for a full year.)*

19. What are the consequences of lower testosterone levels in men in midlife?

*(longer time to achieve erection. Longer refractory period- one ejaculate to another. Some may panic. Myth-need young woman.)*

### KEY

1 → 50 (give answers)

### INTERPRETATION

4. Each section A – D has its own mastery of 60%
5. The overall mastery 76% φ 38/50
6. Please check your marks and make your corrections.

# SESSION **Five**

## Contraceptive Technology in Adolescence

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### FLIP CHART

**General Considerations for providing  
contraceptive services to adolescents:**

- **Adolescent characteristics**
- **Provider characteristics**
- **Clinic characteristics**
- **Ethical considerations**

# **Adolescent Characteristics**

## **Physical Development**

- Menstrual cycle may be less regular
- Body still growing/different nutritional needs
- Small pelvic size
- Cervical ectopy

## **Cognitive Development/Abilities/Skills**

- Lack of information/understanding of reproductive functions
- Thinking /understanding less abstract
- Distortion of risk (“It can’t happen to me.”)
- Less future orientation/live in the present
- Denial of sexual behaviour
- Distortion of body image

## **Emotional/Psychological**

- Guilt
- Self-esteem
- Personal autonomy/separation from parents
- Questions authority (reactance)

## Social

- Often unmarried and fear criticism by parents, partner not supportive peers and providers
- More likely to have multiple partners and gender differences
- Peers an important source of information
- More vulnerable to sexual abuse/coercive relationships
- Media targeting youth promote sexual activity but rarely promote responsibility
- Gender inequity/double standards for boys and girls
- May not have access to money and transportation
- Communications with parent/relationship with parents
- Mixed messages from multiple sources, economic/
- Parenting/political dons.

# **Provider Characteristics**

## **Interpersonal interactions with providers KEY:**

- Nonjudgmental
- Respectful
- Trustworthy/confidential
- Competent
- Friendly
- Good communication
- Listen

## **Clinic Characteristics**

Clinics must:

- Be clean
- Be conveniently located
- Be open at convenient times for teens
- Be set up to encourage privacy
- Encourage use of services/do outreach
- Not have requirements restricting use of services
- Provide appropriate preventive and corrective services/referrals

## Pointers for Group Discussion (4 Groups)

### Group 1: Types of Methods -Side effects

*(See handout on side effects in TRB \_\_)*

Type of method	Side Effect



**Group 3: Hormonal Effects**

*(See handout on side effects in TRB \_\_)*

<b>Method</b>	<b>Hormonal Effects</b>

## **Group 4: Ethical Considerations/ Outreach Opportunities**

*(See handout on HELPING CHOOSE: A METHOD (good & bad dialogues in TRB )*

### **Ethical Considerations**

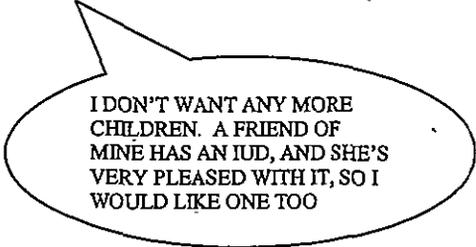
- Confidentiality
- Nonjudgmental provider attitudes
- Vulnerability to be coerced.

### **Outreach Opportunities**

- Postcoital
- Contraceptive/Emergency Contraception
- Postabortion care
- Provision of methods e.g. OC & condoms
- Health fairs
- Libraries or Health Centres

# HELPING CHOOSE A METHOD (Good & Bad Dialogues)

1. CLIENT

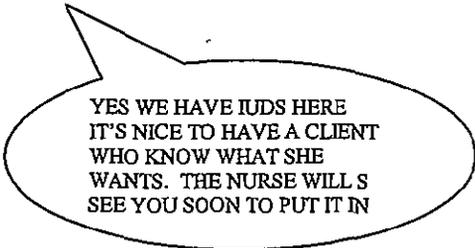


I DON'T WANT ANY MORE CHILDREN. A FRIEND OF MINE HAS AN IUD, AND SHE'S VERY PLEASED WITH IT, SO I WOULD LIKE ONE TOO

What is **wrong** with these dialogues?

1. The provider does not check what the client knows about the IUD.

2. PROVIDER



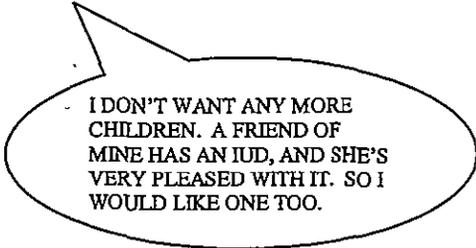
YES WE HAVE IUDS HERE IT'S NICE TO HAVE A CLIENT WHO KNOW WHAT SHE WANTS. THE NURSE WILL S SEE YOU SOON TO PUT IT IN

The provider does not check whether the client knows that other methods are available.

2. The provider ignores what the client wants.

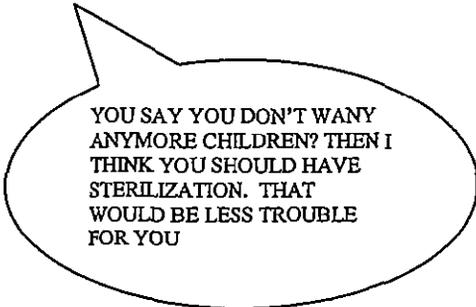
The provider tries to tell the client what method to use. She does not think the client should make her own decision.

3. CLIENT

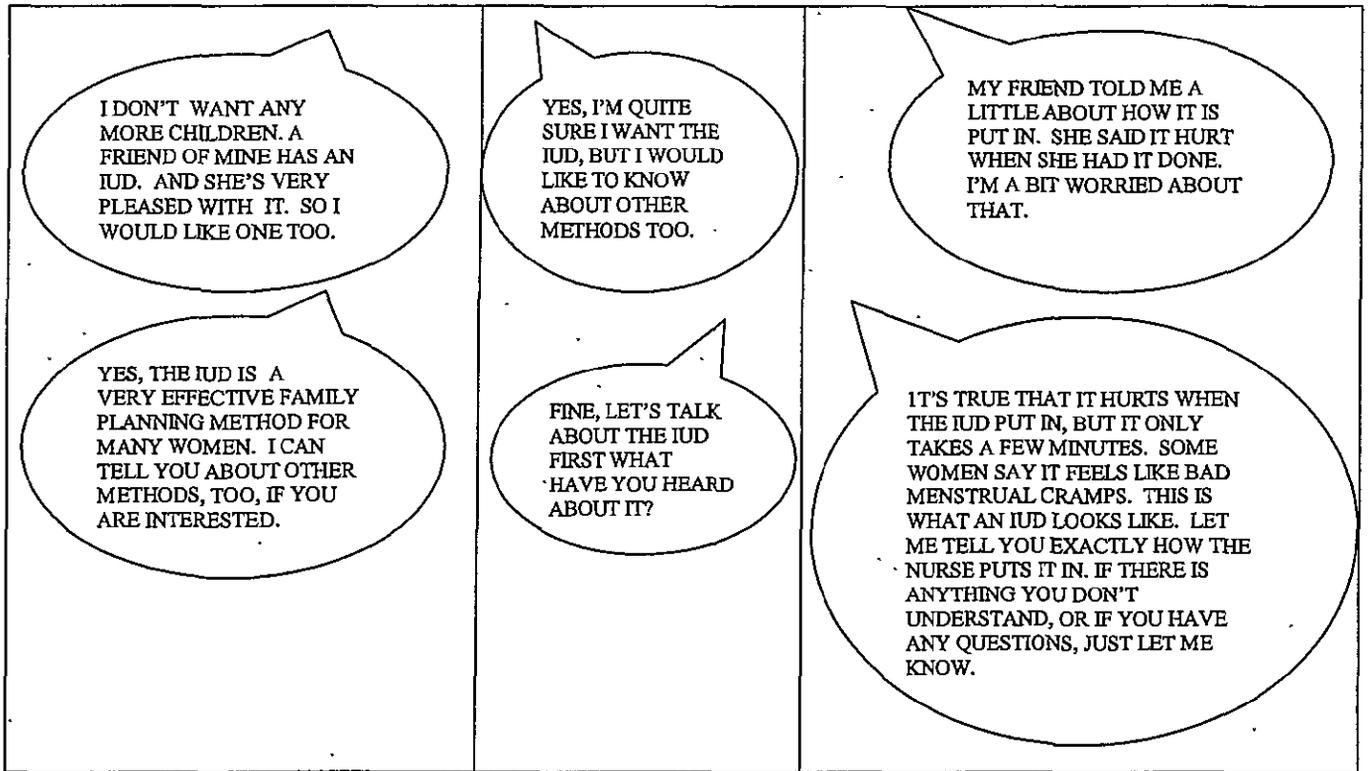


I DON'T WANT ANY MORE CHILDREN. A FRIEND OF MINE HAS AN IUD, AND SHE'S VERY PLEASED WITH IT. SO I WOULD LIKE ONE TOO.

4. PROVIDER



YOU SAY YOU DON'T WANT ANYMORE CHILDREN? THEN I THINK YOU SHOULD HAVE STERILIZATION. THAT WOULD BE LESS TROUBLE FOR YOU



What is **good** about this dialogue?

- The provider does not try to change her client's decision.
- The provider tells her client that there are other methods.
- The provider shows an IUD and promises to explain how the nurse will put it in.
- The provider listens and responds honestly to the client's concern about pain.

# Handout: The Gather Method



## Greet

Greet client

## Ask

Ask client about themselves

## Tell

Tell about Fp methods

## Help

Help client choose a Method

## Explain

Explain how to use a method

## Return

Return for follow-up

<b>Help Clients Choose A Method</b>	<b>Explain How to Use A Method</b>	<b>Return for Follow Up</b>
<p>Help each client match family plans, needs, and preferences with a family Planning method. Listening and Questioning are important here (See page 4.)</p> <p>Ask clients if there is a method they would like to use. Some will know what they want. Others will need help thinking about the choices.</p> <ul style="list-style-type: none"> <li>• To help clients choose, ask them about their plans and their family situations. If the client is uncertain about the future, start with the present: What is the client's family situation now?</li> <li>• Ask clients what their sexual partner wants. What method would he or she like to use.</li> <li>• Ask clients if there is anything they do not understand. Repeat information when necessary.</li> <li>• Some method are not safe or for some clients. When a method is not safe, tell the client and explain clearly. Then help the client choose another method.</li> <li>• Check whether the client has made a clear decision. Specifically</li> </ul>	<p>After the client has chosen a method:</p> <ul style="list-style-type: none"> <li>• Give her or him supplies, if appropriate.</li> <li>• If the method cannot be given immediately, tell the client how, when, and where it will be provided.</li> <li>• For some methods, such as voluntary sterilization, the client may have to sign a consent form. The form says that the client wants the method, has been given information about it, and understands the information. Help the client understand the consent form.</li> <li>• Explain how to use the method.</li> <li>• Ask the client to repeat the instructions. Listen carefully to make sure she or he remembers and understands</li> <li>• Describe any possible side effects and warning signs. Clearly tell the client what to do if they occur.</li> <li>• Ask the client to repeat this information.</li> <li>• If possible, give the client</li> </ul>	<p>At the follow-up visit:</p> <ul style="list-style-type: none"> <li>• Ask the client if she or he is still using the method.</li> <li>• If yes, ask the client if she or he has any problems with the method.</li> <li>• Ask if the client is having any side effects, mentioning them one at a time.</li> <li>• If so, find out how severe they are. Reassure clients with minor side effects that they are not dangerous. Suggest what they can do to relieve them. If side effects are severe, refer for treatment. (See page 24.)</li> <li>• Ask how the client is using the method. Check to see that it is being used correctly.</li> <li>• Ask if the client has any questions.</li> </ul> <p>If a client wants to try another method:</p> <p><b>Tell the client about other methods again and help the client to choose another. Remember- changing methods are not bad. It is normal. No one really can decide on a method without trying it. Also, a</b></p>

<p>ask "What method have you decided to use?"</p> <p>Use the yellow chart on pages 10 and 19 to help clients choose a method.</p>	<p>printed material about the method to take home</p> <ul style="list-style-type: none"> <li>• Tell the client when to come back for a follow-up visit.</li> <li>• Tell the client to come back sooner if she or he wishes or if side effects or warning signs occur.</li> </ul>	<p><b>person's situation can change. Then another method may be better.</b></p> <p>If a client wants to have a child, help her to stop her method. Refer her to have her method removed, if necessary. Prenatal care is important. Tell your client where to go for prenatal care when she becomes pregnant.</p>
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## How to Help Clients with Problems on the Return Visit

Clients have different reasons for making a return visit. Sometimes they want more supplies. Sometimes they come for routine follow-up. Sometimes they have questions or problems with their method. Sometimes they want a new method. Sometimes they want to stop using family planning.

Clients making return visits are important. They all deserve your attention. You can ask these clients if they like their choices and help them if they have problems. Here are some suggestions for helping clients who have side effects, medical complications, or other problems with their methods

# Side Effects

All new pill or IUD users: Tell them that side effects will probably stop after they use their methods for three months. If clients have side effects that they cannot tolerate, always offer to help them choose another method. If clients are very ill, always refer them to a nurse, midwife, or doctor.

Here are some other suggestions:

If a client has:

**(1) Bleeding between periods that lasts less than 7 days**

Pill client: This is not harmful. Tell her to make sure that she takes her pills at the same time every day.

Clients using other methods: Reassure them that this is not harmful.

If bleeding between periods last 7 days or more, refer the client to a nurse, midwife, or doctor.

**(2) Cramping between periods:**

Reassure clients that this is not harmful. Offer acetaminophen or aspirin.

**(3) Headaches:**

If clients who take pills or injectables have severe headaches that do not stop, refer them to a nurse, midwife, or doctor. Otherwise, give acetaminophen or aspirin.

**(4) Painful and/or heavy periods:**

If periods are twice as long as usual or if clients use twice as many pads, refer them to a nurse, midwife, or doctor. If not, reassure clients that this is not harmful. Give

## Serious Medical Complications

If a client has any of the warning signs for pills, IUDs, or injectables (see the blue chart, pages 8 and 21), she needs to see a nurse, midwife, or doctor.

If tubal ligation or vasectomy clients return with red, swollen incision sites that drain pus or blood, clean their

## Other Problems

Clients may have other problems with their methods. Some may forget their method correctly. Some may have heard rumors about their methods. Listen to their

acetaminophen or aspirin for pain.

**(5) Tender breasts and/or weight gain:**

Check whether the client is pregnant.

Client using pills, IUD, or injectables: If pregnant, stop the method. If not, reassure her that this is not harmful.

Clients using other methods: Tell them that these are not usual side effects of other methods.

**(6) Late or missing menstrual periods:**

Check whether the client is pregnant. If so, stop pills, injectables, or IUD. If not:

Pill client: Make sure that she is taking her pills correctly.

Client using injectables: Tell her that this is a common side effect. It is not harmful. It does not mean that she is pregnant.

Client using an IUD: If she has missed two or more periods, refer her to a nurse, midwife, or doctor.

**(7) Nausea and dizziness:**

Check whether the client is pregnant. If so, stop pills, injectables, or IUDs.

Pill client: Tell her to take her pills with food.

Client using injectables: Refer her to a nurse, midwife or doctor.

Client using an IUD: Tell her that nausea and dizziness are not usual side effects of the IUD. Refer her to a nurse, midwife, or doctor if she wishes.

wounds with soap and water and apply clean dressings. then send them to a nurse, midwife, or doctor. A woman

with a tubal ligation who returns with severe abdominal pain or fever within one month needs to see a nurse, midwife, or doctor. So does a man with a vasectomy who has a very swollen and painful scrotum or a fever.

Problems. Answer their questions. Then help them decide if they want to continue using their methods. If not, help them choose another method.

## Why Counselling Counts!

### What is Counselling?

Counselling is one person helping another, as they talk face-to-face. Counseling is one of your most important tasks as a family planning provider. You can do it every day almost every time you talk with a client.

Through counseling you help clients choose and continue to use correctly the best family planning methods for them. The best method is: (1) one that is safe for the client and (2) one that the client wants to use.

Show your clients that you care. Give them correct information. Then they will trust and listen to you. They will use family planning longer. They will come back to you if they have problems. They will tell their friends about family planning.

Good counseling is not hard, but it takes skill. You can counsel well if you believe in family planning and if you learn to:

- Show your clients that you want to help them.
- Find out and understand how your clients feel
- Give your clients accurate information, and
- Help them make their own decisions about family planning.

## **Elements of Informed Choice**

Counseling is an interactive process, where the provider listens to the client's needs, tries to elicit the client's concerns, and offers relevant information to better enable the client to make decisions. The process ideally includes the provider giving a balanced presentation of the advantages and disadvantages of each method and asking the client what she understands about the choices available to her. WHO and others have stipulated the importance of providers NOT coercing or **overly emphasizing certain methods over others**

**The following is a summary of recommendations made by the International Planned Parenthood Federation based on their evaluation of the association between counseling, quality of care, and method continuation:**

1. Counseling on contraception should be focused mainly on the essential information and discussions needed by the client to make an adequate contraceptive choice and for using the method properly and consistently.
2. Counseling should be restricted to the number of issues that can be properly discussed within the available time. The amount of information provided during a counseling session should be accordance with what the client can understand and retain in her memory. We must remember that the process of learning should be a continuous one, and that no one should be expected to learn in one counseling session more than what is reasonably possible.
4. Service providers must remember that every client has different needs and levels of knowledge and understanding of family planning. Therefore the focus of counseling, the counseling techniques and the time spent with the client should be tailored according to the characteristics and needs of the individual client.

The Cooperative Agencies Task Force on Informed Choice has defined further elements of informed choice. The following report summary is taken from: Cooperative Agencies Task Force on Informed Choice. Informed Choice: Report of the Cooperative Agencies Task Force. Baltimore MD, The Johns Hopkins University, 1989.

### **Pointers**

- Show your clients that you care
- Give them correct information  
(they will trust you and listen to you)
- They will use the Fp method longer, they will come back to you if a problem arises. They will tell their friends about Fp
- Find out and understand how your client feels
- Give your client accurate information.
- Help them make their own decisions about Fp

### **A Quick Reminder**

- **Greet** the client politely
- Ask the client how you can help, and offer your time
- Hold the counseling session in a **private place** where no one else can hear.
- Encourage the client to **ask question**

- Ask the client if she or he has **any worries** about family planning or any of the methods.
- **Listen** carefully to what the client says.
- Try to put yourself in the client's place and **respond** to her or his feelings.
- Take a brief **medical and reproductive history** to check if any methods are not safe for the client.
  
- Briefly tell the client about the family planning methods she or he can choose from
- **Use booklets, leaflets and contraceptive samples** when you are explaining the methods
- Let the client choose which method to use.
- Tell the client how to use the chosen method correctly
- Describe any physical examinations, laboratory tests, or other clinical procedures that the client will need.
- Explain possible side effects and warning signs, and tell the client what to do if they occur.
- Ask the client to repeat the instructions.
- Give the client a leaflet or booklet with instructions to take home, if possible.
- Tell the client where to obtain more supplies, if appropriate

- Tell the client when to return for follow-up or when to expect your next visit.
- Tell the client to return any time if she or he has problems or worries.
- Tell the client that it is all right to return for another method if the one chosen does not suit her or him.

# **SESSION** **Six**

## Promoting Healthy Lifestyles in Adolescence

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### **Handouts on:**

#### **Summary**

##### **Promoting Healthy Lifestyles in Adolescence**

- Adolescents perspectives on the changes and events they go through are often very different from those of adults
- Adolescents and adults need to listen to one another and each other and be receptive to facilitate a free exchange between adolescents and adults.
- Your gender and adolescent status can affect your response to adolescents health related, lifestyles concerns

## **The Policy On The Perspective Of Effective Contraceptives To Minors**

- In making policy changes one has to view the health of adolescents from a holistic perspective and take into account the spiritual, psychological and emotional health of the adolescent as well as their physical health.
- The differences in perspectives are partly affected by the perception of people concerning their power or powerlessness. The same policy may empower certain adolescents and victimize others. To the extent that one perceives that a policy change may increase the victimization of one's child or oneself by more powerful groups in the society, this policy will be resisted.

To the extent that the policy in fact, does increase the opportunities for victimization or exploitation of weaker groups by more powerful groups, the policy SHOULD be resisted. The rights of parents to protect the lives of their children and unborn grandchildren have to be balanced against the rights of adolescents to access contraceptives. The issue of adolescent rights and responsibilities has to be considered jointly with the rights and responsibilities of their parents / guardians as these persons also have to bear the outcomes of adolescent sexual experimentation or contraceptive failure.

- For a model of ethical decision-making, which can be used to guide people, please see the attachment.
- Adolescent concerns tend to be about the immediate future, while the concerns of adults are for the longer term. This fact combined with changing body characterizes, the desire to conform to the norms of the peer group; results in the tendency to pursue immediate gratification without adequately considering the long-term repercussion of their behaviour. Adults also have to exemplify the behaviour that they advocate (very important)

- A decision-making and / or decision-valuing model can be useful as a guide to Health Lifestyles. The following is one such model (Decision Valuing)

## **What is Moral And What is Immoral**

All our decisions need to be based upon the universal wish for acceptance and love and centered on the concern for the improvement of human relationships. The following moral code has been developed by Dr. Lester A. Kirkendall to serve as a basic for building a life-affirming moral code.

The criteria are:

### **Moral Behaviour Leads To:**

<b>Moral Behaviour Leads to:</b>	<b>Immoral Behaviour Leads to:</b>
Integrity in relationships	Duplicity in relationships
Trust of others	Distrust of others
Broadening of human sympathies	Barriers between persons and between groups
Co-operative attitudes	Un-co-operative hostile attitudes
Enhanced self-respect	Diminished self-respect
Consideration of others' rights and needs	Exploitation of others
Individual fulfillment and zest for living	Stunning of individual growth and disillusionment

**SESSION**  
**Eight**  
Introduction To Sexuality

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**Clarification of words/terms**

<b>Sex</b>	Sex refers to one's reproductive system (biology) and gender behaviour as male and female. It has to do with biology, physiology
<b>Sexuality</b>	It is the total expression of who we are as human beings. It encompasses, our whole psycho-social development – over values, mental attitudes, physical appearances, beliefs, emotions, personality, likes and dislikes, our spiritual selves, and all the ways in which we have been socialized. It involves our sexual identity, psychic orientation, our entire self –concept. It begins at birth and lasts a lifetime.
<b>Gender Roles</b>	Gender roles are the set of rules laid down by society that say what is appropriate behaviour for persons of our sex. The rules are established by culture, not biology and are usually assigned to us at birth, as soon as someone

	announces, "it's a boy or it's a girl."
<b>Gender Identity</b>	Gender identity is the personal private conviction each of us has about being feminine or masculine. It is the case of how we feel about who we are. It probably becomes fixed around the age of two (2) years old. It is <i>sexual identity</i> .
<b>Self -Esteem</b>	<p>Self –esteem is the way a person view one's self. There are four (4) conditions that must be present for a person to have high self-esteem.</p> <ol style="list-style-type: none"> <li>1. Uniqueness – an individual must feel that he or she is special.</li> <li>2. Connectedness – an individual must feel as though he belongs to some one or to some thing.</li> <li>3. Power – an individual must feel empowered.</li> <li>4. Model – an individual must have a role model to emulate.</li> </ol>

*NB. It is important to note that just because a person has high self-esteem that does not automatically mean that that he has positive based self–esteem. Example, a drug dealer, pimp or murderer can have high self-esteem but it is certainly not positively based.*

*Positive Based Self-Esteem edifies the physical, emotional and spiritual development of an individual and is evident in the behaviour and character of that individual.*

# Introduction to Human Sexuality

Sex refers to one's reproductive system (biology) and gender behaviour as male and female. It has to do with biology, anatomy, and physiology. Gender refers to the psychosocial and cultural aspects of maleness and femaleness.

Sexuality is the total expression of who we are as human beings. It encompasses our whole psycho-social development-our values, mental attitudes, physical appearance, beliefs, emotions, personality, likes and dislikes, our spiritual selves, and all the ways in which we have been socialized, etc. It involves our sexual identity and psychic orientation our entire self-concept. It begins at birth and lasts a lifetime.

Masculinity and Femininity relate to sexuality as 'male' and 'female' relate to sex. Generally, they are defined in the light of particular stereotyped gender roles. A stereotype is something conforming to a fixed pattern, a pattern built up in our minds by the myths, values, attitudes, traditions, and practices of the culture we grow up in.

Sources of Sexual Learning are all the factors that contribute to our psycho-social development-family values, religious beliefs, parental teachings, societal norms, etc.

Gender Roles are the set of rules laid down by society that say what is appropriate behaviour for person of our sex. The rules are established by culture, not biology, and are usually assigned to us at birth, as soon as someone announces, 'it's a boy' 'it's a girl'.

For example, the color blue is usually associated with boys; pink, with girls. Most boys are taught to suppress their feelings through sayings like 'big boys don't cry' while girls are encouraged to express theirs. Even the toys that we buy help to teach children gender role expectations. Dolls, tea sets, cooking utensils teach girls about nurturing while boys play with guns, cars, toy trucks, erect-a-sets.

Men are thought to be stronger than women, both physically emotionally while women are thought to be weak. In some cultures, these notions are

reflected in local customs observed when a baby is born—if it's a boy, the father is hit with a stick, and if it's a girl, water is poured on him.

Gender Identity is the personal, private conviction each of us has about being feminine or masculine. It is at the core of how we feel about who we are.

It probably becomes fixed around the age of two years. It is also called sexual identity.

Sexual Orientation refers to a preference for sharing sexual expression with members of the opposite sex, members of our own sex, or members of both sexes. These preferences may be socially determined, biologically determined, or both we cannot be sure.

Sexism is the conscious or unconscious assumption that members of one sex are, on the whole superior in certain attributes to members of the other sex, solely by virtue of their sex. It confuses biology with culture.

## **Sexual Patterns/Pair Bonding/Orientations**

Heterosexual (straight) preferring emotional/sexual partners of the opposite sex.

Homosexual preferring emotional/sexual partners of the same sex. (The term gay is commonly used by men who prefer same-sex partners, though it can refer to women as well. The more usual term for women who prefer same-sex partners is lesbian.)

Bisexual enjoying emotional/sexual partners of both sexes.

Celibate is one who remains unmarried for religious reasons or takes an oath of celibacy— one who abstains from sexual intercourse.

Asexual having little or no sex drive. Though asexual persons are physically and psychologically male or female, neither sex stimulates them sexually. They have no desire for sex.

## **Sexual Behaviours**

Sexual Behaviours covers a wide range of sexual expressions including kissing, sexual intercourse, masturbation, etc. The following list of sexual behaviours may be considered non-standard or deviant in most cultures.

Incest – sexual intercourse between blood-related family members (e.g., father and daughter, sister and brother).

Frotteurosexual – deriving sexual pleasure from rubbing one's genitals against another person.

Pedophilia – deriving sexual pleasure from children (child molestation)

Pederasty – deriving sexual pleasure from young boys.

Voyeurism – deriving sexual excitement from observing others undressing, having sexual intercourse, kissing, masturbating, petting etc. Sometimes voyeurs are called 'Peeping Toms'.

Coprophilia – deriving sexual pleasure from feces, filth, dirt, soiled underwear, etc.

Necrophilia – deriving sexual pleasure from intercourse with a corpse.

Satyriasis – in men, excessive desire for sexual intercourse.

Nymphomania – in women, excessive desire for sexual intercourse.

Oral Sex – cunnilingus, fellatio, annilingus. Cunnilingus is mouth-to-vulva, fellatio is mouth to penis, annilingus is mouth-to-anus.

Transsexual – a man or woman, most often a man who believes himself trapped in the wrong body and seeks a operation to make his body look more like that of the opposite sex.

Transvestite – usually a heterosexual, not homosexual, man who derives sexual pleasure from wearing women's clothes.

Sodomy – anal intercourse.

Somnophilia – dependent on the fantasy or actually intruding on and fondling a sleeping stranger for sexual arousal.

Troilism – two people engaged in sexual activities while a third person observes.

Asphyxophilia – sexual arousal from employing partial asphyxiation, as by hanging, choking (usually an adolescent male).

Narratophilia – sexual arousal from listening to erotic narratives in song, story, etc.

Pictophilia – sexual arousal dependent on sexy pictures.

Sado-Masochist – Sexual arousal from inflicting and receiving pain.

Drag Queens – a male homosexual who dresses flamboyantly in exaggerated imitation of a woman.

Gerontosexual – sexual pleasure from having intercourse with an old woman or man.

Bestiality/Zoophilia – sexual pleasure from intercourse with animals.

Exhibitionism – sexual pleasure from exposing genitals.

Urophilia – sexual pleasure from urine.

Self – Esteem and Decision Making Planned Parental Association of South Africa Family Life Education 3-113

## Discussion Topics For Four (4) Groups for Activity F. 2

Divide participants into 4 groups to discuss the following:

- Group 1** - Messages they have heard about sexuality from the electronic print media
  
- Group 2** - Messages they have heard about sexuality from friends and romantic partners.
  
- Group 3** - Messages they have heard about sexuality from the church, school, parents and older relatives.
  
- Group 4** - Messages they have heard on sexuality from direct experience in relationships with significant others.

*(Point out that they can record whatever they have heard or learnt directly. There are no right or wrong answers – rather it is experience sharing.)*

# Flip Charts Titles To Record Responses

## Comparison of messages

Similarities	Differences

Why do these similarities and differences occur?

<b>Male Messages</b>	<b>Female Messages</b>

Why do these similarities and differences occur?

Do some of these messages create an unrealistic view about sexuality?

Which messages are positive?

Which messages are negative?

3. Uncomfortable messages  
(List them)
4. Important messages a parent can give to a child on sexuality  
(list them)

# Children Learn What They Live

If a child lives with criticism, he learns to condemn.

If a child lives with hostility, she learns to fight.

If a child lives with ridicule, he learns to be shy.

If a child lives with shame, she learns to feel guilty.

If a child lives with tolerance, he learns to be patient.

If a child lives with encouragement, she learns confidence.

If a child lives with praise, he learns to appreciate.

If a child lives with fairness, she learns justice.

If a child lives with approval, he learns to like himself.

If a child lives with acceptance and friendship, she learns to  
find love in the world.

# SESSION Nine

## Sexuality and Gender Issues

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### Clarification of words, terms

<b>Sex</b>	The biological identity of a person – boy/girl
<b>Sexuality</b>	Total expression of who we are as a human being. It encompasses our whole psycho-social development – our values, mental attitudes, love, sexual physical appearance, physical sexual activity, beliefs, emotions personality, likes, dislikes, our spiritual self and all the ways in which we have been socialized.
<b>Gender</b>	The socially constructed roles and responsibilities assigned to males and females in a given culture or location.
<b>Gender Identity</b>	This is one's personal sense of "maleness" or "femaleness"
<b>Gender Roles</b>	This is the expression through behaviours and expression of "maleness" or "femaleness"
<b>Gender Equity</b>	Allows a woman to be considered for all the opportunities afforded male in the society.
<b>Gender Stereotype</b>	Holding an unjustifiably fixed, rigid or standardized view to which other people

	or things are supposed to conform.
<b>Gender Equality</b>	Equality between the sexes is by definition impossible. Were the two sexes equal, strictly speaking there would not be two sexes but one. Equality means being the same, while equity is being fair.
<b>Gender Discrimination</b>	Unfavourable treatment based on prejudice especially regarding race, colour, age and/or sex.
<b>Gender Script</b>	A device for guiding action and for understanding it. They are plans that persons may have in mind to do or what have been done
<b>Sexual Health</b>	Is the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love

## **HANDOUT: WHY IS GENDER IMPORTANT**

A gender analysis of differences in the condition (material welfare) and position (status) of males and females in Jamaica as these affect their sexual and reproductive health reveals the following:

### **I. Employment:**

1. Among all age groups, most females than males in Jamaica are unemployed. In 1997, 23.5% of women were unemployed versus 10.6% of men.
2. Among young people under 25 years, more females than males were unemployed in 1997, 59.4% of women as against 35.6% of men in the same age group were unemployed.
3. While redundancies and lay-offs have affected both men and women, more females than males have been adversely affected.

### **II. Education:**

1. More males than females in Jamaica, drop out of school, repeat grades and perform badly
2. The enrollment of males drops progressively as they progress from the primary to the secondary to the tertiary level. In 1998, more females than males graduated from UWI, 71% females to 29% males.
3. More males than females choose natural science subjects in high school and more females choose arts subjects.

4. More males than females complain of being humiliated harassed and discriminated against by female teachers and complaints are particularly severe among those attending comprehensive schools.
5. More females than males are exposed to Sex and Family Life Education in and outside of schools. In 1997, some 86% of girls 15-17 versus 81% of boys had received FLE.
6. Mothers are a major source of information but fathers provide very little on matters relating to sex and family life. Yet parents are the preferred source of information.
7. Females 15-19 are more knowledgeable about sex and reproductive health than males. Eg. In the contraceptive Prevalence Survey (CPS) of 1993, 26% of females versus 10% of males knew when it was most likely that a woman would become pregnant during the menstrual cycle.

### III. Sexual Activity.

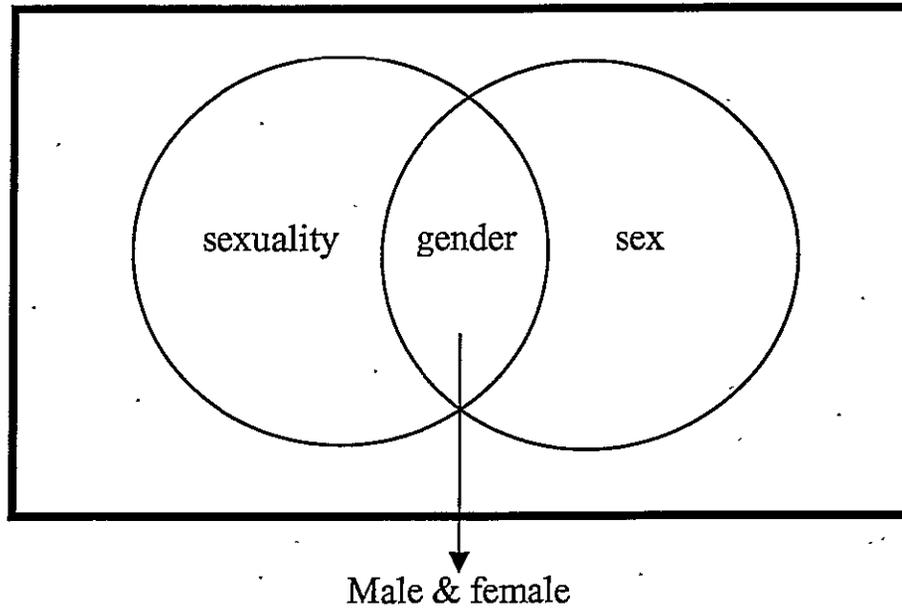
#### Investigate:

- **An early start:** Young men start having sex at a younger age than the girls in 1997. 48.6% of 15 old boys versus 15.5% of fifteen year old girls reported that they had had sex
- **Unsafe sex:** In 1997, a total of 56% of girls < 14 years to 19 years used a contraceptive at first sex as against 31% of boys in the same age group. Both male and female teenagers rely on the condom and to a lesser extent, the pill.
- **More casual partners:** Teenager boys have more casual partners than teenage girls. In 1993, 82% of females versus 46% of males reported that their first partner was their boyfriend/girlfriend. The remainder said that their first partner was either a friend with no sense of commitment or a casual acquaintance.

## Girls have:

- **More mistimed pregnancies:** Between 1989 and 1997, the teenage birth rate increased from 102 births per 1000 teenagers to 112 births in 1997. Some 79% of the pregnancies among girls 15-19 were reported as being mistimed while 4% were unwanted and only 13% were wanted.
- **More health risks:** Teenage girls who become pregnant and who do not receive help are likely to have more children and these children are closely spaced with bad consequences for the nutrition and health of mother and child.
- **More social handicaps and psychological trauma:** Teenage mothers are less likely to complete their education and are less likely to obtain well paying jobs later on unless they receive help. They are also more likely to be ridiculed and upbraided for becoming pregnant while their boyfriends are praised by the society for impregnating them. The boys are prevented from completing their education.

## Venn Diagram: Showing The Relationship Between Sex, Sexuality And Gender



**SEXUAL DEVELOPMENT THROUGH THE LIFE CYCLE**

**FLIP CHART**

**Sexual Development Phases**

Infant & Toddlers	Chn. 3-7 yrs	Pre/adolescence 8-12 yrs	Adolescence 13-19 yrs	Adults 20+ yrs

# Facilitator's Resource

## Circles of Sexuality

### SENSUALITY

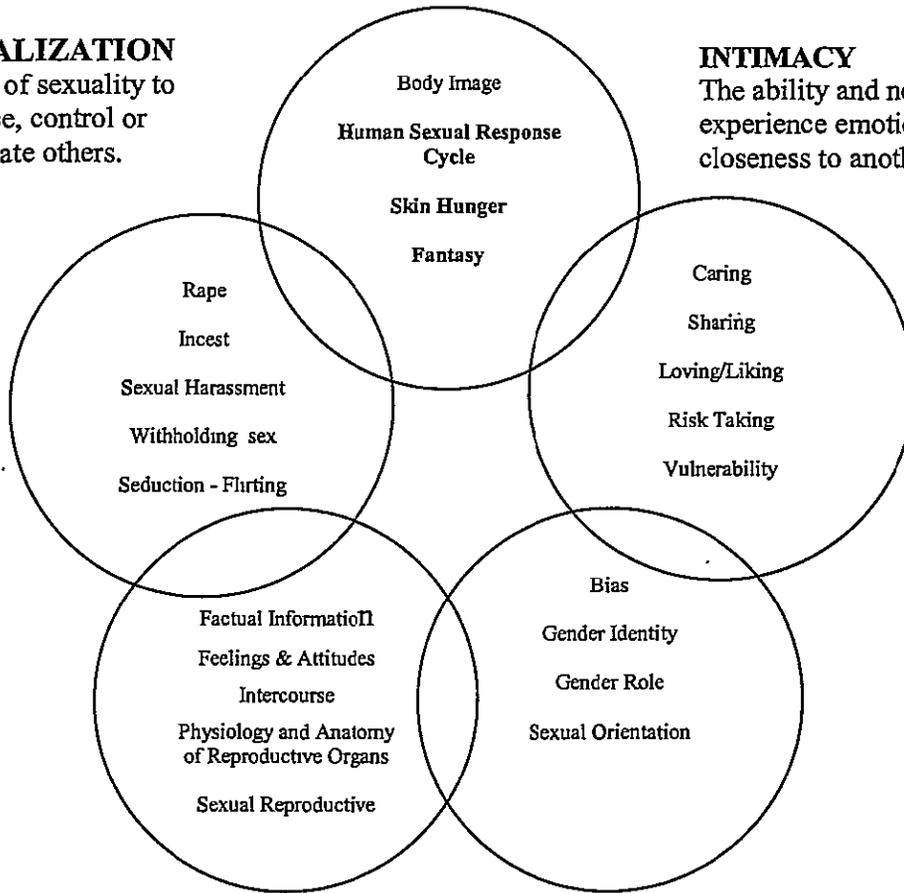
Awareness, acceptance of and comfort with one's own body; physiological and psychological enjoyment of one's own body and the bodies of others.

### SEXUALIZATION

The use of sexuality to influence, control or manipulate others.

### INTIMACY

The ability and need to experience emotional closeness to another



### SEXUAL HEALTH AND REPRODUCTION

Attitudes and behaviors related to producing children, care and maintenance of the sex and reproductive organs, and health consequences of sexual behavior

### SEXUAL IDENTITY

The development of a sense of who one is sexually, including a sense of maleness and femaleness

Sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she or he will become. It includes all the feelings, thoughts and behaviours of being female or male, being attractive and being in love, as well as being in relationships that include sexual intimacy and physical sexual activity.

### **Circle 1:**

SENSUALITY is awareness and feelings about your own body and other people's bodies, especially the body of a sexual partner.

Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give others and us. This part of our sexuality affects our behaviour in several ways:

- ✓ Need to understand anatomy and physiology – with knowledge and understanding, adolescents can appreciate the physiology of their bodies.
- ✓ Body Image – whether we feel attractive and proud of our own bodies and the way they function influences many aspects of our lives. Adolescents often choose media personalities as the standard for how they should look, so they are likely to be disappointed by what they see in the mirror. They may be especially dissatisfied when the mainstream media does not portray positively, or at all, their types of skin, hair, eyes, body sizes of other physical characteristics.
- ✓ Experiencing pleasure and release from sexual tension - sensuality allows us to experience pleasure when others or we touch certain parts of our bodies. As the culmination of the sexual response cycle, males and females can experience

orgasm when they masturbate or have a sexual experience with a partner.

- ✓ Satisfying skin hunger – our need to be touched and held by others in loving, caring ways is often referred to as skin hunger. Adolescents typically receive less touch from family members
- ✓ than do young children. Therefore, many teens satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from a teen's need to be held, rather than from sexual desire.
- ✓ Feeling physical attraction for another person – the centre of sensuality and attraction to others is not in the genitals, but in the brain, the most important “sex organ.” The unexplained mechanism responsible for sexual attraction rests here.
- ✓ Fantasy – the brain also gives us the capacity to have fantasies about sexual behaviours and experiences. Adolescents often need help understanding that the sexual fantasies they experience are normal, but do not have to be acted upon.

## **Circle 2:**

SEXUAL INTIMACY is the ability and need to be emotionally close to another human being and have their closeness returned.

Sharing intimacy is what makes personal relationships rich. While sensuality is about physical closeness, intimacy focuses on emotional closeness. Several aspects of intimacy include:

- ✓ Liking or loving another person –having emotional attachments or connections to others is a manifestation of intimacy.
- ✓ Emotional risk-taking – to have true intimacy with others, a person must open up and share feelings and personal

information. We take a risk when we share our thoughts and emotions with others, but it is not possible to be really close to another person without being honest and open with them.

As sexual beings, we can have intimacy with or without having sexual intercourse. In a full and mature romantic relationship between two people, the expression of sexuality often includes both intimacy and intercourse. Unfortunately, intimacy established through caring and good communication is not always a part of adolescents' sexual experiences.

### **Circle 3:**

**SEXUAL IDENTITY** is a person's understanding of who she or he is sexually, including the sense of being male or female.

Sexual identity can be thought of as three interlocking pieces that together, affect how each person sees her or him. Each "piece" of sexual identity is important.

Gender identity – knowing whether you are male or female. Most young children determine their gender by age two. Gender role – knowing what it means to be male or female, or what a man or woman can or cannot do because of their gender. Some things are determined by the way male and female bodies are built. For example, only women menstruate and only men produce sperm. Other things are culturally determined in our culture only women wear dresses to work, but in other cultures, men wear skirt-like outfits everywhere.

There are many "rules" about what men and women can/should do that have nothing to do with the way their bodies are built. This aspects of sexuality is especially important for young adolescents to understand, since peer and parent pressures to be "macho" or "feminine" increase at this age. Both boys and girls need help sorting out how perceptions about gender roles affect whether they are encouraged or discouraged to make certain choices regarding relationships, leisure activities, education and careers.

Sexual orientation – whether a person’s primary attraction is to people of the same gender (homosexuality), the other gender (heterosexuality) or both genders (bisexuality).

- ✓ Sexual orientation generally begins to emerge by adolescence.
- ✓ Between 3 and 10 percent of the general population is believed to be exclusively homosexual.
- ✓ Heterosexual, gay, lesbian and bisexual youth can all experience same-gender sexual activity around puberty. Such behaviour, including sex play with same gender peers, crushes on same-gender adults or sexual fantasies about people of the same gender are normal for pre-teens and young teens and are not necessarily related to sexual orientation.

#### **Circle 4:**

REPRODUCTION and SEXUAL HEALTH are the capacity to reproduce and the behaviors and attitudes that make sexual relationships healthy, physically and emotionally.

Specific aspects of sexual behavior and reproduction that belong in this circle include:

- ✓ Factual information about reproduction is necessary to understand how male and female reproductive systems work and how conception occurs. Adolescent typically have inadequate information about their own or their partners’ bodies. They need the information that is essential for making informed decisions about sexual behavior and health.
- ✓ Feelings and attitudes are wide-ranging when it comes to sexual behavior and reproduction, especially health-related topics such as sexually transmitted diseases

(including HIV infection) and the use of contraception, abortion and so on. Talking about these issues can increase adolescents' self-awareness and empower them to make healthy decisions about their sexual behaviour.

- ✓ Sexual intercourse is one of the most common human behaviors, capable of producing sexual pleasure and/or pregnancy. In programs for young adolescents, discussion of sexual intercourse is often limited to male-female vaginal intercourse but all young people need information about the three types of intercourse people commonly engage in – oral, anal and vaginal.
- ✓ Contraceptive information describes all available contraceptive methods, how they work, where to obtain them, their effectiveness and side effects. The use of latex condoms for disease prevention must be stressed. Even if young people are not currently engaging in sexual intercourse, they will in the future. They must know how to prevent pregnancy and/or disease.

### **Circle 5:**

**SEXUALIZATION** Is using sex or sexuality to influence, manipulate or control other people.

Often called the “shadow” side of sexuality, sexualization spans behaviors that range from harmlessly manipulative to sadistically violent and illegal. Behaviors include flirting, seduction, withholding sex from a partner to “punish” the partner or to get something you want, sexual harassment (a supervisor demands sex for promotions or raises) sexual abuse and rape. Teens need to know that no one should exploit them sexually. They need to practice skills to avoid or fight against unhealthy sexualization should it occur in their lives.

“Sexual health” is defined by the World Health Organization as:

“the integration of the physical, emotional, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love”

**Sexual health involves:**

- ❖ A capacity to enjoy and control sexual reproductive behaviour in accordance with a social and personal ethic.
- ❖ Freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships.
- ❖ Freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive function.”  
Catherine Chilman, in her article “Promoting healthy adolescent sexuality” in **Family Relations**, 39 (2), 1990 states that adolescent sexual health involves.
- ❖ Increasing ability to communicate honestly and openly with persons of both sexes with whom they have a close relationship.
- ❖ “Acceptance of their own sexual desires as natural but to be acted upon with limited freedom within the constraints of reality considerations, including their own values and goals and those of “significant others” in their lives.
- ❖ “Forming interdependent, rather than dependent or defensively autonomous relationships”.
- ❖ Freedom from “anxieties over their own self-worth and competencies as feminine and masculine persons; they learn to behave and feel in such a way as to experience relatively minor guilt over their own sexuality and that of others”.

- ❖ Growth “towards more egalitarian, less dependent relationships with their parents and a sense of their own gender and sex identity, their own set of values that may be, but are not necessarily, different from those of their parents.”
- ❖ Understanding “that their sexuality is not a thing apart, but an integral aspect of their total lives...thus specific sex behaviours take place within the total context of their life situation and goals”.
- ❖ “As they mature, the development of rewarding mate relationship and use of either abstention or contraceptive techniques to achieve planned timing and numbers of children...”
- ❖ “It does not include the concept that healthy adolescent sexuality involves complete freedom to behave as one wishes so long as contraceptives, including condoms, are used and so long as this behaviour is in private with consenting partners, because the recreational view of sex tends to trivialize the dept of the exceptional intimacy and potential involvement of the total self through intercourse”.

For the purpose of the ASRH in Jamaica, one might add that adolescent sexual health involves the need for adolescents to conduct their sexual lives within the parameters of the laws of the country. In this regard, adolescents need to note that the age of consent of sexual intercourse in Jamaica is sixteen and that sex between same sex couples, with or without the consent of the parties, is illegal here.

### **Rights**

“A right is a benefit that a person is entitled to either because the law states this or because it is the just thing to do based on accepted ideas of right and wrong.

## **QUESTIONS FOR GROUP WORK**

### **ACTIVITY F. 3 - 4**

Three areas of focus- body image of the Jamaican adolescent, intimacy and gender.

#### **GROUP 1**

What is meant by the term body image?

How do you think body image affects adolescent's self-esteem and sexual behaviour?

What are the implications for you when counselling adolescents about sexuality?

(You may refer to Professor Errol Miller's study of body image, its relationship to self-concept, anxiety and certain social and physical variables in a selected group of Jamaican Adolescents, 1967.

#### **GROUP 2**

- (a) What can you do to enhance feelings of intimacy with loved ones in your life?
- (b) What can adolescents do to create similar feelings of intimacy with family members?
- (c) How might you advice adolescents to increase their feelings of intimacy with romantic partners and significant others in their lives without resulting to sexual intercourse or petting to feel loved?

#### **GROUP 3**

- (a) Why is gender important?
- (b) Difference between gender equality and gender equity
- (c) Explore the following:  
(Write down the chores that are regularly performed by each of the members in your household.)
  1. Are all members doing an equal number of chores?

2. Who is over-burdened? (Male/ Female)
3. What are some of the effects of this on the person?
4. Why is this happening?
5. What are sum of your assumptions about what males and female should or should not do?
6. Who are these assumptions hurting?
7. What can be done to share the load more fairly?

### **The Interaction of Gender, Social Class, Colour and Race:**

The problems become acute when gender is combined with social class, colour and race. All of these affect how parents, educators and service providers behave.

#### **Family:**

Jamaica is one of only two countries in this hemisphere in which parents express greater preference for girl babies than boys. The consequences for boy is that:

- more boys are given up for adoption;
- more boys are abandoned and become street children
- more boys are lost to crime and violence

In some homes, despite the national preference for girls, males may be given more food, lighter chores and their illnesses may be treated with greater urgency than those of girls.

It has also been suggested that darker skinned children are more likely to be given up for adoption than light skinned children due to the greater preference for light skinned people in Jamaica. Certainly, the fact that most poor people in this country are black also accounts for the greater prevalence of black children who are abandoned or given up for adoption.

### **The Education System**

More boys than girls perform poorly and report bad relationships with teachers.

### **The Health System**

Research has shown that "physicians are less likely to answer women's questions, less likely to give them technical information, less likely to offer them alternatives for treatment, less likely to diagnose and treat certain diseases in women than in men and more likely to attribute their complaints to psycho-somatic factors". (Ibid, p.4) It may also be true that when compared to their better educated and more wealthy sisters, poor, black, working-class women are less likely to know enough about their own bodies and so may not know what questions to ask or understand the answers that are given. They are more likely to be intimidated or fearful of the doctors and some of the nurses.

### **The Police and Judicial System**

Working class black men commit more crimes and are more likely to be shot and killed by the police and by other working class men in Jamaica.

- **Males 16 – 25 committed 51% of the murders and comprised 50.7% of arrests in all major crimes in 1997.**
- In 1992, twice as many males as females were admitted to the surgical ward of UHWI for:
  - intentional injuries (caused by stab and gunshot wounds, stones, chemical burns and machete wounds) – 52% of all admissions (246 cases);
  - non-intentional injuries (caused by falls, burns, foreign bodies, blunt trauma and sports)- 20% of all admissions (94cases)
  - Road traffic accidents 20% (94 cases)

In summary, the dice is heavily loaded against women in terms of sexual and reproductive health with poor and rural women being particularly at risk while men are at risk due to lack of knowledge and wisdom in their sexual practices, inadequate parenting, poor performance in school and crime and violence. Now, what can you do, personally and professionally to break down destructive gender attitudes and prejudices and create greater equity in Jamaica?

## **Sexually Transmitted Diseases and HIV/AIDS**

Many women and girls are put at risk of acquiring HIV/AIDS and other STDs by the sexual behaviour of their male partners. To reduce infection, one has to eliminate the barriers that deny women control over their own sexual decisions.

### **Males have:**

- **A higher incidence of HIV/AIDS:** in Jamaica up to December 1998, there were estimated to be 20,000 HIV + persons and 3,304 reported cases of AIDS. Of this total, 2,070 were males and 1,234 were females
- Some 67 cases or % of the total number of AIDS cases were Reported in the 10-19 age group. Of these 48 cases or 72% of this adolescent group were males and 19 cases of 28% were females.

### **Women are punished for refusing to have unprotected sex.**

Women who refuse to have unprotected sex face the risk of violence, desertion or infidelity as the men go to the other girls or refuse to support the women and their children. In Jamaica in 1997, 25% of women used condoms to prevent pregnancy.

**Twice as many women as men visited health centers for STDs:** In 1997, 36,061 females as against 16,961 males presented with sexually transmitted diseases in Jamaica. Is this a reflection of the practice whereby some men have multiple partners and consequently for every one infected man there are two infected women?

### **Abortion and pre-natal care:**

Throughout the world, over half a million women die necessarily each year from unsafe abortions and other obstetric emergencies due to social rather than medical reasons.

In Jamaica, one out of three pregnancies lacked adequate prenatal care. Women who are poor and who live in rural areas are more likely to begin pre-natal visits late or to make an insufficient number of visits. The consequences of this include:

- Greater risk of having children who are born with mental and physical handicaps
- Poor nutrition for mother and baby
- Health risks for mother and baby

Forced sex:

“Traditionally, family planning and reproductive health programmes have been built upon the false assumption that all sex is voluntary and that the terms of sexual encounters (such as whether to use birth control) are subject to “negotiation” among partners. This assumption is a dangerous misconception”.

Source: Susan Pfannenschmidt et al. Through A Gender Lens, USAID , and October 1997.

The authors continue:

“Available data indicate that from  $\frac{1}{4}$  to  $\frac{1}{2}$  of women in any given country have been physical abused by an intimate partner, and even more are subjected to ongoing emotional and psychological abuse.

### **Rape and Child Abuse in Jamaica**

- In Jamaica, in 1997, there were 1620 reported cases of rape and carnal abuse, 197 cases of incest and 49 cases of buggery. More females than males are victimized by all except the last
- Domestic disputes accounted for 21% of all murders in 1997.
- In that same year, the Corporate Area accounted for 40% of all cases of rape and carnal abuse in Jamaica

Reproductive Health consequences of sexual violence against women include:

- mental and emotional anguish
- fear of men and sex

- pregnancy loss and low birth rate due to battering during pregnancy
- chronic pelvic pain
- STD/HIV infection
- early sex and sexual risk-taking
- low-self-esteem and
- prostitution

### **The Interaction of Gender, Social Class, Colour and Race:**

The problems become acute when gender is combined with social class, colour and race.

All of these effect how parents, educators and service providers behave.

### **The Family:**

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## **Conclusion**

In summary, the dice is heavily loaded against women in terms of sexual and reproductive health with poor and rural women being particularly at risk while men are at risk due to lack of knowledge and wisdom in their sexual practices, inadequate parenting, poor performance in school and crime and violence.

Now, what can you do, personally and professionally to break down destructive gender attitudes and prejudices and create greater equity in Jamaica?

## **Sexual Development through the Life Cycle**

Many people cannot imagine that all people, including babies, children, teenagers, adults and old people are sexual beings. Some believe that sexual activity is reserved for early and middle adulthood and teenagers often feel that adults are too old for intercourse, or “having sex.” Sexuality, though, is much more than just sexual intercourse, and humans are sexual beings throughout their lifetime.

*Sexuality in infants and toddlers.* Children are sexual even before birth.

Males can have erections while still in the uterus and some boys are born with an erection. Infants touch and rub their genitals because it provides pleasure. Boys and girls can experience orgasms from masturbation, but boys do not ejaculate until puberty. By about age two, children know their gender. They are aware of differences between genitals and in how boys and girls urinate.

*Sexuality in children ages three to seven.* Preschoolers are interested in everything about their world, including sexuality. They may practice urinating in different positions. They are very affectionate and enjoy hugging other children and adults. They begin to be more social and may imitate adult social and sexual behaviors, like holding hands or kissing.

Many young children “play doctor” during this stage, looking at other children’s genitals and showing theirs. This is normal curiosity. By age five or six, however, most children become more modest and private about dressing and bathing.

Children of this age are aware of marriage or “living together,” based on their family experience. They may role-play being married or having a partner while they “play house.” Most young children talk about marrying or living with a person they love when they get older. School-age children may play sexual games with friends of their same sex, touching each other’s genitals or masturbating together. Most sex play at this age happens because of curiosity.

*Sexuality in preadolescent children (ages eight to 12).* Puberty, the time when the body matures, begins between the ages of nine and 12 for most children. Girls begin to grow breast buds and pubic hair as early as nine or 10. Boy’s development of penis and testicles usually begins between 10 and 11. After puberty, pregnancy can occur. Children become more self-conscious about their bodies at this age and often feel uncomfortable undressing in front of others, even a same-sex parent.

Masturbation continues and increases during these years. Preadolescent boys and girls do not usually have much sexual experience, but they often have many questions. They have usually heard about intercourse, petting, oral and anal sex, homosexuality, rape and incest, and they want to know more about these things. The idea of actually having intercourse, however, is unpleasant for most preadolescent girls and boys.

Homosexual experiences are common at this age. Boys and girls tend to play with friends of the same sex and are likely to explore sexually with them. Masturbating together and looking at or caressing each other's genitals is common among boys and girls. Such same-sex behavior is usually unrelated to a child's sexual orientation.

Some group dating occurs. Preadolescents may attend girl/boy parties, dance and play kissing games. By age 12 or 13, some young adolescents will pair off and begin dating or "making out". In some urban areas, boys often experience vaginal intercourse at this age. Girls are usually older when they begin having vaginal intercourse. However, it is not uncommon for young teens to practice sexual behaviors other than vaginal intercourse, like petting to orgasm and oral intercourse.

*Sexuality in adolescents (ages 13 to 19).* Once children reach puberty, their interest in genital sex increases and continues through adolescence. There is no way to predict how a particular teenager will act sexually. As a group, most adolescents explore relationships with one another, fall in and out of “love” and participate in sexual behaviors before the age of 20. One out of three adolescent girls becomes pregnant; many have abortions.

*Adult sexuality.* Adult sexual behaviors are extremely varied. In most cases, they remain a part of an adult’s life until death. At around age 50, women experience menopause, which affects their sexuality. Their ovaries no longer release eggs, and their bodies no longer produce estrogen. They may experience several physical changes; vaginal walls become thinner and intercourse may be painful; there is less vaginal lubrication; the entrance to the vagina becomes smaller.

A lot of women use estrogen replacement therapy to relieve many of these problems. Using vaginal lubricants can also make sexual intercourse easier, once a woman’s vagina produces less lubrication. Most women are able to have pleasurable intercourse and experience orgasm for the rest of their lives.

Adult men also experience some changes in their sexuality, but not at such a predictable time as menopause. Men's testicles slow down their testosterone production after age 20 to 25. Erections occur more slowly. Men also become less able to have another erection after an orgasm. It may take up to 24 hours to sustain another erection. The amount of semen released during ejaculation also decreases, but men are capable of producing a baby even when they are very old - some men have become fathers in their 90s! If it is necessary to remove the prostate, a man's ability to have an erection or an orgasm is unaffected.

Although adult men and women do go through some sexual changes as they age, they do not lose their desire nor their ability for sexual expression.

Even among the very old (those 80 and older), the need for touch and intimacy remains, although the desire and ability to have sexual intercourse may wane.

# SESSION **Ten**

## Counselling Adolescents on Reproductive Health Issues

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### Clarification of words/terms

<b>Communication</b>	Communication is transmitting information, thoughts, and feelings through words, actions or signs from one person to the other on a group.
<b>Communication Process</b>	This is a two-way interaction, which involves the sender, message, receiver, channel and feedback.
<b>Verbal Communication</b>	This involves talking i.e. spoken or written. It is most effective in conveying information. It is the tone of voice that shows the feelings of the communication.
<b>Non-Verbal Communication</b>	This is a language that the body speaks; often at an unconscious level in response to internal or external stimuli e.g. a frown, tapping of feet, and turning away of the face.

# Flip Chart

List of emotions or feelings:

- Pain
- Sadness
- Fear
- Pride
- Anger
- Boredom
- Defensiveness
- Happiness
- Frustration
- Disgust
- Impatience
- Disinterest
- Disapproved

**NB.** Emotional reactions (crying, sobbing)

Size of audience or proximity to other persons

Non- existence of feedback channel (no telephone)

## Communication

Verbal	Nonverbal	Positive	Negative	Feedback
Comfortable (voice)				
	frown			
	nodding			
sweet				

## Barriers

Health Provider	Message	Channel	Adolescent
Sex	Verbose	Quality	Sex
Knowledge level	untimeliness	Noise	Age
Age	readability	inappropriate	Religion
Religion	irrelevance	timeliness	Culture
Attitude	Incorrect target		Attitudes
Culture			SESP
SES			Language
Language			Level of Ed.
Level of Ed.			Lack of interest
Confidentially			Physical defect



Flip chart heading for summarizing strategies that could be used to empower adolescents to break the cycle

<b>Issues</b>	<b>Strategies</b>

# SEXUALLY TRANSMITTED INFECTIONS

## Common STI's in Jamaica

- Yeast infections (Monilia, Candida or Fungus)
- Trichomoniasis
- Gonorrhoea
- Syphilis
- Chlamydia
- Pelvic Inflammatory Disease (PID)
- Hepatitis B
- HIV/AIDS
- Genital Herpes
- Genital Warts
- Cervical Cancer

**Outline on the Aetiology, signs, symptoms, treatments and management of common STI's**

STI's	Aetiology	Signs	Symptoms	Treatments	Management

## Handout – Information on STD's

SEXUALLY TRANSMITTED DISEASE STD stands for Sexually Transmitted Disease. VD stands for Venereal Disease, which is the same thing. Under either name these are diseases that are passed from person to person through sexual contact-genital, oral, or anal. The germs cannot live outside the body – you can't pick them up from toilet seats or doorknobs.

The three kinds of sexually transmitted disease that are the biggest threat to adults and teenagers today are gonorrhea, syphilis, and herpes II. You will find specific information on these three on the pages that follow, along with facts on a fourth disease. AIDS.

AIDS stands for Acquired Immune Deficiency Syndrome, which is a serious and usually fatal disease; AIDS is caused by infection with the Human Immunodeficiency Virus (HIV), which is most commonly transmitted through anal, oral, or genital sex without a condom, or by sharing hypodermic needles. There is as yet no cure for AIDS, and it is spreading rapidly in all parts of the world.

Syphilis and Gonorrhea are curable if treated by a doctor at an early stage of the infection. Herpes it can be treated by a doctor, but no cure for it has yet been found.

It is critically important to know that:

- No vaccine, no pill, no medical treatment can keep you from getting Any STD or becoming HIV-infected if you're exposed to it.
- HIV can remain invisible for years before it turns into AIDS, but it is still infectious. The only way to know for sure if you've been infected is to be tested for the virus.
- If you have had an STD and been cured, you are not immune to that STD or any other-you can be infected again if you're exposed again.
- Gonorrhea and syphilis can be cured if you get adequate treatment soon enough. But not all cases have clearly recognizable symptoms, and sometimes there are no symptoms at all.

So don't take chances. Know the facts. And protect yourself.

## Protecting Yourself and Others

The best way to avoid STD or HIV infection is not to be exposed to it. You can avoid exposure by not having sex with anyone at all.

Or you can avoid exposure by having sex only in the context of a committed, exclusive relationship-one person, one partner, over the course of a lifetime. But if either partner has sex with even one other person who has had sex with someone else, that introduces risk: and the risk goes up as the numbers do. People who have many sex partners are more likely to pick up and pass on some variety of STD, and they are more likely to be exposed to HIV.

Or you can avoid exposure by making sure you're protected during sex, whomever you're with. This means using condoms. Contraceptive foam containing nonoxonyl-9 when used with a condom, can give extra protection against STD's, HIV infection, and pregnancy. (A man may get a little protection from some STD's if he urinates immediately after sex and washes his penis with a soap and hot water, but infection is still possible.)

## Getting Treatment

If anything makes you suspect you have an STD:

- do not try to treat yourself. Only professional diagnosis and treatment will work.
- go immediately to your local health centre or your doctor
- if you test positive for an STD, don't have any kind of sexual contact until you are cured.
- don't masturbate-it can spread the germs to other parts of the body. Don't drink anything alcoholic it may reduce the effectiveness of the medicine being used to treat you.
- get in touch with all the people you've had sexual contact with, so they can be treated.

If anything makes you suspect you have been infected with HIV:

- think seriously about getting tested.  
If you test positive, go to your local health center or your doctor. The sooner you receive medical attention the better.

- tell the people you've had sexual contact or shared hypodermic needles with, so they can get tested and receive medical care.
- use a condom, unfailingly, every time you have sex from now on.

## **BUBOS**

### **Cause**

Bubos is caused by bacteria

### **Mode of Transmission**

It is transmitted mainly by penis-vagina, penis-anus, penis-mouth, vagina-vagina, or vagina-mouth contact. People who have multiple sexual partners are at a greater risk of contracting the disease than those with only one sexual partner.

### **Signs and Symptoms**

Some signs of the disease include swellings around the groin area that look like boils. After a short period, puss is formed in the swelling. Painful blisters develop within five to twenty days of having sexual intercourse with an infected person, and they ripen after 10-15 days followed by fever.

### **Consequences**

If the patient has other diseases, the blisters will take longer to heal and may result in deformity. The open sores provide an easy path for HIV infection. Therefore, people with bubos should avoid sexual intercourse until treatment is concluded.

## **Treatment**

Since the disease can be mistaken for an ordinary boil, those infected often do not seek medical treatment until too late. At which point the swelling would cause terrible pain. It is therefore advisable to seek medical treatment when one observes a strange swelling around the groin. If the boil is already ripe, it has to be cut open in order to drain the puss.

# **CHANCROID**

## **Cause**

Chancroid is caused by an organism called Ducreyi Bacillus

## **Mode of Transmission**

Chancroid is spread through sexual intercourse

## **Signs and Symptoms**

Symptoms appear 2 to 3 days after contact with an infected person. Chancroid first manifests as small pustules on the external sex organs and then as painful ulcers accompanied by swollen glands in the groin area. In males the chancres appear on the edge of the prepuce, glans penis, and shaft of the penis. In females, lesions may be found on the vulva perineum, clitoris, inside the walls of the vagina and on the cervix. The diagnosis of chancroid is easy to make if the patient has genital ulcers.

## **Consequences**

Untreated chancroid causes the inguinal glands to swell. The swelling is known as bubos which eventually rupture and discharge puss. The infection is very painful and destroys tissue around the inguinal glands.

## Treatment

Chancroid is treatable with antibiotics. The open sores caused by chancroid provide an easy path for HIV infection. It is extremely important to get the sores treated immediately and to avoid sexual intercourse until treatment is concluded.

## CHLAMYDIA

Chlamydia trachomatis is a small bacterial micro-organism that multiplies within cells. Within this genus are strains causing three distinct diseases, two of which are sexually transmitted. Chlamydia trachomatis attacks mucous membranes. The other, lymphogranuloma venereum attacks the regional lymph nodes from a primary genital lesion. The most common type of chlamydia is chlamydia trachomatis.

### Chlamydia Trachomatis

**Facts:** Chlamydia trachomatis is spread through sexual contact-penis-

Vagina (genital sex), penis-mouth (oral sex) penis-anus (anal sex), or from a pregnant mother to her unborn child. People can also spread the infection with their hands from one part of the body to another.

**Symptoms:** Eighty percent of women infected with chlamydia trachomatis don't know they have it until it has progressed to a more serious condition – PID. Some symptoms of PID are fever, abdominal pain, vomiting, and tiredness. When women do have early symptoms, they include unusual discharge, pain during sex, abdominal pain, or burning during urination.

Men are more likely to have early symptoms, which include pus or watery or milky discharge from the penis, and pain or burning feeling while urinating.

Because these symptoms are similar to the symptoms of gonorrhea, the infection in men is called nongonococcal urethritis (NGU). Men often don't take these symptoms seriously because they may only appear early in the day and can be very mild.

Chlamydia trachomatis can be treated with antibiotics: both partners need to take the medication. The infection is cured in one or two weeks.

## **ESSENTIAL FACTS ABOUT STIs**

**STI** stands for Sexually Transmitted Infection: those infections that are transmitted by any type of genital, oral, or anal intimate contact (with an infected person). Twenty-one types of infections are currently known, each caused by a different micro-organism. The organisms rarely live outside the body, but close contact spreads them easily. Knowledge of symptoms helps in detection, but some people do not get any symptoms, and occasionally some diseases are without symptoms; exposure requires medical evaluation. Treatment is specific to the disease and should be followed carefully. This incidence of the STI is highest in the age group 15-29.

### **Reason for the spread of STI**

- decrease in use of condoms
- increase in oral-genital sex
- increase in sexual activity and number of sexual partners
- failure to recognize symptoms
- many asymptomatic cases (in gonorrhea, an estimated 20 percent of men and 50-80 percent of women notice no symptoms)
- failure to comply with proper medical treatment

### **Sexually active people should:**

- not have sex with a person who has a sore, discharge, or any other sign of an STI

- use condoms if their partner(s) are sexually active with other people (condom use protects females as well as males)
- go to a doctor or clinic regularly for STI checkups
- go to the doctor or clinic immediately
- follow instructions given by doctor and/or clinic staff
- return for all appointments
- tell all of their sex partners to get tested and treated
- take precautions not to become infected or re-infected

**Additional reminders:**

- anyone who has sex with a person who has an STI can become infected.
- a person can have sex just one time and become infected
- a person can have sex just one time and become infected.
- many people with STI's have no symptoms and are unaware that they are infected. Because these people do not receive treatment, they continue unknowingly to infect people with whom they have sex. This is a major reason for the current STI increase.
- if a woman with STI remains untreated, the infection can cause serious irreversible complications, such as pelvic inflammatory disease (PID).
- a person who receives treatment and does not inform his or her steady sex partner often becomes reinfected.
- condoms effectively limit the spread of STI among men and women
- anyone who often has oral or anal sex needs to ask the doctor for special culture tests for the throat and rectum.

## SEXUALLY TRANSMITTED DISEASES – QUIZ

1. T/F - Some STDs have no obvious symptoms in their early stages
2. T/F -Only people who have had sex with many others are likely to get an STD
3. T/F -STD prevalence is low among adolescents and youth
4. T/F -Some STDs can affect the bones, heart and nervous system if they are not treated.
5. T/F -People who practice good personal hygiene are less likely to get an STD
6. T/F -if a woman has sex with only one man she cannot get an STD
7. T/F -Men with an STD are less likely to have symptoms than women with STD
8. T/F -STD symptoms can include burning or pain when urinating
9. T/F -Some STD's can cause death
10. T/F -Some insects such as mosquitoes and bedbugs can spread STDs.
11. T/F -Some STDs can lead to infertility.
12. T/F -STD symptoms can include an unusual discharge from the vagina or penis
13. T/F -if an adolescent has a sore on or near parts of the body have been involved in sexual contact, it could be an STD
14. T/F-Itching, discomfort or swelling in or around the sex might indicate an STD

15. T/F-Some STD's can lead to cancer
16. T/F-STDs cannot effect newborn babies
17. T/F-You can get an STD by stepping in infected urine
18. T/F-Self-treatment of STDs is likely to cure them
19. T/F-Condoms prevent STD infection
20. T/F-STDs are decreasing in most societies
21. T/F-Taking the pill protects against STDs

### ANSWER KEY PAD TO STD QUIZ

1. True
2. False      You can get an STD after one sexual contact, if either Person is infected.
3. False      STDs are most prevalent among the younger generation
4. True        Syphilis can effect the bones, nervous system and heart if untreated.
5. False      You can get an STD regardless of personal cleanliness if you do not use a condom
6. False      Only uninfected couple who both only have sex with each other can be sure not to get an STD through unprotected sex
7. False      Men are more likely to have symptoms than women
8. True
9. True        HIV (Human Immunodeficiency Virus) is sexually transmitted. Infection leads to AIDS, which is a fatal disease.
10. False     STDs (including HIV) are not spread by insects. However some conditions such as genital warts, genital herpes, Hepatitis B, HIV and Thrush are not always sexually transmitted

11. True      Untreated STDs can infect and block the Fallopian tubes in women and the urethra in men, causing infertility.
12. True
13. True
14. True      Swelling at the top of the legs near the sex organs can also be a sign of STD
15. True      STDs caused by viruses have been associated with cancer of the reproductive tract
16. False      Gonococcal infection in the mother can cause eye infections and sometimes blindness in the newborn infant
17. False      This is a common belief in some countries.
18. False      Self-treatment is likely to be inappropriate, and it may be treating the wrong disease
19. True      However, condoms must be in good condition, and must be put on and used properly to be effective.
20. False      STDs are the most common group of communicable diseases reported in most countries, and are on the increase in most societies
21. False      Only barrier methods protect against STDs. The most effective barrier method is the condom. A female condom has recently been developed and may be available in some places.

## Myths and Facts on HIV

- LR 1. Tongue kissing
- NR 2. Holding hands
- NR 3. Body massage
- NR 4. Masturbating
- HR 5. Vaginal intercourse without condom
- HR 6. Anal intercourse without a condom
- NR 7. Donating Blood
- HR 8. Sharing a needle to shoot drugs
- NR 9. Dry kissing on the mouth
- NR10. Partners using their hands to touch each other's genitals
- LR11 Oral stimulation of the testicles
- NR12 Manual (hand) stimulation of clitoris
- NR13 Undressing a partner
- NR14 Taking a bubble bath with a partner
- NR15 Receiving a foot massage from a partner
- LR16 Oral sex on the penis with a condom
- NR17 Nibbling a partner earlobe
- NR18 Sharing a favorite fantasy with a partner
- NR19 Watching a romantic film with a partner
- LR20 Vaginal intercourse with a condom
- HR 21 Vaginal intercourse (without a condom) with someone who just Tested negative for HIV last month
- HR22\* Drinking or smoking marijuana with a new partner

\*Does not transmit HIV or other infections, but often leads to high-risk sexual behaviours.

# SESSION Twelve

## Substance Abuse

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### Clarification of words/terms

<b>Psychoactive</b>	those substances.
<b>Substances</b>	legal and illegal when taken, affect mental processes i.e. cognition and affect e.g. nicotine, alcohol.
<b>Depressants</b>	are drugs that restrict the activity of the central nervous system, slowing down the pulse and breathing, and lowering the blood pressure, e.g. marijuana, alcohol, opium, heroin, etc. They also reduce the ability to receive information from outside the body through the senses. Vision is impaired, hearing, is impaired, the senses of smell, taste, and touch are impaired, sexual response is impaired, reactions and judgment are impaired. This makes for inability to control normal behaviour, which can lead to aggression, socially unacceptable behaviour, accidents, and harm to oneself and others.
<b>Hallucinogens</b>	are drugs that distort perception – an individual thinks objects are there that are not or events with an overwhelming sense of realism, e.g. LSD stands for (lysergic acid diethylamide.) LSD causes euphoria or simply feelings of detached well being to hallucinations, mental changes and lasting impairment of the mind.

<b>Stimulants</b>	are drugs that increase the blood pressure and give the user a feeling of power, e.g. cocaine. They cause loss of appetite, convulsions, hallucinations or terrifying dreams, or mental illness.
<b>Drugs</b>	<p>Substance (other than food) that affect the chemistry and function of the body and that sometimes cause addiction or habituation</p> <p><i>Six Steps to Prevent Drug and Alcohol Use</i></p> <ol style="list-style-type: none"> <li>1. Knowledge is a powerful weapon against drugs. Talk to your child about alcohol and other drugs carefully explain the health consequences of alcohol and other drug use, and the effect they can have on the child's life in preparation for the future. Correct mistaken ideas perpetuated by peers and the media. Listen carefully to your child talk about alcohol and other drugs. Children are more likely to communicate when they receive positive verbal and nonverbal feedback from parents. Help your child to develop a healthy self-<b>image</b>; self-regard is enhanced when parents praise efforts as well as accomplishments. In turn, when being critical, criticize the actions and not the person.</li> <li>2. Help your child develop a strong system of values. A strong value system can give children the criteria and courage to make decisions based on facts rather than pressure from friends.</li> <li>3. Teach your child how to deal with peer</li> </ol>

	<p>pressure. Explain that saying 'no' can be an important statement about self-worth. Help your child practice saying 'no'. Together, set up some situation for saying 'no' and discuss why it is beneficial to avoid alcohol and other drugs.</p> <p>4. Make family policies that will help your child say 'no'. The strongest support your child can have in refusing to use alcohol and other drugs are to be found in the solid bond created within the family unit. Let your child know that drug and alcohol use is unacceptable within the family and is a violation of the family's rule. The consequences and punishment for such a violation must be clearly spelled out. Encourage healthy activities that may help to prevent children from using alcohol and other drugs. Help make your child's life so full and active that there is no time or place for alcohol and other drugs.</p>
<b>Domestic Violence</b>	<p>Abuse is the use of threat of physical violence against a partner in a primary relationship or family member – resulting in fear and emotional and/or physical suffering. A pattern of coercive control.</p>
<b>Substance Abuse</b>	<p>A dependence or addition to drugs or alcohol.</p>

## DOMESTIC VIOLENCE MYTH/FACT SHEET

Domestic violence is the use or threat of physical violence against a partner in a primary relationship, or a family member, resulting in fear and emotional and or physical suffering.

### Myth/Facts

- 1) Domestic violence is a private affair-it is no one else's business  
\_\_\_\_\_
- 2) Domestic violence is not a big problem  
\_\_\_\_\_
- 3) Only lower class men beat their wives  
\_\_\_\_\_
- 4) Women provoke beating and even enjoy abusive treatment  
\_\_\_\_\_
- 5) A woman can stop the abuse easily by just leaving  
\_\_\_\_\_
- 6) Unemployment or job frustration is the only cause of domestic violence.  
\_\_\_\_\_
- 7) Domestic violence is a power issue; a physically stronger person \_\_\_\_\_ or a person in a position of authority is abusing a weaker or more dependent person.
- 8) A substantial amount of homicides are committed against family \_\_\_\_\_ members.
- 9) The only person ultimately responsible for the battering is the \_\_\_\_\_ person who made the choice to be violent.

- 10) There is no one right decision for a battering victim.  
\_\_\_\_\_
- 11) Domestic violence does not occur 24 hours a day 7 days a week  
\_\_\_\_\_  
There may be peaceful/periods between beatings.
- 12) Both domestic violence and alcoholism are found in families  
from \_\_\_\_\_ all socio-economic, educational,  
religious, ethnic, and racial background.
- 13) Both domestic violence and alcoholism are progressive,  
\_\_\_\_\_ recurring and potentially fatal.

## BATTERING OF ADULT WOMEN

### Types of abuse

<b>Physical</b>	<b>Emotional</b>	<b>Sexual</b>	<b>Economic</b>
Hitting	Name Calling	Rape	Withholding money
Slapping	Constant	Unwanted sexual	Lying about assets
Kicking	Harassment	Practices	Stealing money
Burning	Refusing to speak	Forced sex with other men	Mutilation
Humiliating you	Sexual abuse of your child	With family and friends	

## Chart

### Common Psychoactive Substances (Jamaica)

Type of Substance	Example
Alcohol	Wine, beer, spirits, home-brew
Opioids	Cough, syrup with codeine, heroin, morphine, opium, buprenorphine, methadone, pethidine
Psychostimulants	Amphetamine, methamphetamine, cocaine, crack, coffee and tea, coca products, 'designer' drugs, ecstasy, khat
Hallucinogens	LSD, mescaline, psilocybin, peyote, ayahuasca
Cannabis	Marijuana, ganja, hashish, bhang
Nicotine	Cigarettes, cigars, pipes, chewing tobacco, snuss
Nitrite	Poppers
Depressants	Sedatives, sleeping pills, benzodiazepines, methaqualone, barbiturates, chloral hydrate
Violatile Inhalants	Aerosol sprays, butane gas, petrol/gasoline, glue, paint thinners, solvents, amyl
Others	Betel nut, kava, buri

## **RISK AND CONSEQUENCES**

### **Effects on children**

- Emotional injuries, such as low self-esteem
- Hyperactivity; poor control
- Poor school adjustment
- Aggressive behaviour toward others/delinquency,
- Depression
- Runaway episodes
- Alcohol and drug experimentation or use
- Modelling behaviours learned: Victim/aggressor roles
- Early marriage
- Continuation of violent behaviour in their adult relationships
- Expansion of violence into the community
- Death by Suicide
- Death by homicide

### **Effect on Partner, Friend and Relative**

- Emotional stress and deprivation.
- Disabling injuries
- Perpetuation of social isolation or fear of violence being disclosed
- Continuing violence, which will escalate if alternative behaviours are not learned.
- Difficulty in obtaining, maintaining, and adjusting to employment due to the tense and violent atmosphere.
- Depression – victim may become immobilized due to constant fear and tension
- Substance abuse
- Break-up of family unit; relocation of victim and children
- Expansion of violence into the community
- Death by suicide
- Death by homicide (of either perpetrator or victim).
- Recurrence of violent behaviour with new partner.
- Physical disability, loss of money, loss of job
- Loss of self-esteem, loss of independence

# Why Women Stay In Abuse Situations

## Situation Factors

- Economic dependence
- Fear of children's future
- Lack of job skills
- Fear of uncertainty of legal process
- Cultural or religious constraint
- Fear of greater harm or retaliation
- Lack of alternatives

## Emotional Factors

- Guilt
- Belief that partner will change
- Fear that partner will not survive alone
- Fear of making life changes
- Lack of support and understanding from family/friends
- Fear of independence
- Fear of loneliness
- Love of partner

Recourse for women in abusive situations. Seek help from trusted family/friend/community member.

Seek alternative housing

Talk to a doctor / nurse / social worker about options.

Seek counselling

Recognize the precursors to abusive incidents and leave the situation.

## What do men have to do with domestic violence?

- Rarely victims

- Some are perpetrators
- Supportive family member
- Counsellors

## Annex: Sample Assessment questions

I would like to ask you about your use of alcohol, tobacco products and other substances (show card). Because many of them can affect your health, it is important for me to have accurate information.

1. In your life, which of the following substances have you ever used?

(Check all that apply.)

a) Tobacco products (cigarettes, chewing tobacco, cigars etc.)	
b) Alcoholic beverages (beer, wine, liquor etc.)	
c) Marijuana (pot, grass, hash etc.)	
d) Cocaine or Crack	
e) Stimulants or amphetamines (speed, diet pills, ecstasy etc.)	
f) Inhalants (nitrous, glue, spray paint, gasoline, paint thinner)	
g) Sedatives or sleeping pills (Valium, Librium, Xanax, Haldol, Seconal, Quaaludes, etc.)	
h) Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	
i) Heroin, Morphine, or pain medication (Codeine, Dilaudid, Darvon, Demoral, Percodan, Florinal, etc.)	
j) Other (please specify)	

**Note:** Some of the drugs listed may be prescribed by a doctor (such as Amphetamines, sedatives, pain medications). For prescription medications, interviewers should code only those drugs taken for reasons other than

prescribed by a doctor unless the drug was taken more frequently or at higher doses than prescribed.

If all answers are negative, probe:

- not even once, just to try out:
- not even after receiving medications
- was it on a doctor's prescription?

If after probing it is still 'no to all items, stop the interview.

If 'yes' to any of these items, ask Question 2 onwards for each drug mentioned.

2. In the past three months, how often have you used the substances you mentioned?  
 Never  
 Once or twice  
 Monthly  
 Weekly  
 Daily
3. Have you been worried or concerned about your use of .....?
4. Have you regretted what you did when high or intoxicated on ....?  
If yes, any time in the last 3 months?  
 Never  
 Once or twice  
 Monthly  
 Weekly  
 Daily
5. During the past three months, how often have you had any Problems with family, school, friends, work or yourself, because of your use of.....?
6. Has a friend or relative or anyone else ever expressed concern about your use of .....?

- 7 Have you ever used any of the following drugs by injection?
- Cocaine or Crack
  - Stimulants, amphetamines
  - Sedatives or sleeping pills
  - Heroin, Morphine or pain medication

If the person ever tried any of these by injection, probe:

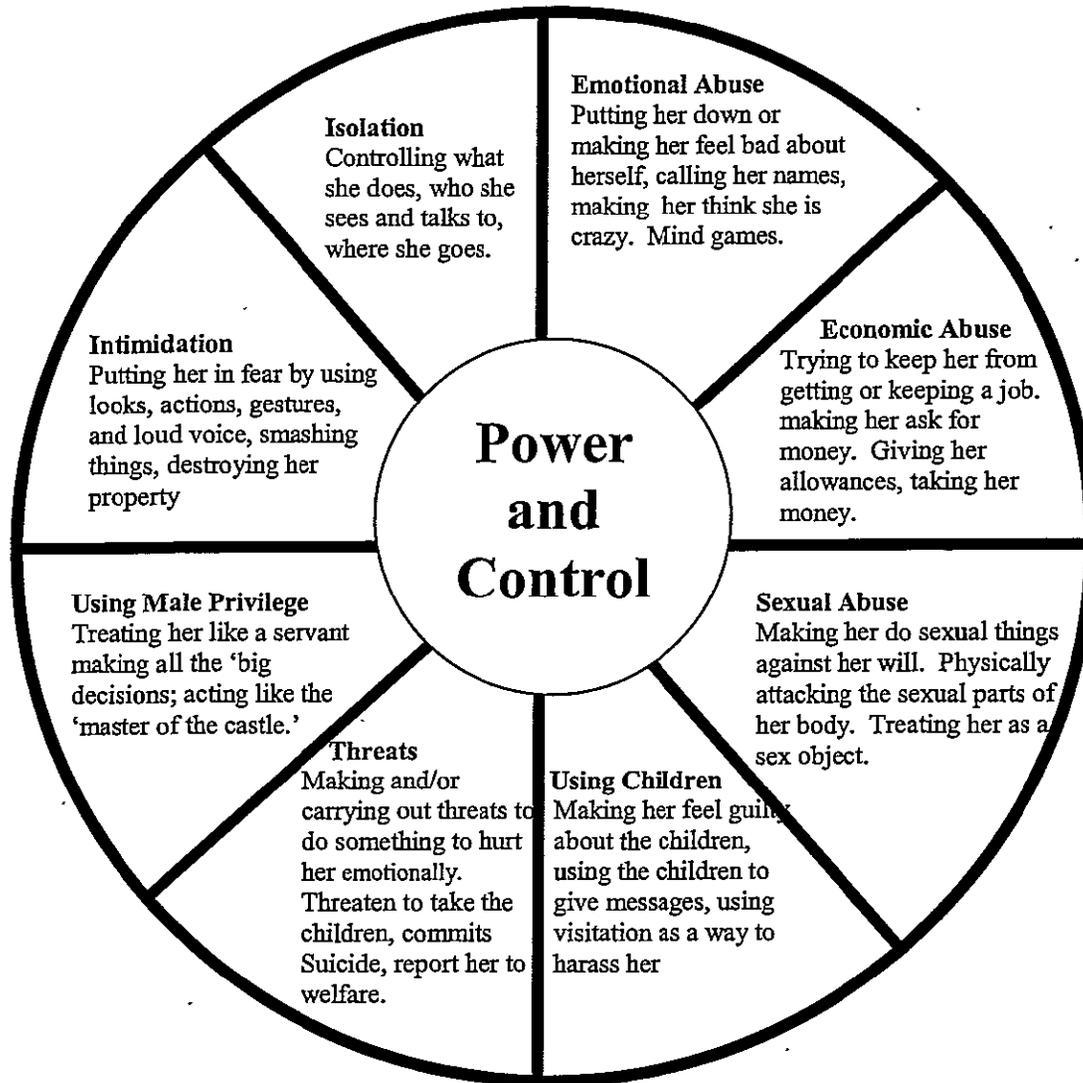
- If yes, when was the last time?

**If the answer to question 7 is yes, a comprehensive assessment is needed.**

## Drug Card

k) Tobacco products (cigarettes, chewing tobacco, cigars etc.)	
l) Alcoholic beverages (beer, wine, liquor etc.)	
m) Marijuana (pot, grass, hash etc.)	
n) Cocaine or Crack	
o) Stimulants or amphetamines (speed, diet pills, ecstasy etc.)	
p) Inhalants (nitrous, glue, spray paint, gasoline, paint thinner)	
q) Sedatives or sleeping pills (Valium, Librium, Xanax, Haldol, Seconal, Quaaludes, etc.)	
r) Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	
s) Heroin, Morphine, or pain medication (Codeine, Dilaudid, Darvon, Demoral, Percodan, Florinal, etc.)	
t) Other (please specify)	

# Power and Control Wheel



# Controlling Behaviour Checklist

## PHYSICAL CONTROLS

- Hitting, grabbing, kicking, chocking, pushing rape, uninvited touching
- Abusing pets, damaging furniture, walls, etc.
- Physical intimidation (e.g. standing in the doorway during arguments, angry gesturing, etc.)
- Throwing things. Threatening violence (verbally or non-verbally).
- Uninvited visits or calls, following her around, checking up on her.
- Not leaving when asked to.
- Isolating her (preventing her from seeing or talking to friends, relatives, etc.)

## PSYCHOLOGICAL CONTROLS

- Criticism (name-calling, swearing, mocking, put downs; ridicule, accusations, blaming, etc.)
- Interrupting, changing topics, out-shouting, non-listening, not responding, not respecting what she says.
- Pressuring her to take care of him emotionally when she doesn't want to, rushing her by being impatient, guilt-tripping, sulking, making her feel sorry for him, making accusations.
- Using money to manipulate, controlling other resources such as the car.
- Sexual coercion.
- Claiming 'the truth,' being the authority, defining her behaviour.
- Emotional withholding: not expressing feelings when appropriate, not giving praise, attention, information, support, concern, validation, not being vulnerable.
- Other forms of manipulation
- Not taking care of himself, not making friends, finding support, etc.

View it is possible that the incident participants recall might raise strong views and feelings, since the experiences might relate to friends and colleagues or their adolescent children as well as to adolescent met in the course of professional duties.

OHT SU 3-9

Use the transparencies below either as a summary of key points for this session or whenever they might clarify a point in the discussion. In any case, encourage questions and prompt participants to answer them before replaying yourself. Refer to material in the handout to elaborate on these bare facts.

OHT SU 3

#### **Why adolescents use substances**

- adolescence is a transition to adulthood
- adults using substances are a model for adolescent experiment and behaviour.
- Individual and social risk and protective factors are related to psychoactive substance use.

OHT SU 4

#### **Factors influencing adolescents' use of substances**

##### **Protective:**

- adolescents' disapproval of socially unacceptable behaviours
- involvement in pro-social activities
- close relationship with parent

OHT SU 5

#### **Factors influencing adolescents use of substances**

##### **Risk:**

- low personal expectations
- feelings of distress
- peer/sibling use of substances

- harmful use of substances by family
- availability of substances in community (often actively promoted by media)

#### OHT SU 6

##### **Type of substance used by adolescents**

- readily available and cheap
- most common: tobacco, alcohol, cannabis, inhalants
- often taken in combination (polydrug use)
- types of substance used change over time

#### OHT SU 7

##### **Motivation for use**

- relaxation/sedation
- increase awareness and alertness (e.g. to work)
- analgesia and relief of hunger
- escape/dreaming
- intoxication

#### OHT SU 8

##### *Consequences of use*

##### **Intoxication:**

- trauma (e.g. falls, road traffic accident, drowning)
- overdose
- blackouts
- unsafe sex

**Consequences of use (cont.)**

**Interpersonal and social problems:**

- family dysfunction, social withdrawal
- school failure and learning difficulties
- criminal behaviour
- violence

**Mental health problems:**

- anxiety
- depression, suicide
- psychotic episodes

## **Why do adolescents use substance?**

Several developmental factors help account for adolescents' attraction to psychoactive substances. Adolescence is a transition to adulthood and many of the behaviours and attitudes people adopt during adolescence are required to enable them to carry out roles and functions. Most of these behaviours and attitudes reflect those in the adult world in which they live. In the process of establishing their own identity, adolescents imitate various adult behaviours and attitudes. They are attentive to the use of legal substances by adults, the conditions under which they are used and the effects they engender.

Indeed, those with commercial interests are all too aware of the need to cultivate the use of substances available for adults during adolescence. Alcohol and tobacco use are supported by mass marketing strategies, which target adolescents through the portrayal of these substances as "cool" things to use. In certain cultures, drinking to intoxication is portrayed as "macho."

## **Patterns of substance abuse among Jamaican adolescents in 1997 – 1998**

In June 2000, Dr. Ken Garfield Douglas prepared a report on Patterns of Substance Use and Abuse Among Post Primary Students in Jamaica: National Adolescent Students' Drug Survey. Displayed below are four

tables from that report. The first, Table 1.6 A shows the percent of persons from grade 9, 11 and 13 who used various types of substances in 1987.

**Table 1.6A**

**Prevalence of Use of Various Types of Substances, Grade 9, 11 and 13 – 1987**

<b>Substance</b>	<b>Lifetime</b>	<b>Annual</b>	<b>30-Day</b>
Tobacco/cigarettes	29.1	n/c	5.1
Alcohol	76.3	n/c	33.7
Cannabis – Tea	28.3	n/c	6.5
Cannabis-smoked	19.8	3.5	4.1
Cannabis- Any other food or drink	5.5	n/c	2.3
Crack	1.5	0.3	0.8
Cocaine	1.9	0.4	0.9
Inhalants	16.7	n/c	10.2
Tranquilizers-prescribed	8.8	n/c	n/c
Tranquilizers	3.8	n/c	1.8
Amphetamines-prescribed	3.1	n/c	n/c
Amphetamines-non-prescribed	1.7	n/c	1.1
Psychedelics (Hallucinogens)	1.5	n/c	0.9
Opiates	1.2	0.7	n/c

n/c – Data not collected

Source: National Schools' Drug Survey – 1987

This table shows that in the 30 day period preceding the study, the students most frequently used alcohol, inhalants, cannabis (ganja) tea, tobacco/cigarettes and smoked cannabis.

Table 3.6 E and F, below, show a comparison of the incidence of use of various types of substances by males and females respectively, in all grades, in 1987 and in 1997.

Table 3.6E  
 COMPARISON OF INCIDENCE OF USE OF VARIOUS TYPES OF  
 SUBSTANCES –  
 ALL GRADES 1987, 1997. (MALES)

Substance	Percent who used by							
	Below Grade 7	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12 /13	Never used
Cigarettes								
1987	16.4	6.6	5.6	5.0	2.5	1.7	0.2	59.6
1997	16.6	6.6	4.7	4.7	0.9	0.9	0.4	63.5
Alcohol								
1987	33.7	15.7	12.7	12.0	4.8	2.8	0.5	14.8
1997	37.5	15.5	10.0	9.5	3.2	2.0	0.7	22.0
Cannabis - smoked								
1987	9.6	4.5	3.4	4.2	1.9	1.6	0.3	74.5
1997	10.4	7.2	5.8	7.2	2.8	1.2	0.5	64.9
Crack								
1987	0.4	0.3	0.3	0.2	0.1	0.2	0.0	98.5
1997	0.6	0.3	0.2	0.4	0.6	0.1	0.0*	97.6
Cocaine								
1987	0.2	0.2	0.5	0.4	0.3	0.2	n/r	98.2
1997	0.3	0.1	0.4	0.3	0.3	0.2	0.1	98.2
Tranquilizers@								
1987	1.8	0.3	0.4	0.4	0.2	0.3	n/r	96.6
1997	1.0	0.2	0.3	0.5	0.1	0.5	0.1	97.2
Amphetamines								
1987	0.9	0.2	0.2	0.3	0.0*	0.1	0.0*	98.1
1997	0.3	0.4	0.3	0.1	0.2	0.3	0.2	98.1

Notes n/r indicates no use reported

\*indicates percentage less than 0.05

@relates to non-prescribed use – Source: National Schools' Drug Surveys – 1987, 1997

Table 3.6F

COMPARISON OF INCIDENCE OF USE OF VARIOUS TYPES OF  
SUBSTANCES –  
ALL GRADES 1987, 1997. (FEMALES)

Substance	Percent who used by							Never used
	Below Grade 7	Grade 7	Grade 8	Grade 9	Grade 10	Grade 11	Grade 12 /13	
Cigarettes								
1987	8.0	3.6	3.1	3.0	1.2	1.2	0.1	78.5
1997	9.8	3.2	3.0	3.3	1.0	0.8	0.2	78.9
Alcohol								
1987	23.4	12.6	10.9	11.8	6.1	2.7	0.4	29.3
1997	22.9	13.5	10.3	9.2	5.7	3.3	0.4	34.7
Cannabis - smoked								
1987	3.6	1.9	1.9	2.4	1.4	0.9	0.1	87.8
1997	3.6	2.4	2.8	3.7	2.4	1.3	0.3	83.2
Crack								
1987	0.2	0.1	0.1	0.2	0.1	0.1	0.0	99.3
1997	0.2	0.1	0.2	0.1	0.0*	0.1	0.0*	99.3
Cocaine								
1987	0.2	0.1	0.1	0.2	0.0	0.1	0.0	99.2
1997	0.1	0.1	0.1	0.1	n/r	0.1	n/r	99.6
Tranquili zers@								
1987	0.7	0.5	0.5	0.5	0.3	0.3	0.0*	97.2
1997	1.1	0.3	0.4	0.5	0.4	0.2	0.0*	97.0
Ampheta mines								
1987	0.3	0.2	0.2	0.2	0.2	0.1	0.0*	98.9
1997	0.3	0.3	0.2	0.3	0.2	0.0	0.1	98.8

1987								
1997								

Notes n/r indicates no use reported

\*indicates percentage less than 0.05

@relates to non-prescribed use – Source: National Schools’ Drug Surveys – 1987, 1997

The tables show that alcohol was the most frequently used substance and that its use was highest among children of both sexes below grade 7. Its use steadily decreased as the grade level increased. Cigarettes and the smoking of cannabis (ganja) came second and third, respectively, in frequency of use by both sexes. Boys were more likely than girls to use these three substances and the use of alcohol and cigarettes had decreased among both sexes during the ten year period 1987 – 1997 whereas the smoking of ganja had increased.

The pattern of decreasing use of substances as the grade levels increased also held true for cigarettes and the smoking of cannabis. This pattern was broken by grade 9 students only as more of whom smoked ganja. Only a miniscule percentage of the entire sample had ever used crack, cocaine, amphetamines and tranquilizers.

The last table to be selected from this study, Table 3.11 A, show the reasons given by adolescents of both sexes for use of various types of substances. Only a small percentage were ignorant of the effect or used it accidentally. Curiosity/Experimentation was the main reason given for substance use, followed by other reasons, peer pressure, fun and celebration and following the crowd.

As far as multiple drug combinations are concerned, in Jamaica in 1994, the National Survey Report on substance Abuse in Jamaica showed that the age group showing the highest proportion of multiple drug use was those under 15 years with half of them using two to three drugs. In order of popularity, the most frequently used combinations were alcohol and tobacco, followed by alcohol and ganja (p. 27).

## REASON FOR DRUG USE

TABLE 3.11A  
PROPORTION OF STUDENTS ACCORDING TO REASONS FOR USE  
OF VARIOUS TYPES OF SUBSTANCES -1997

Reason For Substances	cigarettes	alcohol	cannab	crack	cocaine	tranq (n	amph (	inhalan
Curiosity/ Experimentation	40.2	28.8	32.0	11.9	17.2	6.0	6.5	38.1
Peer pressure	10.7	7.4	16.9	18.7	8.4	7.5	9.7	1.4
Ignorance of the Effect	1.0	0.8	0.6	n/r	n/r	0.9	n/r	10.2
To feel good	1.1	2.2	0.5	0.7	n/r	n/r	0.5	n/r
Fun and Celebration	8.8	22.1	8.3	6.1	3.8	1.6	n/r	8.8
Given by an Adult	0.4	2.2	1.1	n/r	2.8	1.7	n/r	n/r
Medicinal	0.4	0.5	0.7	n/r	n/r	21.2	10.3	0.6
Mental/Physical Health	0.5	0.4	0.8	n/r	n/r	11.2	16.7	0.6
Enhancement	0.9	1.9	4.4	9.9	14.5	1.4	4.9	4.3
To Relax	1.3	0.6	2.8	n/r	n/r	3.2	n/r	0.5
Emotional Problems	3.8	1.6	2.6	3.1	6.3	5.0	1.2	1.4
Accidental	0.3	0.2	0.5	1.5	n/r	n/r	3.4	0.6
Religious	n/r	0.1	1.3	1.0	n/r	n/r	n/r	n/r
Family Influence	4.8	3.3	2.7	n/r	4.9	1.8	n/r	0.3
Following the Crowd	7.4	4.7	7.5	2.4	17.7	1.0	1.1	1.6
Other Reasons	18.4	23.1	17.5	43.6	24.3	37.7	47.0	31.6

# SESSION Thirteen

Crisis Situation: Rape and Sexual Abuse, Incest,  
Domestic Violence, Adolescent Pregnancy

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## Clarification of words/terms

<b>Rape</b>	An act of violence. It is a sexual assault, in which force or the threat of force is use to compel someone to have vaginal, oral, or anal intercourse. The weapon used in rape is sex
<b>Sexual Abuse</b>	Forced, tricked or manipulated, touched or sexual contact, although sexual abuse can occur without touch – obscene phone calls or exposing one’s sexual organs are examples.
<b>Incest</b>	Sexual Intercourse between blood-related family members (e.g. Father and daughter; sister and brother)
<b>Domestic Violence</b>	The use of threat of physical violence against a partner, a primary relationship or family member resulting in fear, emotional and/ or physical suffering. A pattern of coercive control.
<b>Early Pregnancy</b>	Pregnancy among minors or adolescents 10-19
<b>Myths</b>	Myths are opinions, beliefs, idealized fantasies, traditional stories that have no basis in fact, yet are critically held by members of a group. The word “myth “comes from the Greek word “myth as” meaning, fable or story.

<b>Facts</b>	Facts are known truths, events that have actually occurred, something objectively verified, things with real demonstrable existence.
<b>Touch Continuum</b>	Is the range of touch – from lack of touch, to confusing touch, to exploitive touch

**Summary: Discussion Crisis Issues**

<i>Crisis Issues</i>	<i>Contributing Factors</i>	<i>Consequences/Effects on: the adolescent, children, mother, family society.</i>	<i>Myths</i>

## Quiz On Facts About Rape

Respond to each statement by putting a check under "true," "False," or "I don't know."  
Do not guess.

- |  | True  | False | I Don't know |
|--|-------|-------|--------------|
| 1. Rape is forced sexual relations against a person's will.  | _____ | _____ | _____        |
| 2. Rape is committed in Jamaica .....  | _____ | _____ | _____        |
| 3. A husband can rape his wife.....  | _____ | _____ | _____        |
| 4. Over 50 percent of all rapes occur between people who have met before. ....   | _____ | _____ | _____        |
| 5. The majority of rape victims are between 15 and 19 years old .....  | _____ | _____ | _____        |
| 6. The majority of reported rapist are between 15 and 24 years of age. ....  | _____ | _____ | _____        |
| 7. Most rapes occur between people of the same race and similar social positions.....                                  | _____ | _____ | _____        |
| 8. Most rapes occur in urban areas.....  | _____ | _____ | _____        |
| 9. An estimated 50% of all rapes are never reported to the police .....  | _____ | _____ | _____        |
| 10 Rape takes place during daytime hours and often in the victim's home. ....  | _____ | _____ | _____        |
| 11. Studies show that rapists plan ahead and choose women who seem likely victims. ....                                | _____ | _____ | _____        |
| 12. Rapist interviewed say they have poor social relationships with women. ....  | _____ | _____ | _____        |
| 13. Sexual gratification is not the motivating Factor in rape.....   | _____ | _____ | _____        |
| 14. Rape is an expression of hostility, aggression and dominance.  | _____ | _____ | _____        |
| 15. All victims of rape, report that rape is a violent and dangerous attack upon them that deeply affects their lives. | _____ | _____ | _____        |

*(Adapted from a publication of New York Women Against Rape).*

## Scenarios:

1. A woman is walking down a dark street and is attacked from behind. Her attacker forces her to have sex with him.
2. A husband comes home very late and drunk. His wife is sleeping, but he wakes her to have sex. His wife says she is tired, but he insists on having sex. Despite her excuses and resistance, he has sex with her.
3. A high school girl is on a date with a guy. He pays for the whole evening and spends quite a bit of money on the date. At the end of the night, he insists, that he is entitled to sex. She resists, but he says she should have known what was coming, when she accepted all of his gifts.
4. A young woman in a nightclub is dressed in a short skirt, high heels and tight blouse. She is dancing with a man in a sexy manner. After she leaves the nightclub, he follows her out and down a dark street. He forces her to have sex, saying she asked for it and she wanted it.

## CRISIS ISSUES: Key Elements for an Education programme

Crisis issues	Elements for an education programme for adolescents

## DOMESTIC VIOLENCE MYTH/FACT SHEET

Domestic violence is the use or threat of physical violence against a partner in a primary relationship, or a family member, resulting in fear and emotional and or physical suffering.

### Myth/Facts

- 14) Domestic violence is a private affair-it is no one else's business  
\_\_\_\_\_
- 15) Domestic violence is not a big problem  
\_\_\_\_\_
- 16) Only lower class men beat their wives  
\_\_\_\_\_
- 17) Women provoke beating and even enjoy abusive treatment  
\_\_\_\_\_
- 18) A woman can stop the abuse easily by just leaving  
\_\_\_\_\_
- 19) Unemployment or job frustration is the only cause of domestic  
\_\_\_\_\_ violence.
- 20) Domestic violence is a power issue; a physically stronger  
person \_\_\_\_\_ or a person in a position of  
authority is abusing a weaker or more dependent person.
- 21) A substantial amount of homicides are committed against  
family \_\_\_\_\_ members.
- 22) The only person ultimately responsible for the battering is the  
\_\_\_\_\_ person who made the choice to be violent.

- 23) There is no one right decision for a battering victim.  
\_\_\_\_\_
- 24) Domestic violence does not occur 24 hours a day 7 days a week  
\_\_\_\_\_  
There may be peaceful/periods between beatings.
- 25) Both domestic violence and alcoholism are found in families  
from \_\_\_\_\_ all socio-economic, educational,  
religious, ethnic, and racial background.
- 26) Both domestic violence and alcoholism are progressive,  
\_\_\_\_\_ recurring and potentially fatal.

### BATTERING OF ADULT WOMEN

#### Types of abuse

Physical	Emotional	Sexual	Economic
Hitting	Name Calling	Rape	Withholding money
Slapping	Constant	Unwanted sexual	Lying about assets
Kicking	Harassment	Practices	Stealing money
Burning	Refusing to speak	Forced sex with other men	Mutilation
Humiliating you	Sexual abuse of your child	With family and friends	

<b>TOUCH CONTINUUM</b>			
<b>Lack of Touch</b>	<b>Nurturing Touch</b>	<b>Confusing Touch</b>	<b>Exploitive Touch</b>
(good)			(bad)

**The touch continuum** : is the range of touch – from lack of touch, to nurturing touch, to confusing touch, to exploiting touch.

**Lack of touch:** can be good or bad touch. If a person does not get any touching, yet needs and wants it, this lack of touch can be bad. If a person simply does not want to be touched, that is an individual right. In this case, lack of touch can be good.

**Nurturing touch:** is positive and good touch. A touch that feels like something is being given or shared with you - like hugs, kisses, and some games.

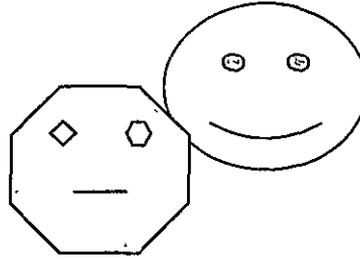
**Confusing touch:** is any touch that is not clearly good or bad. Both good and bad touch may become confusing. There, confusing touches can't be labeled. Any touch may become confusing when:-

- ❖ We are not sure what the person mean by it
- ❖ When the person is saying something that does not fit with the way he or she is touching us (we are getting a double message).
- ❖ When we are not used to the touch, or the touch does not fit in with our values, or we simply do not want to be touched.
- ❖ When the touch gets equated with sex.

**Exploitive touch:** is tricked or forced touch – a touch that feels painful, or as something is being taken away from you, or as if you were being used. Kicks. Hits, slaps. And sexual abuses are kinds of exploitive touch. Even simple touches or games like wrestling or licking may become bad or confusing touch if someone is hurt or forced.

(Adapted from The Child sexual Abuse Prevention Project: An Educational Program for children by Cordelia Kent, MA. NS. 1979)

**ORI & KORI  
HELP ADULTS  
&  
CHILDREN  
LEARN**



- Touching is important. It can make you feel warm, loved and comfortable.
- There are different kinds of touches: ok touches, not ok. touches and confusing touches. You can't tell what kind of touch a touch is by the way it makes you feel.
- It's ok. to say "no" if someone wants to touch you in a way that makes you bad or confused. Your body belongs to you, so you get to decide who touches you and when.
- We all have parts of our bodies that are private. Our swimming suits cover the private parts it's not ok. for just anybody to look at or touch.
- Bigger people should always know better than to touch little people in a way that's not ok.
- If anyone touches you or makes you touch them in a way you don't like, its always ok. to tell someone. If the first person you tell can't help you, it's ok to tell someone else.
- It's always ok to get your questions answered about touching

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# FLIP CHART

## Crisis Issues: Education Programme For Adolescents

Issues	Support System	Privacy	Boundaries

## HIGHLIGHTS OF AN EDUCATION PROGRAMME TO PREVENT SEXUAL ABUSE

In sexual abuse prevention programme we give people accurate information about sexuality and sexual abuse. We teach protection skills that can make an individual less vulnerable to unwanted touch and sexually exploitive situations. Four basic concepts in education aimed at preventing sexual abuse are listed below. We have included the main ideas that need to be covered when discussing each concept.

### **Support systems**

- A support system is a network of family, friends, or people in your community who can help when you have a problem.
- Who are the people in your support system whom you can trust/tell
- What skills do you need to teach these support people? (eg., ability to read a phone book, dial a phone, express yourself verbally, identify a trusted adult.
- How could you tell someone if you had a problem involving touching/sexual abuse?
- Are you part of some one else's support system?

### **Privacy**

- We all have a right to privacy
- it is important to have our privacy respected by others, so we can feel safe
- Your body is your own.
- Respect for body privacy is important
- There are public and private body parts. Private body parts are the areas covered by under wears or bathing suit – or the parts that are particularly “sensitive” or “private” to you.

-No one should touch or look at your private parts (or ask you to touch or look at them) in a way that makes you uncomfortable or confused.

## **Touching**

-Touch is a way in which people communicate and show that they want to be close.

-There are several types of touch: nurturing. (good), exploitive (bad) and confusing.

-Inventory what kinds of touches feel good, bad, or confusing to you and what reactions you have to them

-We need nurturing touches to survive and feel good about ourselves.

-You have the right to control who touches your body and how.

-Being tricked or trapped into sexual contact is wrong.

-You can trust your feelings about touch and decide what kinds of touches are good for you.

## **Asserting Your Boundaries**

-There are protection skills you can learn to make you less vulnerable to sexual abuse. Be aware of your environment, trust your feelings, and assert your boundaries.

-Sometimes people with more power, knowledge, and skill may try to trick or trap you into doing something you don't want to do.

-Letting them know your boundaries through confident words, actions and body posture can help keep you safe and free.

-Responses that are either aggressive or passive are less effective in averting exploitive situations.

- If sexual abuse happens to you, it is not your fault; it is the fault of the offender. Tell a trusted adult who can support and help you.

*You may use any opportunity to begin talking with young people about unwanted touch, confusion and exploitation. There is no one "right" way to begin the process. There are. However, several conditions that can strengthen the success of formalized educational programme.*

- The instructor is well acquainted with the group members.
- The group has some experience discussing controversial or private issues.

The conclusion of personal – safety information is an ongoing family life curriculum connects personal safety with other meaningful preparation for life activities. This approach will enhance the learning.

**(Adapted from Planned Parenthood of Northern New England).**

## **Rape and Child Abuse in Jamaica**

- In Jamaica, in 1997, there were 1,620 reported cases of rape and carnal abuse, 197 cases of incest and 49 cases of buggery. More females than males are victimized by all except the last.
- Domestic disputes accounted for 21% of all murders in 1997.
- In the same year, the Corporate Area accounted for 40% of all cases of rape and carnal abuse in Jamaica.

**Reproductive Health consequences of sexual violence against women include:**

- mental and emotional anguish
- fear of men and sex
- pregnancy loss and low birth rate due to battering during pregnancy
- chronic pelvic pain
- STD/HIV infection
- early sex and sexual
- low self-esteem
- prostitution.

# SESSION **Fourteen**

## Care of Adolescent Pregnancy and Childbirth

---

### HANDOUT – THE CASE OF JANET

*Participants will discuss the following case of an adolescent girl who became pregnant and who gave birth to a child with multiple disabilities.*

#### **Case Study of Janet, an Adolescent Mother of a Child With Multiple Disabilities.**

Janet is fifteen years old and the only child of a deeply religious, hardworking and unmarried seamstress. Janet attends a traditional High School and has been doing well academically. She wants to be a doctor. Unknown to her mother, Janet has been seeing Bill on her way from school. After six months of this relationship, Janet discovers that she is pregnant and is deeply afraid and distressed. Her school grades plummet as she worries about what to do. She keeps her pregnancy secret for as long as possible and when she can no longer hide it, she tells her mother. Miss Brown, Janet's mother, is furious because her only child has deceived

and disappointed her. Additionally, Miss Brown has struggled all of her life to support her only child and Miss Brown's sister who is mentally retarded. Miss Brown has warned Janet on numerous occasions about having boyfriends or engaging in unprotected sex. She was anxiously waiting the time when Janet can graduate from high school and go to work to relieve some of the economic pressure that weighs her down. As the home is torn apart by dissension, Janet does not receive antenatal care until two months before her baby is born.

The day finally arrives and Janet gives birth to a beautiful baby boy. She has had to drop out of school to have her child and to take care of him.

Indeed he seems oblivious of her and is far more interested in flapping his fingers in front of his face or in spinning around aimlessly for long periods of time. Any changes in this routine produce a tremendous tantrum. If she slaps him he bangs his head against the wall.

At last her mother saves enough money to enable Janet to take Barry to the doctor. After several referrals to specialist doctors at the nearest public hospital, Barry is diagnosed as having infantile autism and mental retardation. Janet lives in a deep rural area and no school is willing to take him. She keeps him at home until he is four and then she persuades a

woman who keeps a backyard nursery to keep him in the days. Two months later, Barry becomes very ill. When she takes him to the doctor she discovers that he has contracted polio. For the next few years her life becomes a nightmare, as she has to physically carry Barry wherever she goes. People stare at Barry so she keeps his withered limbs covered by a long shirt and pants as she carries him to and from school. Her mother, Miss Brown is ashamed of her grandchild and is deeply resentful at being forced to support Janet and Barry as well as Miss Brown's own retarded sister. To make matters worse, the baby's father has disappeared saying that the child is not his because he does not physically resemble him.

Janet at age nineteen is deeply depressed. She has a special child. She has not completed high school although she is of above average ability intellectually. She has no job and no prospect of getting anything other than the most menial one. Even that she is unable to accept because she has to physically carry Barry to and from the only basic school that has reluctantly agreed to take him. She has no one to take care of him at home. Her mother must work to support all four of them: herself, her retarded sister, Janet and Barry.

*NB. It is possible to obtain genetic counselling to anticipate ahead of time the likelihood of giving birth to a child with specific disabilities.*

## **Factors That Influence Adolescent Pregnancy And Childbirth**

There are social, economic and biological factors influencing the trends of adolescent pregnancy and childbirth.

### **A. The Socio-Cultural Factors**

#### **Traditional practices**

- Early marriage

This is a cultural phenomenon still practiced widely in Africa, Middle East and parts of Asia. It continues, often despite the presence of laws against it.

- Pressure to have children

In many societies pregnancy is expected to follow soon after Marriage. If marriage is early, early childbirth is almost inevitable.

#### **Changing circumstances of young people**

- Early sexual debut

This may be due to increasing loss of traditional social norms for both adolescent themselves and adults. The trend in the age at first sexual debut (where data exist) has decreased in several countries of the world, though there is still some variation, and there are instances where the age at first sexual debut has remained

unchanged or actually increased.

Risky behavior such as substance use and alcohol abuse are often associated with unprotected sexual activity. Pregnancy may arise from such activity. Girls living in difficult circumstances may resort to substance abuse to escape hunger and other social pressures.

### **Vulnerability of Young People:**

- **Sexual coercion and rape**

There is not enough data on sexual coercion or rape. However there is some evidence that some adolescent pregnancies result from such assaults.

- **Socio-economic factors**

Economic hardships can force young girls to leave home and seek livelihood and support elsewhere. Sexual exploitation and prostitution are sometimes consequences of this. Ignorant of contraception and family planning information and services, the young girl may soon find herself pregnant.

### **B. Biological factors**

The declining age of menarche in developed countries and in many developing countries, accompanied by early sexual debut combine to make adolescent pregnancy and childbirth more common especially when there is lack of access to appropriate information and services as well as decreased schooling. The age of menarche in most African countries has dropped from 14 years to 12 years in the last decade or two.

### **C. Service Related Factors.**

## **Lack Of Access To Reproductive Health Information And Services**

Many adolescents lack accurate information concerning the physical and psychosocial changes that occur during adolescence, their implications and how to go through the changes without undue harm to themselves and others.

This is often because the subject of sexuality is a sensitive one in many societies.

Adolescent pregnancies tend to be highest in regions with the Lowest contraceptive prevalence. Moreover in many developing countries recent gains in contraceptive prevalence has been almost exclusively among older, married women and not adolescents. In some countries policies towards contraceptive services for adolescents remain ambiguous, further impeding access.

Other barriers to the use of health services by adolescents relate health care providers.

- their inability to provide young people the services they need without the consent of parents or guardians.
- not maintaining confidentiality
- who may ask them difficult and embarrassing questions, so putting them through unpleasant and painful procedures.

## **Lack of services for safe termination of pregnancy**

Many adolescent with unwanted pregnancy resort to termination of the pregnancy even in countries where it is against the law.

Availability and access of services for pregnancy termination for this age group influence the proportion that will carry the pregnancy until delivery and maternal mortality from unsafe abortion.

*Population and Development in the Caribbean- A Demographic Survey by Jean – Pierre Guengant, 1985, p9,*

The average number of births per 1000 females under 20 years in Jamaica during the period 1975-1979 was 17 whereas that of Barbados was 1.1 and that of Trinidad and Tobago was 5.4. The disparity between the three countries has continued. What factors contributes to the high incidence of teenage pregnancy in Jamaica relative to that of Barbados and Trinidad.

**Why Are These Complications Worse In Adolescents Than In Adults?**

The above complications are by no means limited to adolescents. Older women also suffer the same. Also, the situations of adolescents vary depending on their marital status and the support available for them to go through pregnancy and childbirth. In addition, social and cultural norms often hinder the ability of adolescents (married and unmarried) to obtain information and access antenatal, delivery and postnatal services. There are however, several reasons why the complications have a worse outcome in adolescents.

1. Adolescents rarely gain access to adequate quality antenatal care (ANC). Unmarried adolescents tend to hide their pregnancies, while many married ones are simply too young and ignorant to know its value. Even when they go for ANC, they often start very late and record rather few attendances. Socio-economic factors further influence the benefits adolescents many gain from ANC. They are less likely to afford prescribed medications or laboratory tests thus delaying the obscuring appropriate interventions.
2. Many adolescents try to deliver at home. Many adolescents come to Hospital only as a last resort, often late and with complications. This Is multi-factorial.

- they have not attended ANC and therefore are afraid to come for delivery
  - they are afraid of hospitals: new surrounds and strange providers
  - they have heard discouraging stories about mistreatment by midwives
  - they cannot afford the cost of institutional delivery
  - Cultural practices dictate that they deliver normally and at home especially the first child
3. Compared to older women, adolescents are, less empowered to make Decisions about their health. The dis-empowerment is both economic and social. If married the husband is likely to be much older and probably polygamous. If single her situation, because of the shame of getting pregnant, leaves her voiceless and even as an outcast. Single Pregnant adolescents in some cultures are given away as younger wives or sent to some distant relatives until their delivery. Physical abuse is not uncommon under these circumstances.
  4. Biologically, young adolescents are not yet mature enough for the Physical and physiological assault imposed on them by a pregnancy. They may also suffer nutritional deficiencies since they are still growing. The pelvic bones are not fully mature, hence there is the likelihood of cephalo-pelvic disproportion. They are not psychologically prepared for motherhood. There is the likelihood of post partum depression and psychosis.
  5. The general ante-partum and intra-partum care that adolescents receive from providers is often wanting. Most providers will be from Communities that frown upon adolescent pregnancy, especially for the single girl. Antenatal attendances or admission for delivery is therefore a most unpleasant experience for the young girl. She receives less attention, can be mocked and called names and response to her appeal for help is often slower 'who told her to get pregnant' is the dominant.

### **Scenario 1**

A doctor and his team are conducting a ward round at the maternity unit on Monday morning. There are 25 patients. Ten of them are teenagers. There is a 14-year-old girl admitted with anemia. Her haemoglobin is 7gm%.

As they reached the bed the nurse started scolding the young girl.

She told her that she has no business getting pregnant. The doctor is more understanding and wants to protect the girl. Her mother is waiting in the corridor. Her husband is no longer talking to her.

**Roles:** doctor, nurses, 14 year old girl, mother

### **Scenario 2**

A woman and her 15 year old pregnant daughter (24 weeks) are in the health centre to see the doctor. He carried out a physical examination of the girl which was within normal limits except that he found her conjunctivae and nail beds to be very pale. He had thus sent them for a blood test and now has the report which reveals that the girl has a haemoglobin of 9 gm%. He is trying to initiate treatment.

**Roles:** doctor, 15 year old pregnant girl (24 weeks), and mother

### **Scenario 3**

The Principal of her school brings a 16 year old school girl (in school uniform) to the emergency department. She has severe lower pains. The teacher does not know what is wrong but suspects that she may be pregnant.

On examination by the midwife a term pregnancy is confirmed. Her blood pressure is 150/100. She is also in labour, 4 cms dilated. The midwife calls the doctor to talk to the teacher. The girl is sent to the labour ward for monitoring of her labour. She delivers a 2-kg male

infant 6 hours later.

**Roles:** doctor, nurse, teacher, and girl

### **Scenario 5**

A 15-year-old single girl has just delivered at the health centre. She is a housemaid and claims that her employer raped her. She does not accept the pregnancy and does not want the baby. She knows nothing about breast-feeding. Her family is in the rural area 500 km away. She has no money and her employer had kicked her out 2 days before she went into labour.

**Roles:** nurse, doctor, and girl

### **Scenario 6**

A 14-year-old girl was discovered to be pregnant by the school nurse during one of her visits. She was referred to the health centre, and after three weeks of hesitation has presented herself. She has come by herself for the first antenatal visit.

**Roles:** nurse, doctor, and girl

### **Scenario 7**

A 15-year-old single girl delivered a baby boy three days ago at this maternity. She is now ready to go home, and the nurse is meeting with her.

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

## **Care of Adolescent Pregnancy and Childbirth**

## **Case Histories and Scenarios: Facilitator's Notes**

### **Case History 1**

- Inadequate access of adolescents to information and services for reproductive health, especially contraception and safe abortion services.
- Inadequate communication on reproductive health issues between adolescents, parents and other adults
- School policies on pregnant adolescents

### **Case History 2**

This case history highlights health issues associated with labour and delivery in adolescents, for example:

- supervision of labour by non-skilled persons
- complications such as prolonged obstructed labour, operative delivery, postpartum fever, and consequence – vesico-vagina fistula.

### **Scenario 1**

- poor attitude of some health workers to adolescents
- dilemma of parents of adolescent girls.

### **Scenario 2**

This scenario should depict the following:

- appropriate counselling of a young pregnant girl whose mother is aware of the situation
- good listening skills
- good knowledge of anaemia during pregnancy, and what to do
- realization that intervention on nutritional problems in adolescents often involves the family, since the control of food in the household often lies beyond the adolescent.

### **Scenario 3**

This scenario should depict the following:

- the commonly occurring disappointment of teachers to pregnancy in their students.
- the commonly occurring denial of adolescents when they are pregnant
- the fact that children of adolescents tend to be of low birth weight.

### **Scenario 4**

This scenario should depict the following:

- denial of some adolescents of their pregnancy
- ignorance of some adolescents concerning issues related to baby care
- appropriate counselling of the health worker regarding post-partum issues, especially breast feeding and contraceptive advise.

### **Scenario 5**

This scenario should depict appropriate counselling of a pregnant Young adolescent covering issues related to support, care, danger Signs, etc.

### **Scenario 6**

This scenario should depict appropriate counselling of an adolescent post-partum covering issues related to breast feeding, contraception, care of the baby.

## Display Chart

### Risk Factors In Adolescent Pregnancy

- child birth
- maternal
- perinatal factors
- antenatal complications
- postpartum problems
- danger to the unborn

#### How Common Is Adolescent Pregnancy And Childbirth?

Adolescent pregnancy and childbirth is not uncommon. The global average rate of births per 1000 females 15-19 years of age is 65. There is, however, wide regional variations (1.2.3). For example:

<b>Rate of births per 1000 females aged 15-19 years</b>	
<b>AFRICA</b>	43/1000 range 45 in Mauritius to 229 in Guinea
<b>MIDDLE EAST</b>	56/1000 range 18 in Tunisia to 122 in Oman
<b>South East Asia</b>	56/1000 range 4 in Japan to 115 in Bangladesh
<b>Latin America</b>	78/1000 range 56 in Chile to 149 in Nicaragua
<b>Europe</b>	25/1000 range 4 in Switzerland to 57 in Bulgaria
<b>North America</b>	42/1000 range 24/1000 Canada to 60/1000 in USA

Indeed in many part of the developing world, the traditional practice of early marriage and the expectation that a baby should come soon after marriage force many young girls into early motherhood. In these traditional societies early motherhood has not been recognized to be a problem, especially since most of these pregnancies occur within the accepted institution of marriage and are presumably wanted.

Adolescent pregnancy of outside marriage is a relatively new phenomenon in these societies and is on the increase. Many of these are undesired and often times unwanted. The declining age at menarche and the rising age of marriage are now exposing girls to a much longer period of being single when they are already biologically capable of conceiving.

It is now recognized that adolescent pregnancy is attended by several combinations that are attributable to both biology and the social environments. Thus event if married, the young adolescent still faces a riskier pregnancy than an older single woman.

Review available data on adolescent pregnancy and childbirth in your country or hospital  
How does it compare with the rest of the world/country?  
Do you think it is declining or rising? Why

# SUMMARY NOTES

A number of factors contribute to adolescent pregnancy. These include: the declining age of menarche, unprotected sex and inadequate access of adolescents to reproductive health information and services.

Adolescents have higher maternal mortality than adults. Adolescent maternal mortality is two to five times higher than that of adults

Their offspring also have higher mortality  
Mortality is two to three times higher than for the offspring of adults

Many complications arising during pregnancy and delivery have worse outcomes in adolescents

Remember that this is because of their status in society, access to appropriate information and services and their level of physical and psychological maturity.

Adolescents usually present late for antenatal care  
adolescents have a:

- higher incidence of premature labour and delivery
- special need for nutrition advice and support
- higher rate of HIV sero-positivity in many settings
- special need for support during and after delivery

# SESSION **Fifteen**

## Abortion

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### **Abortion And Pre-Natal Care:**

Throughout the world, over half a million women die unnecessarily each year from unsafe abortions and other obstetric emergencies due to social rather than medical reasons.

In Jamaica, one out of three pregnancies lacked adequate prenatal care. Woman who are poor and who live in rural areas are more likely to begin pre-natal visits late or to make an insufficient number of visits. The consequences of this include:

- greater risk of having children who are born with mental and physical handicaps

- poor nutrition for mother and baby health risks for mother and baby

# SESSION Sixteen

## Sexual Dysfunctions

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### Clarification Of Words/Terms

Dysfunction	Explanation
<b>Sexual Orientation</b>	The total expression of who we are as human beings.
<b>Heterosexual</b>	Conscious or unconscious assumption that one's sex on the whole is more superior
<b>Homosexual</b>	Gratifying one's self sexually
<b>Bisexual</b>	Preferring emotional/sexual partners of the same sex
<b>Celibate</b>	Personal conviction that each has about being male or female
<b>Asexual</b>	Refers to being male or female
<b>Incest</b>	Sexual relationship with blood-related relatives. (e.g. father and daughter, brother and sister)
<b>Script</b>	A device for guiding action and for understanding

	it. It is a way of organizing our thinking about behaviour. It may also be a plan that persons may have in their heads for what they are doing or is about to do.
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## Sexual Behaviours

Sexual Behaviours cover a wide range of sexual expressions including kissing, sexual intercourse, masturbation, etc. The following list of sexual behaviours may be considered non-standard or deviant in most cultures.

- Incest - sexual intercourse between blood-related family families e.g., father and daughter, sister and brother).
- Frotteurosexual - deriving sexual pleasure from rubbing one's genitals against other person.
- Pedophilia - deriving sexual pleasure from children (child molestation)
- Pederasty - deriving sexual pleasure from young boys
- Voyeurism - deriving sexual excitement from observing others undressing, having sexual intercourse, kissing, masturbating, petting, etc. Sometimes voyeurs are called 'Peeping Toms.'
- Coprophilia - deriving sexual pleasure from feces, filth, dirt, Soiled underwear, etc.
- Necrophilia - deriving sexual pleasure from intercourse with a Corpse.
- Satyriasis - in men, excessive desire for sexual intercourse.
- Nymphomania - in women, excessive desire for sexual intercourse.
- Oral Sex - cunnilingus, fellatio, annilingus. Cunnilingus is

- mouth-to-vulva, Fellatio is mouth-to-penis,  
Anilingus is mouth-to-anus.
- Transsexual - a man or woman, most often a man who believes himself trapped in the wrong body and seeks a operation to make his body look more like that of the opposite sex.
- Transvestite - usually a heterosexual, not homosexual, man who derives sexual pleasure from wearing women's clothes
- Sodomy - anal intercourse.
- Somnophilia - dependent on the fantasy or actually intruding on and fondling a sleeping stranger for sexual arousal.
- Troilism - two people engage in sexual activities while a third Person observes.
- Asphyxiophilia - sexual arousal from employing partial asphyxiation, as by hanging, choking (usually an adolescent male).
- Narratophilia - sexual arousal from listening to erotic narratives in a Song, story, etc.
- Pictophilia - sexual arousal dependent on sexy pictures.
- Sado-Masochist - sexual arousal from inflicting and receiving pain.
- Drag Queens - a male homosexual who dresses flamboyantly in Exaggerated imitation of woman.
- Gerontosexual - sexual pleasure from having intercourse with an Old woman or man.
- Bestiality/  
Zoophilia - sexual pleasure from intercourse with animals.

Urophilia - sexual pleasure from urine.

## **A Message To ... Adolescent Girls And Women**

Sexuality is the total expression of who we are as human beings. Each of us is born with our own individual sexuality and we will have it until the day we die. It includes all of the wonderful things, which make us, who we are. Sexuality is a precious gift from God. It is a combination of our emotions, attitudes, behaviour, personality, spirituality, biology, our intellect, likes, dislikes, and much more.

From the moment we are born, we are given scripts, which tell us what roles we should play, how we should behave, and what we should think about ourselves and others. These scripts are given to us by our parents, school, family, peers, society, culture, religion, politics, the media including radio, TV, magazines, commercials, our environment, and even the six o'clock evening news. Our lifestyles and taste for material things are largely influenced by these factors.

When girls are young, they are given dolls, stuffed animals, and tea sets which teaches them to be demure, nurturing, and homemakers. On the other hand, boys are given guns, erector sets, and trucks, which teaches them to be assertive, aggressive and tough.

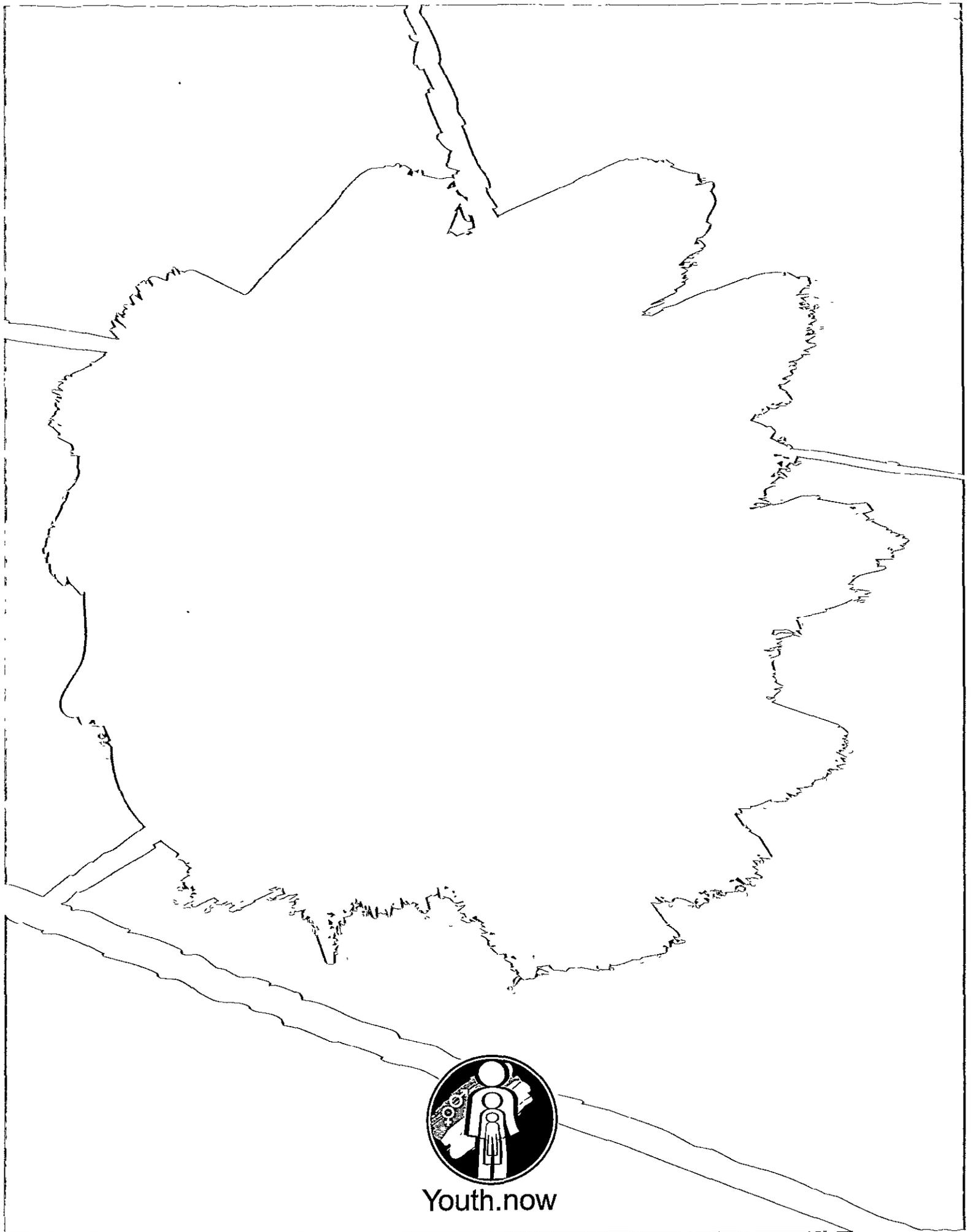
Scripts are always changing, and they never stop coming even as we get older. It is no wonder why so many young girls fall victim to out of wedlock pregnancies, sexual abuse, domestic violence, HIV/AIDS and other forms of abuse. Too often girls are given scripts that teaches them to be victims. They are not given the scripts they need to cope with growing up. These scripts fail to prepare them for handling the emotional and physical challenges of puberty and adolescence. Girls are taught that they are sex objects, and ornaments. The scripts they receive tell them nothing about the sacredness of their bodies, or that they are uniquely designed and

wonderfully made by God. They know little or nothing about their real value, inner beauty or about what true femininity is.

Adolescent girls and adult women spend countless hours perfecting outer beauty. They go into debt and spend disproportionate amounts of money on clothes, jewelry, fancy hair-dos, nail sculptures, make-up, perfumes, and plastic surgery. Always trying to conform to shallow images of beauty. Too many women use their bodies for sex in exchange for love, or perhaps some material gain. They form unhealthy relationships with men who abuse them, they defile their bodies, and even have babies with men they know don't want them. The bottom line is, they're looking for love and affirmation in all the wrong places.

The good news in all of this is that "scripts" can be changed and even destroyed. When young girls are made aware of awesome impact scripts can have on their lives, they can change them. They can begin by treating their body's as a sacred gift from God, and not allow them to be used as a tool for negotiating relationships or things. Girls should reject social scripts, which make them victims, and be told that "No one can abuse them without their consent. And, that when they accept negative scripts, they ultimately act them out."

We want young girls to celebrate their femaleness, by being good to themselves. We want to encourage them to turn away from eternal things which bring death and embrace eternal things which bring life. Remember, sexuality is a precious gift from God. Whenever a man tells you that he loves, need or wants you, remember that you are worthy to be love, but only in a manner which will honor and glorify God.



Youth.now