Youth-Friendly Postabortion Care Supplemental Training Module

Appendix 2: Participant's Handouts

OCTOBER 2012

POSTABORTION CARE
PAC
CONSORTIUM

Participant Handout 1.1A: Overview of YFPAC Supplemental Training Module: Purpose, training objectives, and agenda

This training module is a supplemental training that is designed to be added to a comprehensive PAC health provider training. The goal of the training module is to improve providers' abilities to provide high-quality PAC services to adolescent clients aged 10-19.

At the end of the training, participants will be able to:

1. Describe the period of adolescence,
2. Establish YFPAC services,
3. Provide adolescents with PAC care and treatment that takes into consideration their unique needs,
4. Explain and provide contraceptive options to adolescent PAC clients,
5. Demonstrate appropriate, non-judgmental and comprehensive counseling of adolescent PAC clients, including contraceptive counseling and referrals.

Full Supplemental Training Module

DAY 1	
Time	**Session**
9:00am–9:30am	Session 1: Overview of YFPAC Supplemental Training Module
9:30am–11:15am	Session 2: An Overview of Adolescence
11:15am–11:30am	Tea Break
11:30–1:30pm	Session 3: Youth-Friendly Postabortion Care Services
1:30pm–2:30pm	Lunch
2:30pm–4:00pm	Sessions 4.1, 4.2A, and 4.2B: Counseling Adolescent PAC Clients
4:00pm–4:15pm	Tea Break
4:15pm–4:45pm	Sessions 4.3: Counseling Adolescent PAC Clients
DAY 2	
Time	**Session**
9:00am–9:15am	Welcome and refresh
9:15am–10:45am	Session 4.4: Counseling Adolescent PAC Clients
10:45am–11:30am	Session 5: PAC Procedures for Adolescent Clients
11:30am–11:45am	Tea Break
11:45am–1:15pm	Sessions 6.1-6.3: Postabortion Contraception for Adolescent Clients
1:15pm–2:15pm	Lunch

2:15pm– 4:15pm	Session 6.4-6.6: Postabortion Contraception for Adolescent Clients
4:15pm–4:30pm	Tea Break
4:30pm-5:00pm	Session 7: Referrals for Adolescent Postabortion Clients
5:00pm-5:30pm	Session 8: Closing Summary and Post-test or Wrap-up

Participant Handout 1.1B: YFPAC Optional Pre-Test

1. What age range does adolescence refer to? (circle one)
   a. 7-15
   b. 15-19
   c. 10-30
   d. 10-19
   e. 15-24

2. Name three reasons why adolescents often seek late, cheaper, and unsafe abortions.

   _____

   _____

   _____

3. Having specially trained providers serve adolescents seeking PAC is important because: (Circle all that apply)
   a. Communicating with adolescents can require special care with regards to language, tone, and establishing trust
   b. Adolescents are very demanding and require a trained provider to navigate rude attacks
   c. Healthy life-long habits are established in adolescence
   d. Adolescents may ask to see a training certificate
   e. Adolescents are particularly vulnerable to poor SRH outcomes

4. What are the five elements of PAC as endorsed by the PAC Consortium?

   _____

   _____

   _____

   _____

   _____

5. Name three essential minimum standards for YFPAC services:

   _____

   _____

   _____

6. What are the three most important concerns that adolescents have when it comes to SRH and YFPAC service delivery? (Circle three)
   a. Privacy
   b. Pain-free experience
   c. Confidentiality
   d. Respect
   e. Television or games at the health center
   f. Brochures that they can take home with them

7. Which of the following are good counseling techniques for adolescent PAC clients? (Circle all that apply)
   a. Ask close-ended questions (yes/no questions) so that the client feels more comfortable
   b. Speak in understandable terms, avoid overly technical language
   c. Look directly at the patient, nod your head, and listen actively
   d. Sit behind a desk or above the patient so there is distance and she knows that she should respect you
   e. Avoid using questions that start with “why” and/or other judgmental language

8. As the PAC visit may be the first time the adolescent is visiting a health facility, name at least two other SRH concerns that the provider should screen for and either treat or refer for additional services.

   _____

   _____

9. How soon can women, including adolescent women, become pregnant following an abortion that occurs during the first trimester of the pregnancy?
   a. 3 months later
   b. In as few as 10 days
   c. 6 months later
   d. When her monthly bleeding (menses) returns

10. In almost all cases, how soon after a young woman is provided with PAC should a contraceptive method be initiated?
    a. On the same day as the PAC visit in almost all cases
    b. As soon as her monthly bleeding returns
    c. In three months
    d. In one week

11. Which method of contraception may not be suitable for an adolescent PAC client?
    a. Implants
    b. Combined oral contraceptives
    c. Condoms
    d. Sterilization
    e. Injectable contraceptives

12. Which is the best way for adolescents to prevent both unintended pregnancy and STIs?
    a. Emergency contraceptives
    b. Implants
    c. Correct and consistent use of condoms, or use of condoms plus another contraceptive method (called dual method use)
    d. Oral contraceptives

13. Which of the following aspects must be taken into account when counseling adolescent clients on contraception? (Circle all that apply)
    a. Risk of sexually transmitted infections
    b. Effectiveness of method
    c. Patient preference for a particular method
    d. Availability and access to methods
    e. Concerns that might be more relevant to adolescents such as weight gain, skin complexion, and discreteness of the method

14. What are important characteristics to remember when referring an adolescent for services elsewhere? (Circle all that apply)
    a. If the referral is for a particular method of contraception not available at the facility, provide the adolescent with an acceptable alternative for use until the referral visit is complete
    b. Refer the adolescent to the facility that is the farthest away because adolescents like to maintain privacy
    c. When possible, refer adolescents to youth-friendly services
    d. Clearly explain to the client the importance and purpose of the referral as well as how to get there and what to expect
    e. Refer the adolescent to private health facility because adolescents always prefer private facilities

Participant Handout 2.3A: Stages of Adolescent Development

Stages of Adolescent Development: Physical, Sexual, and Emotional Changes		
Early Adolescence (10-13)	**Middle Adolescence (14-16)**	**Late Adolescence (17-19)**
• Onset of puberty and rapid growth • For women: menarche; development of breasts; widening of hips; appearance of pubic and underarm hair; development of the vulva • For men: growth of the penis, scrotum, and testicles; nighttime ejaculation; morning erection; development of back muscles; appearance of pubic and underarm hair • Both sexes: accelerated growth; increased perspiration; presence of acne; changes in facial features; change in tone of voice; activation of sexual desire; interest in physical changes • Beginning to consider other influences outside of the family • Beginning to think abstractly • Increasing concern with image and acceptance by peers • Behavioral expressions of emotion: withdrawal, hostility, impulsiveness, non-cooperation	• Continued physical growth and development • Develop more analytical skills; greater awareness of behavioral consequences • Strongly influenced by peers, especially on image and social behavior • Increasing interest in sex; intimate relationships begin with others • Greater willingness to assess own beliefs and consider others • Behavioral expressions of emotion: withdrawal, hostility, impulsiveness, non-cooperation • Concern about sexual identity and decision making • Feelings of being misunderstood and/or rejected	• Reach physical and sexual maturity • Improved problem solving abilities • Develop greater self-identification • Peer influence lessens • Intimate relationships more important than group relationships • Increased ability to make adult choices and assume adult responsibilities • Behavioral expressions of emotion: withdrawal, hostility, impulsiveness, non-cooperation • Feelings of being misunderstood and/or rejected • Concern about sexual identity and decision making

Participant Handout 3.3A: Characteristics of Youth-Friendly Services

The characteristics of youth-friendly services pertain to the providers, the health facility itself, and to the program design. To successfully serve adolescent clients with reproductive health care, service programs must attract, adequately and comfortably meet the needs of, and retain these clients by considering the following characteristics:

Provider Characteristics	Health Facility Characteristics	Program Design Characteristics
• Specially trained staff • Nonjudgmental • Can communicate well with young people and support informed choice • Respect for young people • Offer privacy and confidentiality • Allow adequate time for client-provider interaction	• Adequate space and privacy • Convenient hours • Convenient location • Separate space and/or special times • Comfortable surroundings • Peer counselors available onsite • Supportive policies that do not restrict services based on age, marital status, gender, or parental/familial/partner approval • Policies that allow adolescents to have a companion accompany them during counseling and procedures, if the adolescent so desires • Equipment, treatment, and pain management take into consideration the special needs of adolescents • Policies that allow providers to spend adequate time with clients	• Youth involvement in design and mechanisms for continuing feedback • Youth representatives on health facility board or management committees • Drop-in clients welcomed • Short waiting times • No fees or affordable fees • Publicity and recruitment that inform and reassure youth • Both young men and young women welcomed and served • Wide range of SRH services (e.g., PAC, contraception, HIV services) and contraceptive methods available • Referrals for necessary services available • Educational material available onsite and for clients to take home

Participant Handout 3.3B: Youth-Friendly PAC Technical Guidelines

TECHNICAL GUIDANCE ON YOUTH-FRIENDLY PAC*

Recognizing that unsafe abortion is a major contributor to maternal mortality, particularly for young women, the Postabortion Care (PAC) Consortium[1] is pleased to introduce *Technical Guidance on Youth-Friendly PAC*. This document is intended to be used by program managers and technical staff to improve the quality and access to life-saving PAC services for adolescents. Drawing on the body of literature on youth-friendly services and unsafe abortion among adolescents and on Consortium members' youth programming experience, the Youth-Friendly PAC Working Group examined the special needs of adolescent PAC clients. Using the PAC Consortium's *Essential Elements of Postabortion Care: An Expanded and Updated Model*[2] as a framework, the Working Group developed recommendations for making existing PAC services more youth-friendly. Monitoring and evaluation measures were also included so that managers and staff can ensure that PAC services offered to young people[3] are meeting their various needs.

I. Why Focus on Adolescents Within PAC Programs?

Adolescence, defined by the World Health Organization as a stage of development between the ages of 10-19, is a time marked by great physical and psycho-social change and a move toward independence from parents and caretakers. Adolescents account for 1/5 of the world's population and approximately 87% live in developing countries, where the legal indications for abortion may be highly restricted (for example, in cases of rape and incest or to protect the life and health of the woman).[4,5] Although practices differ by region and culture, more young people are engaging in pre-marital sexual behavior, which is linked to the trend of both women and men marrying at later ages. This results in a longer period of time during which sexual activity and pregnancy can take place outside of marriage, which in many settings is unsanctioned. These trends are sure to continue, as social changes that influence these behaviors increasingly are underway throughout the world. Such changes include people's access to different forms of media and new ideas, urbanization, migration, changes in traditional communication channels through which adults pass on information and guidance to young people, increased educational

Different Kinds of Adolescents

Adolescents are not a homogeneous group and are comprised of young women and men who are:

- At different stages of physical and psycho-social development
- In-school and out-of-school
- Married and unmarried
- HIV-, HIV+, or without knowledge of their HIV status
- Ethnic minorities
- Of different sexual orientations (heterosexual, homosexual and bi-sexual)
- Commercial sex workers or street youth
- Living in poverty
- Orphans or vulnerable youth

[1] The organizations that participated in the PAC Consortium Youth Friendly PAC Working Group included Pathfinder International, Ipas, Family Health International, CATALYST Consortium, IPPF, IntraHealth, and JHPIEGO

[2] PAC Consortium Community Task Force, Postabortion Care Consortium. 2002. *Essential elements of PAC: An expanded and updated model.*

[3] Adolescents comprise the 10 to 19 year age group, while youth usually refer to those between the ages of 15 and 24, and young people includes both youth and adolescents. "Youth," "young people" and "adolescents" will be used interchangeably in this document.

[4] UNFPA. 2003. *State of world population 2003. Making 1 billion count: investing in adolescents' health and rights.* New York: UNFPA.

[5] de Bruyn, M. and S. Packer. 2004. *Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling, and Clinical Care*. Chapel Hill, NC: Ipas.

opportunities for girls and women, and opportunities for young men and women to interact socially and vocationally.[6]

Young people often are more vulnerable to unwanted pregnancy and unsafe abortion due to their psycho-social development, power and gender imbalances vis-à-vis adults and males, poverty, sexual abuse and coercion, as well as traditional/cultural values that prevent or limit access to sexual and reproductive health (SRH) information and services. Less than 5% of the poorest young people use modern contraceptive methods and 1/3 of women in developing countries give birth before the age of 20.[7,8]

Due to the cultural and religious sensitivities surrounding abortion, it is difficult to determine the exact incidence of abortion. However, it is estimated that as many as 4.5 million adolescent women seek an abortion each year.[10,11,12,13] Of these, 40% are conducted under unsafe conditions and 95% of all unsafe abortions take place in developing countries, where abortion is legally restricted or highly inaccessible.13 An analysis of data on unsafe abortion by age indicates that the age pattern differs markedly from region to region. For example, the proportion of women aged 15–19 years in Africa who have had an unsafe abortion is higher than in any other region of the world and almost 60% of unsafe abortions are among women under the age of 25. This contrasts with Asia where 30% of unsafe abortions are among women less than 25 years and Latin America and the Caribbean where 42% of unsafe abortions are among women less than 25 years.[14]

In Nigeria, the Society of Gynecologists and Obstetricians estimates that about 10,000 or 50% of the Nigerian women who die annually from unsafe abortion are adolescents and that abortion complications are responsible for 72% of all deaths among women under 19 years of age.[9]

Young women are more apt than older women to delay seeking an abortion as well as resort to cheaper and unsafe providers due to denial or unawareness that they are pregnant, fear of their parent's reaction, and/or lack of financial resources to obtain an abortion, all of which increase their risk of complications, including death. Also, they frequently delay seeking care for abortion-related complications once they occur. As a result, adolescents are more likely to suffer serious complications from unsafe abortion relative to other groups. In addition, very young adolescents also have higher rates of spontaneous abortion (i.e., miscarriage).[15,16,17,18,19]

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[6] Senderowitz, J. Hainsworth, G. and Solter, C. 2003. *A Rapid Assessment of Youth Friendly Reproductive Health Services.* Technical Guidance Series, No. 4. Watertown, MA, Pathfinder International.
[7] Ibid
[8] deBruyn, M. and S. Packer. 2004. Adolescents, Unwanted Pregnancy and Abortion: Policies, Counseling, and Clinical Care. Chapel Hill, NC: Ipas.
[9] Raufu, A. November 2002. *Unsafe Abortions Cause 20,000 Deaths a Year in Nigeria.* British Medical Journal. 325:988.
[10] Treffers, P. December 2002. *Issues in Adolescent Health and Development: Adolescent Pregnancy.* WHO/FCH/CAH/02.08 & WHO/RHR/02.14. Geneva, WHO.
[11] United Nations General Assembly. *Report of the Round Table on Adolescent Sexual and Reproductive Health and Rights: key future actions.* Available: http://www.unfpa.org/webdav/site/global/shared/icpd/rtable1.pdf
[12] Alan Guttmacher Institute (AGI). 1998. *Into a New World. Young Women's Sexual and Reproductive Lives,* New York: AGI.
[13] Pathfinder International. 1998. *Insights from Adolescent Project Experience,* Watertown, MA: Pathfinder.
[14] World Health Organization (WHO) 2004. *Unsafe abortion, Fourth edition, Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2000.* Geneva, WHO.
[15] McCauley, A. and Salter, C. 1995. *Meeting the needs of young adults.* Population Reports, Series J, No. 41. Baltimore: John Hopkins School of Public Health, Population Information Program.

Service Barriers and Definition of Youth-Friendly Services

Adolescents are less willing and able to seek both family planning services to prevent unwanted pregnancy and unsafe abortion or to seek PAC services in the case of an unsafe abortion, for the following reasons:

- National laws and policies restricting access to services based on legal age and/or marital status
- Inconvenient hours of facility operation
- Lack of transportation
- High cost of services
- Limited understanding of their bodies and conception
- Little knowledge of available services and their location
- Belief that the services are not intended for them
- Concern that the staff will be hostile or judgmental
- Concern that services lack privacy and confidentiality and fear that their parents might learn of the visit
- Fear of medical procedures and contraceptive methods, including side effects
- Embarrassment at needing or wanting services
- Shame, especially if the visit follows sexual coercion or abuse[20]

To address these barriers to care for adolescents, the PAC Consortium seeks to both improve the quality of PAC services so that they better meet the unique needs of adolescent clients and to increase adolescent women's access to these services. "Access" refers to comprehensive services that are affordable and located in places that are easily accessible to adolescents, that the language and words used during adolescents' care is understandable and meaningful to them, and that policies exist and are implemented that eliminate social and service barriers for adolescents.

The concept of "youth-friendly" services addresses both quality and access issues. Although there are variations on the definition of youth-friendly services, in general, youth-friendly services are defined as services that attract, adequately and comfortably meet the health care needs of, and retain adolescent clients. Youth-friendly PAC services are those that:

- Offer privacy and confidentiality.
- Employ specially trained providers who deliver services in a non-judgmental manner, are comfortable communicating with young people on sensitive topics, and support informed choice.
- Are affordable or free for adolescent clients.

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[16] WHO. 1997. *Postabortion family planning: a practical guide for programme managers*. Geneva: WHO.
[17] Shawky, S. and Milaat, W. 2000. *Early teenage marriage and subsequent pregnancy outcomes*. Eastern Mediterranean Health Journal. Volume 6, Issue 1. Cairo: WHO Eastern Mediterranean Regional Office
[18] Advocates for Youth. 2005. *Youth's reproductive health: Key to aceiving the millennium development goals at the country level.* Washington DC: Advocates for Youth.
[19] International Institute of Population Studies. 1995. *National family health survey: MCH and family planning*. Bombay: IIPS.
[20] Senderowitz, J. Hainsworth, G. and Solter, C. 2003. *A Rapid Assessment of Youth Friendly Reproductive Health Services*. Technical Guidance Series, No. 4. Watertown, MA, Pathfinder International.

II. ESSENTIAL ELEMENTS OF PAC

Comprehensive PAC services as defined by the PAC Consortium are comprised of five elements of care:

- **Community and service provider partnerships** for prevention (of unwanted pregnancies and unsafe abortion), mobilization of resources (to help women receive appropriate and timely care for complications from abortion), and ensuring that health services reflect and meet community expectations and needs;
- **Counseling** to identify and respond to women's emotional and physical health needs and other concerns, including contraception;
- **Treatment of incomplete and unsafe abortion** and complications that are potentially life-threatening;
- **Contraceptive and family planning services** to help women prevent an unwanted pregnancy or practice birth spacing; and
- **Reproductive and other health services** that are preferably provided on-site or via referrals to other accessible facilities in providers' networks.

The specific needs of adolescent clients and recommended actions as they relate to each of the essential elements are further explored below.

Community and Service Provider Partnerships

Community-service provider partnerships, comprised of community members (youth, parents, teachers, community and religious leaders, men and women), adult and youth lay health workers, traditional healers, and formally trained service providers, can facilitate community dialogue on sensitive issues (e.g., adolescent sexual activity, sexual abuse or coercion, and unwanted pregnancy) and create an enabling environment to support the provision of needed SRH information and contraceptive services to young people. These partnerships not only play a vital role in the prevention of unintended pregnancies and unsafe abortion and but also can increase access to sustainable high quality PAC services for young people. Such partnerships provide an opportunity for community input on the quality of PAC services for adolescents as well as how services are best organized. Placing PAC within a larger context such as safe motherhood or adolescent SRH may encourage greater community participation.

While community involvement is a necessary ingredient to sustainable comprehensive PAC services, in some cases it may hinder the provision of comprehensive PAC services, especially in communities where influential leaders and community members hold very conservative views about adolescent sexuality, pregnancy outside of marriage, and abortion. Although the ideal is to form community-provider partnerships, it is important that program managers and providers are realistic about the extent to which they can involve the community. In challenging situations, they may need to look for allies beyond the traditional community leaders and work with community women's groups or traditional birth attendants. Taking incremental steps and developing solid alliances is important to working with the community.

Creating partnerships among stakeholders requires a range of innovative strategies in which young people must play an active and ongoing role. Programs may have to first work with adolescents to help them build skills so they can participate as equals. In addition, it may be necessary to sensitize

adult partners so that they respect and encourage adolescents' perspectives and participation. Strategies to create community-provider partnerships can include:

- Conducting community meetings and discussion groups in which a range of stakeholders, including different cohorts of youth, participate. Skilled facilitation is needed so that no one group or perspective dominates the discussion. In some cultural contexts, it may be necessary to work separately with men and women. The aim of such activities should be to develop strategies for positive change, including ways to support young women who experience unwanted pregnancy and unsafe abortion and need PAC services.
- Developing spaces in which like-minded stakeholders meet to develop proposals for improving information and services available to young people. Youth-developed proposals are particularly important in fomenting change.
- Holding informational and skills-building workshops that help people to understand the issues of pregnancy, contraception, abortion, and postabortion care and provide opportunities to build youth-adult partnerships to address these issues in non-judgmental ways.
- Conducting communication campaigns that engage the talents of young people and help to disseminate messages about the challenging topics of sexuality and reproductive health throughout the community, linking these themes with experiences that are relevant to youth, including poverty, inequality, unequal access to power and decision-making, and gender-based violence.
- Capitalizing on existing youth programs and interventions to strengthen community-provider linkages. Community interventions such as peer education have great potential to help prevent unwanted pregnancies and unsafe abortion by providing SRH information and non-clinical contraceptive methods. They also can refer young women in need of PAC services and provide youth feedback about the quality of services.
- Working with schools to address the need for SRH education and life skills. Teachers and school headmasters can be mobilized to prevent unwanted pregnancy and unsafe abortion by educating young people on how to make healthy choices and protect themselves. They can also play an important role in recognizing signs of unsafe abortion and referring for needed PAC services.

Community-service provider partnerships that encourage youth participation in all stages of service delivery, including formation, communication, implementation, and monitoring can result in innovative ways to deliver services to young people that meet their range of needs.

The following sections outline the basic youth-specific components that should be included in the other four elements of PAC. There are some components however that apply to the overall PAC visit, these are described below.

Overall PAC visit

It is important to review national laws, health policies, and standards and guidelines around PAC services. In most cases, the legal framework is supportive of PAC services and providers should be aware that it is their responsibility to provide confidential and quality services to all women, even adolescents.

The adolescent client should be asked who they would like to have involved in their care (e.g., partner, friend, a caring adult, or parents). The provider should then include them in ways that will be supportive to the adolescent client during the procedure and in the recovery process.

Privacy and confidentiality should be stressed for all clients, particularly adolescent clients who face additional stigma due to their age and the fact that in many cases they are not married or in a formal union. Where feasible, a separate waiting room for youth clients can provide a sense of privacy and alleviate fears of being seen by adult community members.

A common barrier to seeking PAC services is the fear of negative provider attitudes. Therefore providers should be sensitized through training and supervision that all PAC clients deserve and have the right to the same treatment and standard of care regardless of whether their abortion was induced or spontaneous. Providers should also be aware that sexual coercion or violence, which is common among adolescents in many contexts, may be the cause of the unwanted pregnancy and subsequent abortion. In these cases, they should also remember that the younger the adolescent, the higher the chance that the sexual offender is a close relative or a direct family member, which has implications with regard to confidentiality, the client's overall care, and referral needs.

Facilities and providers need to be extremely sensitive to the length of the facility stay when providing services to adolescent clients. Adolescents are often supervised by either their parents or their schools, and may not be able to stay away for long periods of time without explanation, which can be a barrier to seeking services. If adolescents are aware that they will receive discreet, timely PAC services, they may be more likely to seek those services.

Counseling

For some adolescents, the PAC visit may be their first time they have come to a health facility for a reproductive health service. Many adolescents may not have adequate knowledge about conception or how to prevent a future unwanted pregnancy, and they may have questions regarding other SRH issues. The provider should maximize the opportunity of the PAC visit to address multiple SRH needs and provide information on: (1) what to expect during treatment or procedures, (2) any medication or drugs, (3) complications and when to return to the facility, (4) contraception, (5) sexually transmitted infections (STIs)/HIV prevention and (6) SRH decision-making and (7) condom negotiation.

When counseling adolescent clients, it is important to remember that:

- Counseling should be tailored to the specific needs and characteristics of each young person since "adolescents/youth" are not a homogeneous group. Differences in age, developmental stage, educational/literacy level, and marital status all affect the counseling session, including what types of information should be provided and how to effectively communicate the information.
- Adolescents may be more fearful and less likely to have the support of family members or partners than older PAC clients. Therefore a supportive and empathetic approach is needed.
- Young people often are less informed and rely on information from their peers, which may be incorrect, therefore myths and rumors need to be addressed.

- Adolescents may not discuss their real problem or concern at the beginning of the counseling session. Providers must allocate more time and special care to counseling adolescent clients including ensuring two-way communication and being patient.
- Providing verbal support and explaining what is happening during the treatment procedure when women are conscious throughout the process can serve as an important means of pain management.
- Additional support can be provided through peer counseling or lay counseling programs. See below under *Referral for Other RH Services*.

During **counseling**, the provider should:

- Provide clear and simple information on what to expect during physical exam, treatment, and any other procedures. Describe the pain and/or discomfort that the adolescent might feel during treatment during uterine evacuation and offer pain management options, including supportive accompaniment by a friend or partner if the client desires.
- Encourage the adolescent client to talk about her feelings regarding the abortion. Remember these feelings are often mixed, and the provider may help the adolescent elaborate her loss, clarify her thoughts regarding the pregnancy and abortion, and plan when to become pregnant again, if she desires. Be clear about the immediate return of fertility, and discuss all contraceptive options for her and her partner. See below under *Postabortion Family Planning* for more information.
- Screen for sexual abuse and gender-based violence (GBV). If providers are required to report cases of sexual abuse or GBV to law enforcement authorities, discuss with the adolescent how this will be addressed. Providers must be trained beforehand and a screening protocol for GBV must be in place to ensure that providers discuss this issue in a confidential and empathetic manner, and respond appropriately when GBV is disclosed.
- Screen for STIs/HIV and help the client assess her risk of STIs/HIV. Dual protection to prevent unintended pregnancy and STIs/HIV should be emphasized.
- Give clear instructions on any follow-up care, including any needed medications, and discuss post-treatment danger signs and symptoms that would require the client to immediately return to the facility. Give clients the name of a contact person, such as the attending physician or nurse in charge who can be reached night or day, in case they need to return to the clinic.

Treatment of complications

While treatment of abortion complications is similar for both adult and adolescent clients, there are some additional aspects that should be considered when treating young people.

- Technical issues for adolescent clients include using a smaller speculum during exam and procedure, using misoprostol to facilitate cervical dilation/ripening, and additional attention to pain management.
- Because of the time sensitivity, adolescents should not be required to stay for 24 hours after the procedure as are many other PAC clients. An outpatient manual vacuum aspiration (MVA) or electric vacuum aspiration (EVA) procedure is preferable to facilitate timely discharge, when this is clinically possible.
- Adolescents often wait longer before seeking an unsafe abortion. This has implications for the severity of complications and can influence the type of provider that can provide treatment as

well as the type of technology that can be used (e.g., MVA, EVA, dilation and curettage [D&C]/sharp curettage [SC], and/or misoprostol).

- In addition to the benefits of MVA or EVA associated with time considerations mentioned above, MVA or EVA is preferred by the World Health Organization over D&C for adolescents because severe complications are less likely.[21]
- Clinical procedures for using MVA, EVA, D&C, or misoprostol are often the same as for an adult client. However lack of knowledge of what to expect and limited emotional support from family can lead to increased anxiety and pain. Pain management, especially for nulliparous women, may require additional treatment strategies (e.g., cervical priming with medical compounds or light sedation during the procedure). Extra support to the youth client during the procedure and attention to pain management can also improve the client's overall PAC experience.
- During treatment, providers should take note of any other SRH problems (e.g., STIs) that are detected and make sure that the client receives appropriate care or referral.

Postabortion Contraceptive/Family Planning Services

As discussed earlier, the PAC visit may be the first time that an adolescent has ever accessed RH services and therefore it is imperative that the client receives postabortion contraceptive counseling and services. Because young people often do not return to the facility for follow-up care, it is important that contraceptive methods (at a minimum condoms) are available to adolescent clients before they are discharged from the PAC facility.

During postabortion contraceptive service provision, the provider should:

- Clarify the adolescent client's reproductive intentions at the outset. For those who want to become pregnant, emphasize the need to wait six months before becoming pregnant again.22 Assess and discuss physical and emotional readiness to become pregnant again (e.g., if the client is severely anemic or depressed).
- Remember that age is not a contraindication for any contraceptive method therefore adolescent clients should be offered a range of methods. However, the IUD is not recommended if infection is present and sterilization is usually not appropriate for adolescent clients.
- Discuss dual protection from both unwanted pregnancy and STIs/HIV in an integrated manner. Demonstrate proper condom use (for both male and female condoms) and ask the client to return the demonstration.
- Help the client learn how to negotiate condom use. Young people often do not possess the life and communication skills needed to negotiate using condoms with their partner.
- Remember that young people may need extra information and help in learning to use their method (e.g., linking daily activity to taking a pill) and may have different concerns than adult clients (e.g., weight gain or acne). In addition, young people may not have a safe place to keep a method (e.g., a packet of pills) so certain methods like injectables may be more acceptable to them.
- Use visual aids and youth-focused IEC materials to reinforce family planning messages.
- Where emergency contraceptive pills (ECP) are legal, include information about ECP in case of contraceptive method failure or unprotected intercourse, and provide an advance supply of

[21] WHO. 2003. *Safe abortion: technical and policy guidance for health systems.* Geneva: WHO.

ECP, if possible. If a prescription is needed to obtain ECP, provide the prescription so that clients have the method on hand in case of future unprotected sexual intercourse.

- If possible and the client desires, involve male partners in contraceptive counseling.

Provision of or Referral for Other Services

The PAC visit is often the first time a young person has attended a RH facility and as a result, she may need other SRH services beyond PAC. In addition, an adolescent who has been sexually abused or is in a vulnerable situation (e.g., a street child or an orphan) may need social services in addition to health services. As much as possible, direct provision of SRH and other health services should be provided at the primary facility that the adolescent client first visits. In many cases, adolescent clients may not return to the facility or will not go to the referred facility. However, when it is necessary to refer a client, the following points should be taken into consideration:

Types of Referral Services

- Sexuality education and/or SRH counseling and information
- HIV/AIDS counseling
- Voluntary HIV counseling and testing (VCT)
- STI testing/treatment
- Counseling/support for gender-based violence and sexual coercion
- Treatment, care and support for HIV positive youth
- Legal, emotional, and financial support for orphans and vulnerable children (OVC)

- When possible, refer adolescents to facilities that offer youth-friendly services or to facilities or organizations that are receptive to adolescent clients.
- Providers should take time and explain clearly to the adolescent client the purpose and importance of the referral. Adolescents generally have less familiarity and experience with different services, medical procedures, and their purposes.
- Referral cards or slips should note the type of service/counseling the adolescent client requires and can also be kept as part of record keeping between the primary site and the referral site. The card can also highlight the fact that this client is an adolescent and requires special attention and more expedient services/treatment.
- If possible, provide clients with easy to read and understandable materials that:
    - Explain the services they will obtain at the referral site..
    - Describe the client's right to confidential services.
    - Provide general information on SRH.
- Providers should be aware of community-based SRH services (e.g., peer providers, outreach services, non-traditional condom distributors, and youth-friendly pharmacies) and be willing to refer back to the community for services when appropriate. For example, an adolescent PAC client may need life skills, emotional support, and an on-going supply of condoms to exercise her decision to prevent future pregnancies and STIs/HIV. This type of on-going support may be more easily found through networks of peer providers or other youth programs.
- In some countries there are youth hotlines or websites on SRH, in such cases, the phone number or website address should be given to adolescent clients for more information.

Participant Handout 3.3C: Youth-Friendly PAC Assessment Tool[†]

III. Monitoring and Evaluation

OBJECTIVES	PROCESS AND RESULTS INDICATORS
1. Develop community and service provider partnerships that involve adolescents in defining needs related to YF PAC services and ways of addressing those needs	• Level of participation (# of adolescents, description of the roles they play, number of community meetings/dialogues where both youth and adults participate, description of the impact that youth participation makes in process and decision-making) in developing partnerships and defining the important issues to be addressed in the partnerships • Formal partnership agreements include explicit language about the needs of and services provided to adolescents
2. Provide counseling to all adolescents receiving PAC services	• % of adolescent women who receive counseling to address their health-related needs and concerns • % of adolescent women interviewed who state that their health needs and concerns were addressed by health facility staff • % of adolescent women whose counseling took place in a private and confidential manner (people could not see or overhear the adolescent during counseling, with or without parents or guardians, according to the adolescents' wishes) • Of the adolescent women who want their male partners to be involved in the counseling process, % who are counseled along with their male partners *(when he is available)*
3. Provide clinical treatment to all adolescents experiencing complications of unsafe abortion	• % of adolescent women treated per type of medical procedure (MVA, EVA, D&C/SC, misoprostol, or MVA/SC with misoprostol) • % of adolescent women treated who themselves gave verbal or written informed consent for the medical procedure
4a. Offer information to adolescent women (and their male partners when young women so desire) about the range of contraceptives available; 4b. Provide adolescents with the contraceptive method(s) they choose	4a. • % of adolescent women who received information about contraceptives (% per type of contraceptive) • % of adolescent women who received information about contraceptives without the previous consent of their parents or guardians • Of the adolescent women who want their male partners to be involved in the counseling process, % received information about contraceptive methods along with their male partners *(when he is available)* 4b. • Of the adolescent women who want contraceptive(s), % who receive any method before leaving the health facility • Of the adolescent women who want contraceptive(s), % who receive their desired method before leaving the health facility (denote type of method) • Of the adolescent women who want contraceptive(s), % who received method(s) without parental/guardian consent • % of adolescent women leaving the facility with a. male condom b. female condom (either as a sole method or in addition to a method)
5. Provide adolescents with other reproductive health services they need at the time of PAC or directly afterward	• % of adolescent women screened for gender-based violence, especially sexual violence (in their lives in general and as a cause of the pregnancy resulting in unsafe abortion) • % of adolescent women identified as having other SRH needs at the time of PAC services (by type of need identified) • Of the adolescent women identified as having other SRH needs, % who receive direct care in the same health facility • Of the adolescent women identified as having other SRH needs, % who are referred to other services for care

[†] Postabortion Care Consortium, "Technical Guidance On Youth-Friendly PAC", accessed October 11, 2012, http://www.pac-consortium.org/attachments/article/19/YFPAC%20Tech%20Guidance.pdf

Participant Handout 4.4A: Scenarios for Counseling Role Plays

Scenario 1

Joana is a 19-year-old adolescent who works in a small store in the capital city. Joana lives with her uncle who she rarely sees. Most of her family lives in a rural area a few hours from the city and Joana sends the little money she earns to them. Joana started dating George about six months ago. He has a good job and is able to help her buy clothes and other things she needs. She thinks George might have other girlfriends, but she doesn't want to seem jealous and make George leave so she doesn't ask. Joana and George have been having sex for five months and rarely use a condom. Because they had sex many times without getting pregnant, Joana assumed that she wasn't able to get pregnant with George. When she missed her period two months in a row, Joana got scared. Her friend at her job gave her some pills to take to make sure she wasn't pregnant. The pills caused Joana to bleed heavily at her job one day and her friend rushed her to the nearest hospital where she was admitted for treatment. Joana is a PAC client in your clinic and you have treated her. You are counseling her after she has stabilized.

Scenario 2

Lucy is a 16-year-old young woman who works as a housemaid in a wealthy family's home. She doesn't have any free time, but she does see a young man from down the street every once in a while. He is very smart and Lucy thinks he is good looking. Sometimes he stops and talks to Lucy when she is cleaning outside. Lucy enjoys his company and she and the young man begin to see each other more regularly and start to have sex. Lucy was forced to leave school when she was very young and no one ever talked to her about sex or how a woman gets pregnant. Lucy didn't know that sex could make you pregnant on the first time and she didn't know how to tell if she was pregnant. When Lucy missed her period for three months, she asked the woman in the house where she worked if she knew what was wrong with her. The woman was furious with Lucy and called her stupid for getting pregnant. The woman threatened to kick Lucy out of the house and leave her without any job or home. That night, Lucy stuck something inside herself to end the pregnancy. The woman of the house found Lucy bleeding and brought her in for treatment. You are talking with Lucy after her treatment and she has rested and regained some of her strength.

Scenario 3

Pauline is 15 and a PAC client. She is not in school and helps her mother in her shop. During counseling, Pauline begins to tell you about her "friend" who has been molested by her stepfather and became pregnant. Her friend is "too shy" to come to the clinic for help, and Pauline wants to help her friend prevent the stepfather from molesting her again. You begin to suspect that there is no friend and Pauline is the one who has been impregnated by her stepfather. As you talk further with Pauline, you learn that her father is dead, and that Pauline's mother's new husband has been molesting Pauline at home when her mother is in the shop.

Participant Handout 4.4B: Observation Checklist for Counseling Role Plays

TASK OR ACTION	YES	NO	COMMENTS
Provider assures confidentiality?			
Friendly/welcoming/smiling/respectful?			
Not judgmental?			
Listens attentively/nods head to encourage and acknowledge client's responses?			
Uses open-ended questions (i.e., not yes/no questions)?			
Uses non-technical terms and language the patient can understand?			
Listens to client's responses closely and patiently?			
Provides encouragement and reassurance?			
Responds to client's non-verbal communication?			
Is non-directive (i.e., doesn't tell the client what she has to do or not do)?			
Asks the client if she has any questions?			
Answers client's questions?			
Summarizes and ensures a common understanding of the discussion?			

Please record any additional observations/comments for feedback to the participants:

Participant Handout 5.1A: Procedural Considerations

- Adolescents are particularly concerned about privacy. Ensure that the procedure can be conducted in complete privacy.
- To protect the client's dignity, only ask the client to undress after you have completed the history, answered her questions, and are ready for the procedure. The client should only be asked to remove her bottom clothes (she can leave her top on) and should be provided with a cover sheet.
- A smaller speculum should be used during the exam and procedure than would normally be used for an adult woman.
- Perform examinations gently and slowly; explain what to expect before any action—repeat this information as necessary.
- The same PAC treatment options exist for adolescents and adults. Please refer to complete clinical PAC training for comprehensive training in treatment options. Be aware that adolescents often wait longer to seek services, which may result in more severe complications and may limit the type of treatment that can be used.
- The provider should comprehensively counsel clients on the characteristics of the different procedures that the adolescent is able to receive based on uterine size and available services at the facility. The provider should give compassionate and comprehensive counseling, taking into consideration the following:
  - MVA and misoprostol are highly effective and associated with fewer complications. They are preferable to D&C, which is only recommended when no other safe options are available.
  - For adolescents, there may be additional considerations for using misoprostol for PAC compared with adults and the evidence on acceptability of misoprostol for PAC among adolescents is limited. Adolescents may prefer misoprostol because it is simple, avoids surgery and anesthesia, and has a shorter recovery time than other procedures. On the other hand: bleeding for 1-2 weeks may make the method less discrete for adolescents seeking privacy; the necessary follow-up visit within 1-2 weeks may be particularly difficult for adolescents; and the longer duration of the treatment (over several days) may cause anxiety for the adolescent who wants to be sure the PAC procedure is resolved.
  - The counselor should make sure that the client understands all the characteristics of the different treatment options and must obtain full informed consent from the adolescent client.

Participant Handout 5.1B: Strategies for Pain Management

Lack of knowledge of what to expect and limited emotional support from family or community can lead to **increased anxiety and pain**. Pain management, especially for nulliparous women, may require additional treatment strategies. Extra support to the adolescent client during the procedure and attention to pain management can improve the client's overall PAC experience.

Here are some strategies for pain management for adolescent clients:

- Understand all the options to treat and prevent pain during PAC including different medication options and ensure the client receives adequate treatment for pain. Please refer to a complete clinical PAC training for guidance.
- Talk with the adolescent client throughout the procedure.
- Explain each step of the procedures before it is performed.
- During the procedure, move slowly, without jerky or quick motions.
- Show the client how to take slow deep breaths to minimize the pain. Ask her to breathe slowly in through the nose and out through the mouth to help her relax and to focus more on the breathing than on the pain.
- Tell the adolescent client she should ask for additional pain medication if the pain becomes too strong and reassure her that she can ask you to pause briefly at any point. This will reduce fear by assuring the client that she will not have to endure extreme pain.
- Avoid giving wrong impressions during the procedure (e.g., saying "this won't hurt" when it will hurt, or "I'm almost done" when you're not).
- If the client wishes, she can have a supportive friend, partner, or relative at her side to draw attention away from pain.
- Have a relaxing picture on the ceiling of the room that the young woman can focus on to help the adolescent client focus on something else other than the procedure.

Participant Handout 5.1C: Post-Procedure Considerations

- An adolescent may not be able to stay away from home or other obligations as long as an adult woman. She may not have permission from her family or husband to leave her home or community and would be missed after a period of time. An outpatient MVA or EVA procedure or misoprostol is preferable to facilitate timely discharge, when this is clinically possible.
- Provide counseling about contraceptive options and provide the method during the visit to prevent future unintended pregnancies (see Session 6).
- Considering that the PAC visit may be the adolescent's first visit to a health facility for SRH-related issues, it is critical that the provider use the opportunity to address other important SRH needs. In particular, the provider should conduct HIV counseling and testing as well as testing and treatment for other STIs. In addition, the provider should counsel the adolescent about risk for HIV and other STIs and on dual protection. Dual protection can be achieved through correct and consistent condom use or through dual method use. Dual method use means using condoms to protect against HIV/STIs and unintended pregnancy, as well as a second contraceptive method for better protection from unintended pregnancy. Please refer to complete clinical PAC training for more information.
- As adolescent girls are among the most vulnerable to SGBV, providers should use the PAC visit to screen and counsel clients on SGBV and connect adolescent clients with appropriate resources (see Session 4). Please refer to complete clinical PAC training for more information.

Participant Handout 6.2B: Postabortion Contraceptive Methods for Adolescents
(bolded are most relevant characteristics for adolescents)

Method	Timing after Incomplete Abortion	Characteristics	Remarks
Male and female condoms	Begin use as soon as intercourse is resumed. Provide client with enough condoms to use for several months.	• **Provide protection against pregnancy and STIs (including HPV and HIV)** • **Require skills to use properly and negotiate use with a partner** • **Resupply must be available** • **Less effective than hormonal methods or IUD at preventing pregnancy** • Option for interim method if initiation of another method must be postponed • No medical supervision required • Easily obtained • Require use with each episode of intercourse • Can interrupt the sex act	• Do not resume sexual activity if there has been a vaginal or cervical injury until after it has healed.

Method	Timing after Incomplete Abortion	Characteristics	Remarks
Combined Oral Contraceptives (COCs)	Begin pill use immediately after a first or second trimester abortion, preferably on the day of treatment.	• **Some COCs can reduce acne, improve regularity of menstruation, and reduce menstrual cramps** • **Can cause nausea, weight gain, breast tenderness, headaches, mood changes, or dizziness** • **Does not protect against HIV and STIs** • **Can be started immediately even if infection is present** • **Requires remembering to take the pill every day and having a constant supply available** • Effective • Effectiveness may be lowered when TB and some ARV medications are used, though this is not the case with most ARVs. • Can be provided by non-physicians • Does not interfere with intercourse	• If started within seven days of miscarriage or abortion, no need for a backup method. • If started more than seven days after first- or second- trimester abortion, start COCs any time it is reasonably certain she is not pregnant. Use backup method for first seven days of taking the pill. • Dual method use with condoms is recommended to prevent both HIV/STIs and unintended pregnancy. • Do not resume sexual activity if there has been a vaginal or cervical injury until after it has healed.

Method	Timing after Incomplete Abortion	Characteristics	Remarks
Progestin-Only Pills (POPs)	Begin pill use immediately after a first- or second-trimester abortion, preferably on the day of treatment.	• **Requires daily use at the same time of the day to be effective** • **Resupply must be available** • **Can cause nausea, weight gain, breast tenderness, headaches, mood changes or dizziness.** • **Does not protect against HIV and STIs** • Effective • Effectiveness may be lowered when certain TB and ARV medications are used, though this is not the case with most ARVs. • Can be started immediately even if infection is present • Can be provided by non-physicians • Does not interfere with intercourse • Some women using POPs experience changes in their monthly bleeding, including frequent bleeding, infrequent bleeding, prolonged bleeding, or no monthly bleeding. Generally, it is not harmful. • POPs are the only pill option for exclusively breastfeeding women from six weeks to six months after birth.	• In cases of severe and unexplained vaginal bleeding, use POPs with caution until the cause of bleeding has been identified or resolved. • If started within seven days of miscarriage or abortion, no need for a backup method. • If started more than seven days after first- or second-trimester abortion, start POPs any time it is reasonably certain she is not pregnant. Use backup method for first two days of taking the pill. • Dual method use with condoms is recommended. • Do not resume sexual activity if there has been a vaginal or cervical injury until after it has healed.

Method	Timing after Incomplete Abortion	Characteristics	Remarks
1-month, 2 month, and 3-month Injectables (e.g., DMPA, NET-EN)	May be given immediately after abortion in the first or second trimester.	• **No daily action required except for injection every one, two, or three months (depending on type of injection)** • **A discrete method—no obvious external sign person is using contraception** • **May cause weight gain** • **Monthly bleeding is likely to eventually become lighter, less frequent, or stop altogether.** • Effective • Easily administered by non-physician • Does not interfere with intercourse • May cause irregular bleeding; excessive bleeding may occur in rare instances • Typically a four-month delay in return to fertility after stopping DMPA, but return to fertility could be longer • Must return to clinic for injections • Does not protect against HIV and STIs	• If started within seven days of an abortion or miscarriage, no backup method is needed • In cases of severe and unexplained vaginal bleeding, use DMPA with extreme caution until the cause of bleeding has been identified or resolved • Dual method use with condoms recommended to prevent HIV/STIs as well as unintended pregnancy. • Do not resume sexual activity if there has been a vaginal or cervical injury until after it has healed.

Method	Timing after Incomplete Abortion	Characteristics	Remarks
Implants	May be inserted immediately after abortion in the first or second trimester.	• **Highly effective** • **Long-term contraception (3-5 years)** • **A discrete method—if client is afraid parents/partner will find pills or condoms this can be a good method** • **May cause irregular bleeding or amenorrhea** • **Some women experience weight gain, headaches, dizziness, nausea, or mood changes** • Immediate return to fertility on removal • Does not interfere with sex • No supplies needed by client • Trained provider required to insert and remove • Does not protect against HIV and STIs	• If inserted within seven days of an abortion or miscarriage, no backup method is needed. • In cases of severe and unexplained vaginal bleeding, use implants with extreme caution until the cause of bleeding has been identified or resolved. • Dual method use with condoms recommended to prevent HIV/STIs as well as unintended pregnancy. • Do not resume sexual activity if there has been a vaginal or cervical injury until after it has healed.

Method	Timing after Incomplete Abortion	Characteristics	Remarks
Copper-bearing intrauterine device (IUD)	IUD can be inserted immediately or within twelve days of a first- and second- trimester induced or spontaneous abortion as long as there are no signs of infection.	• **Highly effective** • **Long-term contraception (12 years)** • **Discrete—no obvious external sign person is using contraception** • **May increase menstrual bleeding and cramping during the first few months** • **Immediate return to fertility following removal** • Does not interfere with intercourse • Convenient • No daily action required • Trained provider required to insert and remove • Pain and cramping during insertion and the first few days afterwards • Does not protect against HIV and STIs	• If inserted within 12 days of an abortion or miscarriage, no backup method is needed. • If infection is suspected, delay insertion until the infection has been resolved and use an interim method. • In cases of uterine perforation, or serious vaginal or cervical injury, do not insert until serious injury has healed. • In cases of severe and unexplained vaginal bleed, delay insertion until bleeding has been resolved. • Do not insert if a woman has symptoms of current pelvic inflammatory disease, purulent cervicitis, gonorrhea, or chlamydia. • Use clinic judgment if client is at high-risk of STIs—in some cases the benefit of the IUD may outweigh the risks (see WHO Medical Eligibility Criteria for more information). • Dual method use with condoms is recommended.

Method	Timing after Incomplete Abortion	Characteristics	Remarks
Emergency Contraceptive Pills (ECPs)	Can provide an advance supply of ECP immediately postabortion	• **Safe for women of all ages** • **Appropriate for use after unprotected intercourse (including rape or contraceptive failure)** • **Should be used as soon as possible after unprotected intercourse** • **May change the time of the woman's next monthly bleeding** • Reduce risk of unintended pregnancy and need for abortion • Provide a bridge to the practice of regular contraception • Drug exposure and side effects are of short duration • Though it should be taken as soon as possible after unprotected sex to be most effective, ECPs can prevent pregnancy when taken up to five days (120 hours) after unprotected sex. • Doesn't provide ongoing protection against pregnancy • May cause nausea, vomiting, headaches, dizziness, cramping/abdominal pain, or breast tenderness • Does not protect against HIV and STIs • In countries without a dedicated emergency contraceptive product, COCs may be used in high doses (See: *Family Planning: A Global Handbook for Providers*).	• Advance supply of ECP can be given in case of method failure. • Make sure the client is well counseled on the need to take ECP as soon as possible but within 120 hours of unprotected sexual intercourse. • Do not resume sexual activity if there has been a vaginal or cervical injury until after it has healed.

Participant Handout 6.2C: Medical Eligibility Chart[‡]

Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use –

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD)

CONDITION		COC	DMPA	Implants	Cu-IUD
Pregnancy		NA	NA	NA	
Breastfeeding	Less than 6 weeks postpartum				NC
	6 weeks to < 6 months postpartum				
	6 months postpartum or more				
Postpartum	Less than 21days, non-breastfeeding				NC
	< 48 hours including immediate post-placental	NC	NC	NC	
	≥ 48 hours to less than 4 weeks				
	Puerperal sepsis				
Postabortion	Immediate post-septic				
Smoking	Age ≥ 35 years, < 15 cigarettes/day				
	Age ≥ 35 years, ≥ 15 cigarettes/day				
Multiple risk factors for cardiovascular disease					
Hypertension	History of (where BP cannot be evaluated)				
	BP is controlled and can be evaluated				
	Elevated BP (systolic 140 - 159 or diastolic 90 - 99)				
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)				
	Vascular disease				
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE				
	Acute DVT/PE				
	DVT/PE, established on anticoagulant therapy				
	Major surgery with prolonged immobilization				
Known thrombogenic mutations					
Ischemic heart disease (current or history of) **or stroke** (history of)				I C	
Known hyperlipidemias					
Complicated valvular heart disease					
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies				
	Severe thrombocytopenia		I C		I C
	Immunosuppressive treatment				I C
Headaches	Non-migrainous (mild or severe)	I C			
	Migraine without aura (age < 35 years)	I C			
	Migraine without aura (age ≥ 35 years)	I C			
	Migraines with aura (at any age)		I C	I C	
Vaginal bleeding patterns	Irregular without heavy bleeding				
	Heavy or prolonged, regular and irregular				
	Unexplained bleeding (prior to evaluation)				I C

CONDITION		COC	DMPA	Implants	Cu-IUD
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels				
	Persistently elevated β-hCG levels or malignant disease				
Cancers	Cervical (awaiting treatment)				I C
	Endometrial				I C
	Ovarian				I C
Breast disease	Undiagnosed mass	*	*	*	
	Current cancer				
	Past w/ no evidence of current disease for 5 yrs				
Uterine distortion due to fibroids or anatomical abnormalities					
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I C
	Vaginitis				
	Current pelvic inflammatory disease (PID)				I C
	Other STIs (excluding HIV/hepatitis)				
	Increased risk of STIs				
	Very high individual risk of exposure to STIs				I C
Pelvic tuberculosis					I C
Diabetes	Non-vascular disease				
	Vascular disease or diabetes for > 20 years				
Symptomatic gall bladder disease (current or medically treated)					
Cholestasis (history of)	Related to pregnancy				
	Related to oral contraceptives				
Hepatitis	Acute or flare	I C			
	Chronic or client is a carrier				
Cirrhosis	Mild				
	Severe				
Liver tumors (hepatocellular adenoma and malignant hepatoma)					
HIV	High risk of HIV or HIV-infected				
AIDS	No antiretroviral therapy (ARV)				I C
	Clinically well on ARV therapy	see drug interactions			
	Not clinically well on ARV therapy	see drug interactions			I C
Drug interactions, including use of:	Nucleoside reverse transcriptase inhibitors				
	Non-nucleoside reverse transcriptase inhibitors				
	Ritonavir, ritonavir-boosted protease inhibitors				
	Rifampicin or rifabutin				
	Anticonvulsant therapy**				

Source: Adapted from *Medical Eligibility Criteria for Contraceptive Use*. Geneva: World Health Organization, updated 2008. Available: http://www.who.int/reproductive-health/family_planning/guidelines.htm

Category 1 There are no restrictions for use.

Category 2 Generally use; some follow-up may be needed.

Category 3 Usually not recommended; clinical judgment and continuing access to clinical services are required for use.

Category 4 The method should not be used.

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Unlike previous versions of the MEC Quick Reference Chart, this version includes a complete list of all conditions classified as Category 3 and 4 by WHO.

I/C (Initiation/Continuation): A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. For example, a client with current PID who wants to initiate IUD use would be considered as Category 4, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, the category is the same for initiation and continuation.

NA (not applicable): Women who are pregnant do not require contraception.

NC (not classified): The condition is not part of the WHO classification for this method.

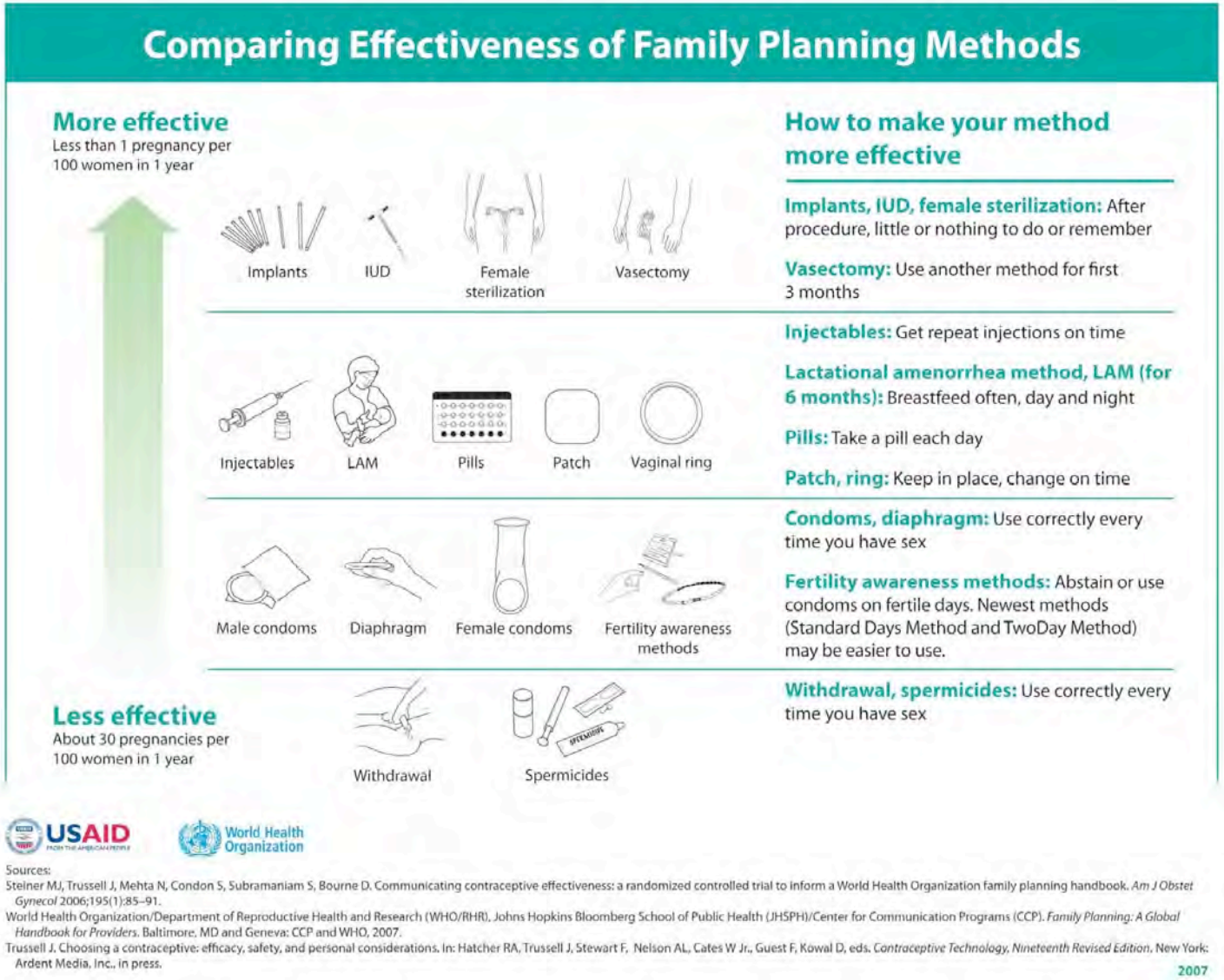
* Evaluation of an undiagnosed mass should be pursued as soon as possible.

** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

fhi Family Health International

[‡] Family Health International 360, "Quick Reference Chart for the WHO Medical Eligibility Criteria For Contraceptive Use" (2009), accessed September 12, 2012, http://archive.k4health.org/toolkits/fphivintegration/quick-reference-chart-who-medical-eligibility-criteria-contraceptive-use.

Participant Handout 6.2D: Contraceptive Effectiveness Chart[§]



[§] Family Health International 360, "Comparing Effectiveness of Family Planning Methods" (2007), accessed September 12, 2012, http://www.fhi360.org/nr/shared/enFHI/Resources/EffectivenessChart.pdf.

Participant Handout 6.4B:
Fact and Realities about Common Rumors and Misinformation around Contraceptive Methods

Rumor or Misinformation about COCs	Facts & Realities: Information to Combat Rumors
I only need to take the pill when I sleep with my boyfriend or husband.	A woman must take her pills every day in order not to become pregnant. Pills only protect against pregnancy if she takes them every day because they stop the egg from growing and being released to meet the sperm. If she misses one pill, she should take two as soon as she remembers.
I am still protected from pregnancy when I stop taking the pill if I have been using it long enough.	A woman is only protected for as long as she actually takes the pill every day.
Pills make you weak and unable to work.	Sometimes adolescents feel weak for other reasons, but they are also taking the pill, so they think it is the pill that causes the weakness. If a young woman feels weak, she should keep taking her pills every day and go to see a doctor. Pills do not make an adolescent weak. A doctor should be seen to try to find out what else is causing weakness in a young woman. If an adolescent is feeling weak, a pregnancy would almost certainly make her feel much worse than taking the pill.
The pill will build up in your body. Pill residues settle in the uterus so that the adolescent has to have her uterus cleaned every year in order to prevent the formation of a lump.	It is not possible for pills to accumulate in the body. Pills are swallowed and dissolved in a young woman's body just like other medicines and food. The substances in the pill are taken up by the digestive system and pumped throughout the body by the blood. (Demonstrate how a pill dissolves in a glass of water.)
The pill is dangerous and causes cancer.	Numerous studies have disproved this rumor. The pill has been used safely by millions of adolescent women for over 30 years and has been tested more than any other drug. In fact, studies show that the pill can protect women from some forms of cancer, such as cancer of the ovary, the lining of the uterus, and breast.
The pill causes abnormal or deformed babies.	There is NO medical evidence that the pill causes abnormal or deformed babies. There have always been incidences of abnormalities and birth defects long before the pill was invented. Birth defects are usually caused by genetic (e.g., Down Syndrome) or environmental factors (e.g., drugs, exposure to toxic waste and chemicals).
Taking the pill is the same as having an abortion.	The pill is taken to prevent the egg from ever meeting the sperm; it does not cause an abortion. The pill prevents the body from releasing an egg so that fertilization cannot occur, preventing a pregnancy (and therefore any chance of an abortion).

Rumor or Misinformation about COCs	Facts & Realities: Information to Combat Rumors
The pill causes the birth of twins or triplets.	The pill has no effect on the tendency toward multiple births. The tendency to have twins usually runs in families. That is, if there have been multiple births in either the young man's or young woman's family, then the chances of having twins are greater.
The pill prolongs pregnancy. "A young woman who took the pill before she got pregnant delivered almost two months after her expected date of delivery."	The pill does not prolong pregnancy in any way. An example such as this was probably a simple case of not calculating the date of conception (the day that the sperm fertilized the egg) correctly.
Women who take the pill for several years need to stop the pill to give the body a "rest period."	A "rest period" from taking pills is not necessary and a woman may use COCs for as many years as she wants to prevent a pregnancy. A rest period would not be beneficial and would disrupt the young woman's preferred and successful method of contraception.
The pill can't be used following an abortion.	The pill is appropriate for use immediately after an abortion (spontaneous or induced) if the abortion occurred in either the first or second trimester, and should be initiated within the first seven days postabortion, or any time the provider can be reasonably sure that the client is not pregnant. The body starts releasing eggs from the ovaries almost immediately postabortion. Immediate use of the pill post abortion does not affect a woman's ability to get pregnant in the future after she stops using the pill.
The pill causes infertility or makes it more difficult for a young woman to become pregnant once she stops using it.	Studies have clearly shown that the pill does not cause infertility or decrease a young woman's chances of becoming pregnant once she stops taking it.

Rumor or Misinformation about Copper-Bearing IUDs	Facts & Realities: Information to Combat Rumors
The thread of the IUD can trap the penis during intercourse.	The strings of the IUD are soft and flexible, cling to the walls of the vagina, and are rarely felt during intercourse. If the string is felt, it can be cut very short, (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis, because it is located within the uterus and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot cause injury to it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.)
A young woman who has an IUD cannot do heavy work.	Using an IUD should not stop a young woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.
The IUD might travel inside a young woman's body to her heart or her brain.	There is no passageway from the uterus to the other organs of the body. The IUD is placed inside the uterus and unless it is accidentally expelled, stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. (Tell the client that she can feel the string if she wants to, especially after menstruation, to confirm that it is in place. Teach the client to feel the string.)
A young woman who was using an IUD became pregnant. The IUD became embedded in the baby's forehead or another body part.	The baby is very well-protected by the sac filled with amniotic fluid inside the mother's womb. If a young woman gets pregnant with an IUD in place, the health provider should remove the IUD immediately due to the risk of infection. If strings are not visible, refer the woman to a provider who can use an ultrasound to assess the situation. If for some reason the IUD is left in place during a pregnancy; it is usually expelled with the placenta or with the baby at birth. If a woman becomes pregnant with the IUD, she has an increased risk of preterm delivery or miscarriage.
The IUD rots in the uterus after prolonged use.	Once in place, if there are no problems, the IUD can remain in the uterus up to 12 years. The IUD is made up of materials that cannot deteriorate or "rot." Rather, it simply loses its ability to protect a woman from pregnancy after 12 years.

Rumor or Misinformation about Copper-Bearing IUDs	Facts & Realities: Information to Combat Rumors
An IUD can't be inserted after an abortion.	For spontaneous or induced abortions in the first and second trimester, the IUD may be inserted immediately postabortion if no infection is present, or during the first twelve days postabortion (or any time you can be reasonably sure the client is not pregnant). It is possible for the IUD to come out of the vagina on its own if it is not placed correctly. Expulsion rates vary greatly, with higher expulsion rates after second trimester incomplete abortions. To minimize the risk of expulsion, only providers with proper training and experience should insert IUDs.
The IUD causes ectopic or tubal pregnancy.	IUDs decrease the risk of ectopic pregnancy compared to no method of contraception. However, a woman who becomes pregnant with an IUD in place has an elevated risk of ectopic pregnancy.

Rumor or Misinformation about Condoms	Facts & Realities: Information to Combat Rumors
Using a condom is like taking a shower with a raincoat on.	Many couples are not bothered by condoms. Types of condoms vary widely and a couple should choose a brand that will suit them best and give them the most pleasure.
If a condom slips off during sexual intercourse, it might get lost inside the young woman's body.	A condom cannot get lost inside the young woman's body, because it cannot pass through the cervix, which is the small opening between the vagina and the uterus. If the condom is put on properly, it will not slip off. The condom should be rolled down to the base of the erect penis. If it comes off accidentally, instruct the client to pull it out carefully with a finger, taking care not to spill any semen.
There is too much danger of condoms breaking or tearing during intercourse.	Condoms are made of thin but very strong latex rubber and they undergo extensive laboratory tests for strength. (Demonstrate how strong the condom is by blowing it up like a balloon or pulling it over your hand and wrist.) Condoms are meant to be used only once. There is less chance that a condom will break or tear if it is stored away from heat and placed on the erect penis leaving enough space at the tip for the ejaculate. A condom is more likely to break if the vagina is very dry, or if the condom is old (past the expiration date). Use of a water-based lubricant can help prevent breakage due to vaginal dryness.
Using more than one condom at a time increases your protection.	This is not true. Actually, using two condoms can increase the likelihood of the condoms breaking because they rub together.

Rumor or Misinformation about injectable contraceptives (DMPA)	Facts & Realities: Information to Combat Rumors
A young woman who uses DMPA will never again be able to get pregnant.	Sometimes there is a delay of 6 to 12 months after the last injection for a young woman to be able to become pregnant again. In a study in Thailand, almost 70% of former DMPA users became pregnant within the first 12 months following discontinuation and 90% conceived within 24 months, a percentage comparable to pregnancy rates for the general population.
Injectable contraceptives cause cancer.	Research has clearly proven that DMPA does not cause cancer. In fact, it has been shown to protect against ovarian cancer.
DMPA causes nausea.	Nausea is not common with injectables. In fact, many women on injectable contraceptives find that their appetite becomes stronger.
A young woman will not have enough breast milk if she uses DMPA while breastfeeding.	Studies have shown that the amount of breast milk does not decrease when breastfeeding women are using DMPA. DMPA also does not affect the breast milk itself, the duration of breastfeeding, or the growth and development of the infant.
DMPA stops menstrual bleeding (amenorrhea) and that is bad for a young woman's health.	DMPA causes women to stop menstrual bleeding because adolescent women using DMPA do not ovulate (release eggs). This kind of lack of monthly bleeding is not harmful. It helps prevent anemia, (low iron problems) and frees adolescent women from the discomfort and inconvenience of monthly bleeding.
DMPA causes amenorrhea, resulting in pregnancy or a tumor.	No monthly bleeding is one of the signs of pregnancy, but not all amenorrhea (lack of bleeding) means that a young woman is pregnant. The stopped monthly bleeding experienced with DMPA use is due to the thinning of the lining of the uterus and is not harmful in any way. Amenorrhea is sometimes a sign of a tumor or cancer of the endometrium (uterine lining) or ovary. However, DMPA amenorrhea is not only "normal," but there is evidence that DMPA may actually help prevent endometrial and ovarian tumors.
Young women need to stop using DMPA and have a "rest" after several injections.	There is no limit to the number of years that DMPA can be used without the need to give the body a "rest." Also, if a woman has been using DMPA for a long time, it does not build up in the body and does not have any long-term harmful effects. The time needed to clear the drug from the body is the same for multiple injections as for one.

Rumor or Misinformation about injectable contraceptives (DMPA)	Facts & Realities: Information to Combat Rumors
DMPA causes masculine characteristics in females, such as facial hair.	Studies have shown that the use of DMPA will not cause a woman to look more masculine, such as growing facial hair.
DMPA will result in retained monthly bleeding, causing blood toxicity.	DMPA prevents the lining of the uterus to build up. This excess lining is part of what is released during a woman's menses. Since DMPA prevents the lining from building up in the first place, there is nothing to "retain" or cause a problem. Some women may mistakenly believe they are pregnant when they do not get their normal menstruation, but this is a common effect of DMPA and generally not a sign of pregnancy.
DMPA will result in a decrease in libido.	DMPA sometimes has a slight effect on a young woman's libido. However, the sense of security against the risk of pregnancy may increase the libido of the young woman.
DMPA is still in the "developmental stage" and adolescents shouldn't be experimented on.	DMPA was developed in the 1960s. Since then, it has been approved as a long-acting contraceptive method and is now marketed in more than 90 countries. To date, over 30 million women have used DMPA, over 100,000 have used it for more than 10 years, and between 8 and 9 million women currently rely on DMPA for contraceptive protection, without problems.
Adolescents can't use DMPA because it reduces bone density.	Though some studies have shown small reductions in bone mineral density, they have also shown that bone density returns when the person stops using DMPA. It is not known if adolescents who use DMPA can regain all bone mineral if they use it long into adulthood. However, considering this evidence, the WHO has determined that the benefits of DMPA for adolescents generally outweigh the risks (it is a two on the medical eligibility criteria for women under 18, a one for women 18-45, and a two for women over 45).

Participant Handout 6.5A: Observation Checklist for Male Condom Use[**]

Place a checkmark next to the step as the person conducting the condom demonstration completes the action:

1. _____ Look at the condom packet to make sure that it has not expired or that it has not been damaged—it should not be sticky and there should be no air pockets in the package.

2. _____ Roll the packet between your fingers. If it sounds crinkly, it is too dried out for safe use.

3. _____ Open the condom packet carefully along one side (to avoid tearing the condom) and take the condom out. Do not use your teeth to tear open the packet.

4. _____ Put a condom on only when the penis is erect.

5. _____Pinch the tip of the condom to keep a small empty space, without air, to hold semen. This prevents the condom from breaking.

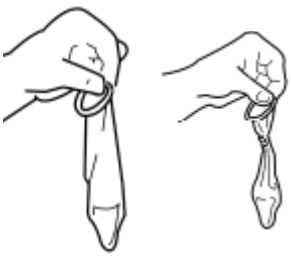
6. _____ Hold the condom so that the tip is facing up and it can be rolled down easily.

7. _____ Place the condom on the tip of an erect penis.

8. _____ Unroll the condom all the way to the bottom of the penis.

9. _____ Immediately after sex, the man or woman must hold on to the rim of the condom while the man carefully removes the penis without spilling the semen. The penis must be removed while still erect to ensure that the condom does not slip off.

10. _____ Remove the condom away from your partner.



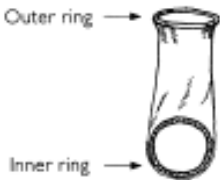
11. _____ Tie the used condom in a knot to avoid spilling the semen and dispose in a latrine, (not in a flush toilet because it may clog) or burn or bury it.

[**] Source of illustrations: Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. Where women have no doctor: A health guide for women. Berkeley, California: Hesperian Foundation. pp. 202-203.

Participant Handout 6.5B: Observation Checklist for Female Condom Use[††]

Place a checkmark next to the step as the person conducting the condom demonstration completes

1. _____ Carefully open the packet.



2. _____Find the inner ring at the bottom, closed end of the condom.

3. _____ Squeeze the inner ring between the thumb and middle finger.

4. _____ Guide the inner ring all the way into the vagina with your fingers. The outer ring stays outside the vagina and covers the lips.

5. _____ When you have sex, carefully guide the penis through the outer ring. If it is outside the ring, it will not protect you from pregnancy or STIs.

6. _____ Immediately after sex, before the woman stands up, squeeze and twist the outer ring to keep the semen inside the pouch, and pull the pouch out gently. Do not flush it down the toilet. Only burn it, bury it, or put it in a latrine.

[††] Source of illustrations: Burns, A.A., R. Lovich, J. Maxwell, and K. Shapiro. 1997. Where women have no doctor: A health guide for women. Berkeley, California: Hesperian Foundation. p. 204.

Participant Handout 6.6A: Contraceptive Counseling Scenarios

Scenario 1

Chi Chi is 16 and a PAC client. During counseling, you begin to discuss the various contraceptive methods that are available at the clinic. During the conversation, Chi Chi mentions that a lot of her friends believe that using the pill will make you infertile, and that condoms usually break. Her boyfriend, who is 17, pressured her a bit to have sex, and also said that using condoms is like wearing a raincoat in the shower. When you ask her about her own experiences, she says she didn't use contraception, based on what her friends and her boyfriend said but never thought she would get pregnant and have an abortion. Her cousin had a clandestine abortion last year and got very sick, and now she is afraid she will never be able to have children. Chi Chi is very worried that she won't be able to have children as well. She is also worried about dealing with the pressure from her boyfriend regarding his lack of interest in using condoms.

Scenario 2

Aisha, 19, is a PAC client. She is married and has a six month old baby that she is still breastfeeding. She is surprised that she got pregnant, since she thought that breastfeeding mothers could not get pregnant. No one had ever talked to her about contraception after the baby was born. During counseling, you come to understand that the abortion was induced because she has not yet weaned the child. She feels she is too young and was afraid of a second pregnancy so soon after the first. She is not sure what her husband would say, but she thinks she would like to use an FP method to be sure she doesn't get pregnant again right away.

Scenario 3

Elsa is a 15-year-old PAC client. During the initial physical exam, you suspect that Elsa might have an STI. After the procedure, you explain to Elsa that she has an STI, and so will also need to take medication to treat this infection. In the initial assessment, Elsa admitted that she was not using condoms or any other type of contraceptive method. You are concerned that Elsa may have more than one partner because she mentioned a few men had been pressuring her to have sex. During the counseling session, you want to help her choose the right method that will protect her from both future pregnancies and STIs.

Scenario 4

Mary is 15 ½ and a secondary school student in form three. Her boyfriend said that if they used two condoms, they would be extra safe. Unfortunately the condoms broke and she got pregnant. Mary was sick with worry over what her family would say and that she would have to leave school. Mary attempted an abortion with a traditional healer and came in bleeding profusely. You are discussing with Mary the correct use of contraceptives and condoms, but Mary interrupts you and says that she doesn't need contraception, because she is sure she is never going to have sex again. She can't take the stress.

Participant Handout 6.6B: Contraceptive Counseling Observation Checklist

Task or Action	Yes	No	Comments and Notes
PROVIDER COUNSELING AND COMMUNICATION			
Provider assures confidentiality and privacy?			
Friendly/welcoming/smiling/respectful?			
Not judgmental?			
Listens attentively/nods head to encourage and acknowledge client's responses?			
Uses open-ended questions (i.e., non yes/no questions)?			
Uses non-technical terms and language the client can understand?			
Provides encouragement and reassurance?			
Responds to client's non-verbal communication?			
Is non-directive (i.e., doesn't tell the client what she has to do or not do)?			
Asks the client if she has any questions?			
Answers client's questions?			
Summarizes and ensures a common understanding of the discussion?			

Task or Action	Yes	No	Comments and Notes
CONTRACEPTIVE COUNSELING AND STI RISK ASSESSMENT			
Helps client assess her risk for other unintended outcomes including repeat pregnancy, STIs or HIV?			
Identifies behaviors and other factors that could increase or reduce client risk?			
Assesses what, if any, contraceptive method she has used in the past and determines any problems with those methods?			
Determine the level of communication between her and her partner on contraception, STIs, and HIV?			
Offers communication options for patient's partners/family members (i.e., group counseling sessions, communication techniques)?			
Informs patient about the availability of safe and effective contraceptive methods?			
Discusses protection, including dual method use, to protect her from pregnancy, STIs, and HIV?			
Asks which method(s) interest client?			
Ask what client knows about the method?			
Corrects any myths, rumors, or misinformation?			
Describes how the method works and its risks, and benefits, and side effects?			
Discusses what to do if there are problems?			
Discusses how client will obtain resupply of the chosen method and indicates when client should return to the clinic for a resupply, if necessary?			
Screens patient for SGBV?			
Provides negotiation skills to overcome barriers of condom and/or contraceptive use?			

Task or Action	Yes	No	Comments and Notes
REFERRALS			
Refers client to VCT if not offered onsite			
Refers client to any other necessary resources (e.g., GBV services, child health services)?			

Please record any additional observations/comments for feedback to the participants.

Participant Handout 8.1A: YFPAC Optional Post-Test

1. What age range does adolescence refer to? (circle one)
   a. 7-15
   b. 15-19
   c. 10-30
   d. 10-19
   e. 15-24

2. Name three reasons why adolescents often seek late, cheaper, and unsafe abortions.

   _____

   _____

   _____

3. Having specially trained providers serve adolescents seeking PAC is important because: (Circle all that apply)
   a. Communicating with adolescents can require special care with regards to language, tone, and establishing trust
   b. Adolescents are very demanding and require a trained provider to navigate rude attacks
   c. Healthy life-long habits are established in adolescence
   d. Adolescents may ask to see a training certificate
   e. Adolescents are particularly vulnerable to poor SRH outcomes

4. What are the five elements of PAC as endorsed by the PAC Consortium?

   _____

   _____

   _____

   _____

   _____

5. Name three essential minimum standards for YFPAC services:

   _____

   _____

   _____

6. What are the three most important concerns that adolescents have when it comes to SRH and YFPAC service delivery? (Circle three)
   a. Privacy
   b. Pain-free experience
   c. Confidentiality
   d. Respect
   e. Television or games at the health center
   f. Brochures that they can take home with them

7. Which of the following are good counseling techniques for adolescent PAC clients? (Circle all that apply)
   a. Ask close-ended questions (yes/no questions) so that the client feels more comfortable
   b. Speak in understandable terms, avoid overly technical language
   c. Look directly at the patient, nod your head, and listen actively
   d. Sit behind a desk or above the patient so there is distance and she knows that she should respect you
   e. Avoid using questions that start with “why” and/or other judgmental language

8. As the PAC visit may be the first time the adolescent is visiting a health facility, name at least two other SRH concerns that the provider should screen for and either treat or refer for additional services.

   _____

   _____

9. How soon can women, including adolescent women, become pregnant following an abortion that occurs during the first trimester of the pregnancy?
   a. 3 months later
   b. In as few as 10 days
   c. 6 months later
   d. When her monthly bleeding (menses) returns

10. In almost all cases, how soon after a young woman is provided with PAC should a contraceptive method be initiated?
   a. On the same day as the PAC visit in almost all cases
   b. As soon as her monthly bleeding returns
   c. In three months
   d. In one week

11. Which method of contraception may not be suitable for an adolescent PAC client?
   a. Implants
   b. Combined oral contraceptives
   c. Condoms
   d. Sterilization
   e. Injectable contraceptives

12. Which is the best way for adolescents to prevent both unintended pregnancy and STIs?
   a. Emergency contraceptives
   b. Implants
   c. Correct and consistent use of condoms, or use of condoms plus another contraceptive method (called dual method use)
   d. Oral contraceptives

13. Which of the following aspects must be taken into account when counseling adolescent clients on contraception? (Circle all that apply)
    a. Risk of sexually transmitted infections
    b. Effectiveness of method
    c. Patient preference for a particular method
    d. Availability and access to methods
    e. Concerns that might be more relevant to adolescents such as weight gain, skin complexion, and discreteness of the method

14. What are important characteristics to remember when referring an adolescent for services elsewhere? (Circle all that apply)
    a. If the referral is for a particular method of contraception not available at the facility, provide the adolescent with an acceptable alternative for use until the referral visit is complete
    b. Refer the adolescent to the facility that is the farthest away because adolescents like to maintain privacy
    c. When possible, refer adolescents to youth-friendly services
    d. Clearly explain to the client the importance and purpose of the referral as well as how to get there and what to expect
    e. Refer the adolescent to private health facility because adolescents always prefer private facilities