

Youth-Friendly Postabortion Care Supplemental Training Module

Trainer's Manual

OCTOBER 2012

POSTABORTION CARE
PAC
CONSORTIUM

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Acronyms

ARV	Antiretroviral
COC	Combined oral contraceptive
D&C	Dilation and curettage
ECP	Emergency contraceptive pill
EVA	Electric vacuum aspiration
HPV	Human papilloma virus
IUD	Intrauterine device
MVA	Manual vacuum aspiration
PAC	Postabortion care
PPT	PowerPoint
STI	Sexually transmitted infection
SRH	Sexual and reproductive health
VCT	Voluntary counseling and testing
WHO	World Health Organization
YFPAC	Youth-friendly postabortion care

Contents

Acknowledgements

The Youth-Friendly Postabortion Care (YFPAC) Supplemental Training Module was developed by the Youth-Friendly Task Force of the Postabortion Care Consortium (PAC Consortium). The lead authors on the training module are Callie Simon, Gwyn Hainsworth, and Mayra Nicola, from Pathfinder International, and Donna McCarraher, Somer Cooper, and Allison Prickett, from FHI 360.

The lead authors are grateful to the following individuals for their thorough review and contribution: Maria de Bruyn, Ipas; Betty Farrell, EngenderHealth; Anna de Guzman, Ipas; Nuriye Nalan Sahin Hodoglugil, Venture Strategies Innovations; Yolande Hyjazi, JHPIEGO; Ellen Israel, Pathfinder International; Olivia Moseley, Pathfinder International; Nyanda Labor, Planned Parenthood Federation of America; Ricky Lu, JHPIEGO; Alice Mark, Ipas; Tsigue Pleah, JHPIEGO; and Sara Stratton, IntraHealth.

Content in this module has been adapted from the following publications:

- EngenderHealth. (2003). *Counseling the postabortion client: A training curriculum.* New York: EngenderHealth. Retrieved from: http://www.engenderhealth.org/pubs/maternal/pac-counseling.php
- Extending Service Delivery (ESD). (2008). *Postabortion care: Counseling adolescent clients - a pamphlet.* Washington, DC: Pathfinder International. Retrieved from: http://www.pac-consortium.org/index.php/youth
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- Senderowitz, J., Solter, C., and Hainsworth, G. (2002). *Module 16: Reproductive health services for adolescents.* Watertown, MA: Pathfinder International. Retrieved from: http://www.pathfinder.org/publications-tools/Module-16-Reproductive-Health-Services-for-Adolescents-Training-Curriculum.html Turner, K. L. and Chapman, K. Page. (2008). *Abortion attitude transformation: A values clarification toolkit for global audiences.* Chapel Hill, NC: Ipas. Activities adapted for young women by Deborah McSmith, Evelina Borjesson,

Laura Villa and Katherine L. Turner. Retrieved from: http://www.ipas.org/~/media/Files/Ipas%20Publications/ VALCLARE08.ashx

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Notes for Organizers and Trainers

Introduction

Unsafe abortion is a tremendous global health problem and a major contributor to maternal mortality—unsafe abortions kill an estimated 47,000 women each year.[1] The unique social, economic, and physical vulnerabilities of adolescents, as well as their limited access to sexual and reproductive health (SRH) information and services, put them at particular risk of unintended pregnancy and its consequences. Postabortion care (PAC) is a strategy to treat complications from abortions and prevent future unintended pregnancies and unsafe abortions by providing contraception and comprehensive counseling.

The PAC Consortium was formed over a decade ago to inform the reproductive health community about complications related to miscarriage and incomplete abortion, and to promote PAC as an effective strategy for addressing this global problem. Recognizing that adolescents are more vulnerable to unintended pregnancy and unsafe abortion, and that adolescents have unique needs, the PAC Consortium formed the Youth-Friendly Task Force. The Youth-Friendly Task Force has worked to call attention to the importance of PAC for adolescents and to provide guidance on implementing youth-friendly PAC (YFPAC). In 2006, the task force published technical guidance on YFPAC with recommendations to improve the quality of and access to PAC services for adolescents. To complement the technical guidance on YFPAC and support the implementation of YFPAC, the PAC Consortium has developed this supplemental training module to train health care providers to provide YFPAC services to adolescents (10-19).

Rationale

Adolescents are often more vulnerable to unintended pregnancy and unsafe abortion due to their psychosocial development, poverty, sexual abuse, and coercion, as well as traditional or cultural values that prevent or limit access to SRH information and services, including contraception. Less than 5 percent of the poorest young people use modern contraceptive methods and one-third of women in developing countries give birth before the age of 20.[2] Although the World Health Organization's (WHO) 2008 estimates of unsafe abortion and deaths due to unsafe abortion are not disaggregated by age, the 2003 estimates suggest that approximately 18 percent of global deaths due to unsafe abortions occur among women under

[1] WHO. (2011). *Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2008.* (6th ed.). Geneva: WHO.

[2] UNFPA. (2003). Making one billion count: Investing in adolescents' health and rights. In UNFPA, *State of world population* 2003. New York: UNFPA.

the age of 20, and nearly half (46 percent), of all abortion-related deaths occur among women under the age of 25.[3] Adolescents clearly have a dire need for PAC services that can reduce maternal morbidity and mortality and prevent unintended pregnancy and repeat abortion. Furthermore, a substantial body of evidence has demonstrated that SRH services must be tailored to the unique needs of young people to improve service quality, accessibility, and use.[4,5] As key SRH services, PAC services should be made youth friendly so they appropriately and effectively address the needs and rights of adolescents.

Purpose

This training module is designed to be supplemental to a comprehensive PAC health provider training.[6] The goal of the training module is to improve providers' abilities to offer high-quality PAC services to adolescent clients aged 10-19.[7] At the end of the two-day supplemental training, participants will be able to:

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

The Supplemental YFPAC Training Module IS:

- A training module that could be added to a comprehensive PAC training;
- A compendium of training content and activities that could be added to relevant sections of a comprehensive PAC training. (For example, the material on Postabortion Care Procedures for Adolescents could be added to a training section on PAC procedures during a comprehensive multi-day training.)

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[3] WHO. (2007). *Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003.* (5th ed.). Geneva: WHO.

[4] UNAIDS Interagency Task Team on Young People. (2006). *Preventing HIV/AIDS in young people: A systematic review of the evidence from developing countries.* Geneva: UNAIDS and WHO.

[5] Tylee, A., Haller, D. M., Graham, T., Churchill, R., and Sanci, L. (2007). Youth-friendly primary-care services: How are we doing and what needs to be done? *Lancet.* 369: 1565-1573

[6] See for example: Ipas, *Woman-centered postabortion care*; Pathfinder, *MVA for treatment of incomplete abortion*; JHPIEGO *Postabortion care course;* USAID Postabortion Care Working Group, *Postabortion Care Training*.

[7] The WHO defines adolescents as 10-19 years old, youth as 15-24, and young people as 10-24. This training module focuses primarily on adolescents 10-19, but occasionally refers to all young people. Providers may see people younger than 10 or older than 19 to whom this knowledge, skills, and attitudes will apply.

- A training module that could serve as a refresher or structured on-the-job training on YFPAC for practicing PAC providers (who have previously been trained using a comprehensive PAC curriculum).

The Supplemental YFPAC Training Module IS NOT:

- A standalone training manual. It does not include sufficient information or the necessary clinical practicum to act as a comprehensive PAC training.

Trainer and Participant Profiles

The YFPAC Supplemental Training Module is intended to train PAC providers. As the training is supplemental, participating providers should be practicing PAC providers who have undergone a comprehensive PAC training prior to this training or concurrent with this training. The training should be organized to accommodate up to 20 participants.

The supplemental training may be conducted by one trainer, but it is recommended that two trainers lead the training to ensure sufficient coverage of activities and allow for trainers to share presentation and facilitation duties. The trainers should have experience in participatory training methods, reproductive health topics including PAC, and training clinical providers. Trainers with experience in PAC, youth-friendly services, interpersonal communication, and counseling are ideally suited to implement this supplemental training.

Supplemental Training Content

The YFPAC Supplemental Training Module is designed to be supplemental to a comprehensive PAC training and offers flexibility in planning, conducting, and evaluating the training.

Trainers should thoroughly review the participants' prior training and formulate the training schedule based on this assessment. Sessions in the module can be lengthened or shortened based on the participants' level of training and expertise. The module can and should be adapted for different contexts by reviewing the examples, case studies, and role plays, and adapting them according to local practices, culture, language, health issues, and statistics.

In addition, the Supplemental Training Module Session 2 includes introductory exercises that allow providers to explore their values, opinions, and preconceptions regarding adolescent sexuality and PAC. Trainers may feel that participants need further reflection and values clarification to become fully supportive of adolescents' sexual and reproductive health and to provide compassionate care to adolescents. In this case, trainers may consider leading participants through additional reflection activities before delving into the technical content of the training. For more resources with reflection and values clarification activities related to adolescents, PAC, and SRH, please visit the Postabortion Care Consortium website's YFPAC resources: www.pac-consortium.org.

Overview of the Sessions

SESSION 1: Overview of YFPAC Supplemental Training Module

This session provides an overview of the supplemental module including its purpose, training objectives, and agenda.

SESSION 2: An Overview of Adolescence

This session introduces participants to the period of adolescence, including the physical and psychosocial changes that adolescents experience. In addition, the session covers factors that make adolescents particularly vulnerable to unintended pregnancy and unsafe abortion.

SESSION 3: Youth-Friendly Postabortion Care Services

This session describes barriers to SRH services that adolescents might experience, characteristics of YFPAC, and strategies to make services youth friendly. The session will also discuss the national adolescent SRH and PAC policy environment.

SESSION 4: Counseling Adolescent PAC Clients

This session addresses values, principles, and key issues in adolescent counseling; the importance of privacy and confidentiality; and counseling in the case of sexual and gender-based violence (SGBV). It also includes several case studies and scenarios that give providers an opportunity to demonstrate comprehensive and compassionate PAC counseling skills.

SESSION 5: Postabortion Care Procedures for Adolescent Clients

This session presents the special considerations for treatment of adolescent PAC clients.

SESSION 6: Postabortion Contraception for Adolescent Clients

This session focuses on the contraceptive methods available for adolescent PAC clients, the unique contraceptive considerations of adolescent clients, common myths and misconceptions among adolescent clients, and the importance of dual protection to protect against HIV/STIs and unintended pregnancy. It also includes several case studies that give providers an opportunity to practice effective PAC contraceptive counseling skills.

SESSION 7: Referrals for Adolescent Postabortion Clients

This session describes the importance of screening and providing referrals, steps that may make referrals more successful, and local resources available for adolescent referrals.

SESSION 8: Closing Summary

This session concludes the training and reviews the key training module objectives.

Training Schedule

The full supplemental training will take two days and can be conducted using the following schedule.

Schedule 1: 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 refresher
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 Optional Post-test and Feedback Form

Schedule 2: Illustrative Shortened Training

Depending on the existing skills of the PAC providers in the training, the trainer may choose to implement a modified training curriculum. The schedule below is illustrative of a one-day training that assumes strong baseline knowledge of PAC counseling, postabortion contraception, and referrals.

Time	Learning Objective
9:00am-9:15am	**1.1** Overview YFPAC supplemental training module
9:15am-10:00am	**2.2** Reflect on values related to adolescent sexuality and PAC
10:00am-10:30am	**2.4** Describe the unique vulnerabilities and behaviors that put adolescents at risk for unintended pregnancy and unsafe abortion
10:30am-11:15am	**3.1** Explain why adolescents need tailored PAC services
11:15am-11:30am	Tea Break
11:30am-11:40am	**3.2** Define YFPAC
11:40am-12:30pm	**3.3** Discuss strategies for making PAC services youth friendly
12:30pm-12:45pm	**4.2A** Describe key techniques for counseling adolescent clients
12:45pm-1:45pm	Lunch
1:45pm-2:30pm	**5.1** Discuss important considerations for clinical treatment of adolescent PAC clients
2:30pm-3:30pm	**6.1** Review healthy timing and spacing of pregnancy and postabortion contraception
3:30pm-4:00pm	**6.2A** Explain the postabortion contraceptive methods that are appropriate for adolescents
4:00pm-4:15pm	Tea Break
4:15pm-5:15pm	**6.6** Demonstrate appropriate contraceptive counseling techniques
5:15pm-5:30pm	**7.1** Describe key considerations for referring adolescents to other health and psychosocial services
5:30pm-6:00pm	**8.1** Review key training learning objectives

Supplemental Training Organization

The YFPAC Supplemental Training Module consists of a trainer's manual with two appendices and a PowerPoint presentation.

The trainer's manual includes instructions for the trainer as well as the content and necessary technical information.

Appendix 1 consists of trainer's tools including an optional pre-test, a training feedback form, and additional resources.

Appendix 2 consists of participant handouts for group exercises and for reference. Materials should be photocopied and available by the time training begins.

The PowerPoint presentation includes sets of slides designed to correspond to the training guide. The trainer may modify the slides so they are relevant to the local setting and training plan.

Training Methodology

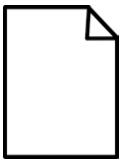
Different training techniques are employed throughout the module to stimulate adult learning and provide participants with knowledge and skills. The training techniques include:

- **Presentations:** Presentations are used to convey new information as well as to review content with which participants may already be familiar.
- **Discussion:** Discussion provides an opportunity for participants to ask questions and clarify issues that are unclear to them. It is also a chance for the trainer to evaluate the participants' views and level of knowledge and understanding.
- **Brainstorming:** Brainstorming involves generating ideas in a group quickly and without judgment. Every idea is accepted.
- **Group Work:** Some learning objectives include group work, which is usually followed by a session in which feedback is provided to the class as a whole.
- **Role Play:** Role play allows participants to practice putting together the knowledge, attitudes, and skills they have learned. This technique is useful when practicing skills such as counseling. Observers of the role play will use an observation guide to make the most of the learning experience and provide constructive feedback. At the end of the role play, the trainer should engage the group in constructive feedback and draw the group's attention back to the objectives or to the main points the role play was designed to demonstrate.

Guide to Symbols

References to the PowerPoint (PPT) slides and participant handouts appear as both text and symbols. The symbols have number designations that refer to specific objectives and the sequence within the specific objectives. Participant handbook references and PPT slide sets are arranged in chronological order and correspond to the numbered symbols in the methodology section.

Symbol for participant handout



Symbol for PowerPoint slide

SESSION 1:

Overview of YFPAC Supplemental Training Module

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
1.1 Review YFPAC supplemental training module				
Trainer Presentation	PPT Slide Set 1.1A	1.1A 1.1B – Optional Pre-test	• Review purpose of module, training goal and objectives, and agenda. • Make copies of Participant Handouts.	15 minutes for Trainer Presentation 30 minutes for Optional Pre-test
			Total Time Required:	**15-45 minutes**

RESOURCE REQUIREMENTS

- Overhead projector and/or LCD

Learning Objective 1.1:
Overview of YFPAC supplemental training module: Purpose, training objectives, and agenda

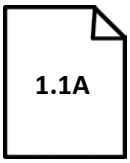
Methodology
Trainer presentation

Time
15 minutes

Trainer Presentation
The trainer should:

1. Introduce the session and review the session learning objectives and agenda using **Content: Overview of the YFPAC Supplemental Training Module** (use PPT Slide Set 1.1A).
2. Distribute **Participant Handout 1.1A: Overview of YFPAC Supplemental Training Module: Purpose, training objectives, and agenda.**
3. (Optional) Distribute **Participant Handout 1.1B: YFPAC Optional Pre-test (also Trainer's Tool 1.1B)** and allow participants 30 minutes to complete the pre-test. Use **Trainer's Tool 1.1C – YFPAC Pre-Test and Post-Test Answer Key** to score the pre-test.
4. Ask if there are any questions.

Content: Overview of the YFPAC Supplemental Training Module (use PPT Slide Set 1.1A and distribute Participant Handout 1.1A)



This training module is a supplemental training that is designed to be added to a comprehensive PAC health provider training or used as a refresher training for practicing PAC providers.[8] The goal of the training module is to improve providers' ability to provide high-quality PAC services to adolescent clients aged 10-19. The YFPAC Supplemental Training Module is organized around the five essential elements of PAC: community and service provider partnerships, counseling, treatment of incomplete and unsafe abortion, contraceptive and family planning services, and reproductive and other health services. For each of the five elements, the training focuses on the unique considerations and specific needs of adolescent clients.

Training Goal
To improve providers' ability to provide high-quality PAC services to adolescent clients. At the end of the training, participants will be able to:

1. Describe the period of adolescence,

[8] See for example, Ipas *Woman-centered postabortion care*; Pathfinder *MVA for treatment of Incomplete abortion*; JHPIEGO Postabortion care course.

2. Establish YFPAC services,
3. Provide adolescents with PAC care and treatment that take into consideration their unique needs,
4. Explain and provide contraceptive options to adolescent PAC clients,
5. Demonstrate appropriate, nonjudgmental, and comprehensive counseling of adolescent PAC clients, including contraceptive counseling and referrals.

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2:30pm–4:00pm	Sessions 4.1, 4.2A, and 4.2B: Counseling Adolescent PAC Clients
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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 Optional Post-test and Feedback Form

SESSION 2:

An Overview of Adolescence

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
2.1 Describe the burden of unsafe abortion among adolescents				
Trainer Presentation	PPT Slide Set 2.1A	None	• Review content section.	15 minutes
2.2 Reflect on values related to adolescent sexuality and PAC				
Exercise	None	None	• Review and adapt questions to the context and participants. • Make two flipchart papers: one that says "Agree" and one that says "Disagree."	40 minutes
2.3 Identify the stage of biological and cognitive development				
Trainer Presentation and Brainstorming	PPT Slide 2.3A	2.3A	• Review content sections. • Make copies of Participant Handout 2.3A.	20 minutes
2.4 Describe the unique vulnerabilities and behaviors that put adolescents at risk for unintended pregnancy and unsafe abortion				
Trainer Presentation and Brainstorming	None	None	• Review content sections. • Prepare three flipcharts labeled *Vulnerabilities of Adolescents.*	30 minutes
			Total Time Required:	**105 minutes (1 hour, 45 minutes)**

RESOURCE REQUIREMENTS

- Pens, markers, flipchart paper, tape, "sticky notes" (if available), blank paper, colored paper
- Overhead projector and/or LCD

Learning Objective 2.1:
Describe the burden of unsafe abortion among adolescents

Methodology
Trainer presentation

Time:
15 minutes

Trainer Presentation
The trainer should:

1. Introduce the session and present **Content: The Sexual and Reproductive Health of Adolescence** (use PPT Slide Set 2.1A). (10 minutes)
2. Ask if there are any questions. (5 minutes)

Content: The Sexual and Reproductive Health of Adolescence (use PPT Slide Set 2.1A)

Adolescence refers to the period of a young person's life between the ages of 10 and 19. During this transition to adulthood, adolescents develop biologically, psychologically, and socially. Though adolescence can be a very healthy period of life, adolescents may be particularly vulnerable to threats to their SRH and rights due to their age, gender, peer and family pressures, cultural customs, coercion, and violence.

Adolescents are not a homogeneous group, but rather are composed of young women and men who are at different stages of physical and psychosocial development. Adolescents may be in or out of school; employed or unemployed; married or unmarried; and parents or not. Adolescents may have different health statuses and living conditions: they may be HIV negative, HIV positive, or without knowledge of HIV status; of different sexual orientations and gender identities; living in poverty or on the street; or orphans. The period of adolescence is experienced differently in different cultures and contexts. In some countries, a 14-year-old female adolescent may be married and viewed by her community as an adult, while in other countries she would still be considered a child by her community. Adolescents differ across contexts, but in all settings the stages of biological, psychological, and social development that they pass through make them different from adults and different from children. Counselors and care providers need to understand the unique stages of adolescence and the context in which adolescents live in order to help them attain a desired state of general and reproductive health and fulfill their sexual and reproductive rights.

One of the major health concerns among adolescents is early and unintended pregnancy. Young women are more likely than older women to experience unintended pregnancy due to socioeconomic factors, gender power imbalances and abuse, lack of SRH information and services, and, especially, a lack of knowledge about and access to contraception. In addition,

they may be prevented from using contraceptives by parents, spouses, providers, and/or the social environment in which they live.

Among the world's poorest young people, only 5 percent use modern contraceptives, and roughly one-third of adolescent women in developing countries have given birth before the age of 20.[9]

Adolescents (both married and unmarried) who experience unintended pregnancy are more likely than older women to delay seeking care and treatment for pregnancy-related complications and induced abortion. This is due to barriers such as: they are unaware or deny they are pregnant; they fear retaliation and judgment from parents, partners, and peers; or they do not know where to go, whom to ask for help, or how to obtain the necessary financial resources. This is evident in the estimates of unsafe abortion for adolescents. The World Health Organization 2008 abortion estimates did not include adolescent statistics, but the estimates from 2003 indicate that 2.5 million unsafe abortions (or 14 percent of all unsafe abortions) in developing countries are among women under 20 years of age.[10] In Africa, 60 percent of unsafe abortions are among women under the age of 25.[11] Almost half of all deaths due to unsafe abortion in developing regions occur among women under the age of 25.[12]

[9] UNFPA. (2003). Making one billion count: Investing in adolescents' health and rights. In UNFPA, *State of world population* 2003. New York: UNFPA.

[10] WHO. (2007). *Unsafe abortion (4th ed.) – Global and regional estimates of the incidence of unsafe abortion and associated mortality in 2003.* Geneva: WHO.

[11] Ibid.

[12] Ibid.

Learning Objective 2.2:
Reflect on values related to adolescent sexuality and PAC

Methodology
Exercise

Time
40 minutes

Values Clarification Exercise: Agree or Disagree?
The trainer should:

1. Explain that the purpose of the exercise is to explore feelings, attitudes, and values regarding adolescents and PAC, and how those values might influence how providers care for adolescent clients. (25 minutes for steps 1-4).
2. Put up signs reading “Agree” and “Disagree” on either side of the room (on the wall or floor).
3. Explain that you will read five statements, one at a time. After each statement, participants should move to the side of the room based on whether they agree or disagree with the statement. Participants should be honest about their feelings and resist being influenced by where other participants move.
4. Begin the exercise using **Content: Values Clarification Statements.** Use the following process for each of the five statements.
    a. Read statement aloud and ask participants to move to the side of the room based on whether they agree or disagree with the statement.
    b. Ask one participant from each side of the room to explain the reason for their response and facilitate a brief discussion after each statement to encourage further reflection. Please note that the point is to encourage participants to think about how the values they hold might impact access to and quality of services, but should not make anyone feel defensive about their response. If any participants would like to move to the other side of the room based on someone’s point they may.
5. After the five statements have been read, ask participants to sit down and then lead them in a discussion using **Content: Discussion Questions.** (15 minutes)

Content: Values Clarification Statements
1. Adolescents should not have sex.
2. Adolescents should never have an abortion for any reason.
3. Parents of an adolescent who is receiving PAC should be informed, whether the adolescent agrees or not.
4. PAC counseling should focus on ensuring that youth abstain from sex.

5. If I provide postabortion contraception, it is as if I am encouraging the adolescent to have sex again.

Content: Discussion Questions

The purpose of this exercise is not to persuade others to adopt certain positions, but rather to listen and reflect on what we think and feel about various issues.

- What observations do you have about your own responses to these statements?
- What about your responses or others' responses to these statements surprised you?
- What is the relationship between your attitudes to these statements and your ability to provide high-quality and compassionate care to adolescents?
- Use these questions to probe participants to reflect further on how the beliefs reflected in these statements might affect providers' ability to offer compassionate care to adolescents.
  - **Regarding statement #1:** If an adolescent does have sex, either by choice or by coercion, what role can the provider play to ensure that she remains healthy?
  - **Regarding statement #2:** Why do you think some adolescents might seek an abortion? Do you think that a provider's view on abortion should prevent him or her from treating a patient who needs PAC and saving her life? How can providers help adolescents to prevent future unintended pregnancies?
  - **Regarding statement #3:** What do you think will encourage your clients to trust you and come back to the health facility? If a provider tells the adolescent's parents, will this damage the trust that the adolescent has in the provider/facility?
  - **Regarding statement #4:** It can be difficult or impossible for a young person to abstain for various reasons. How can we ensure that young people remain healthy when they are not able to abstain? How can providers ensure adolescents have the information and services needed to make their own decisions?
  - **Regarding statement #5:** Research shows that providing accurate information and contraception does not lead to increased sexual activity among young people. It only ensures that they are protected if they choose to have sex. How can you, as a provider, ensure that the adolescent lives a healthy life?
- How can you be a better provider of PAC and other services to adolescent clients? How can you ensure that adolescents' right to comprehensive sexual and reproductive health care is respected and fulfilled?

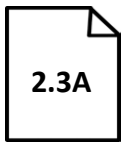
Learning Objective 2.3:
Identify stages of biological and cognitive development

Methodology
Trainer presentation and brainstorming

Time
20 minutes

Trainer Presentation and Brainstorming
The trainer should:

1. Introduce session by presenting **Content: Introduction to Adolescent Development** (use PPT Slide 2.3A). (10 minutes)
2. Ask participants to brainstorm on the physical, sexual, and emotional changes and characteristics that adolescents may have during each stage of adolescence. Write the suggestions on flipchart paper. Supplement participants' suggestions using **Content: Stages of Adolescent Development.** After the discussion distribute **Participant Handout 2.3A** for additional information. (10 minutes)



Content: Introduction to Adolescent Development (use PPT Slide 2.3)

- Adolescents are different from adults:
  - They have different needs because of their physical and psychological development.
  - They have different cognitive abilities and skills, which means they understand and process information differently from adults and children.
- An adolescent may pass through three stages of development. The timing of those stages varies and some of the changes are heavily influenced by culture and individual development.
- It is important for providers to understand the stages of development and the changes that occur during adolescence so they can respond to the unique needs of different adolescent clients.
- The three stages of adolescence are:
  a. Early adolescence (10-13)
  b. Middle adolescence (14-16)
  c. Late adolescence (17-19)

Content: Stages of Adolescent Development (Participant Handout 2.3A)

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

Learning Objective 2.4:

Describe the unique vulnerabilities and behaviors that put adolescents at risk for unintended pregnancy and unsafe abortion

Methodology

Trainer presentation and brainstorming

Time

30 minutes

Trainer Presentation and Brainstorming

The trainer should:

1. Present **Content: Introduction to Vulnerabilities and Behaviors that Place Adolescents at Risk.**
2. Label three flipchart papers with *Vulnerabilities of Adolescents* and post at the front of the room.
3. Give each participant colored paper with tape or sticky notes, if available.
4. Ask participants to brainstorm different reasons and ways that adolescents are vulnerable to poor SRH outcomes such as sexually transmitted infections (STIs), unintended pregnancy, and unsafe abortion. Vulnerabilities can be physical, emotional, economic, and structural. Have participants write down at least two or three reasons why adolescents may be vulnerable on sticky notes (or small pieces of colored paper) and post the sticky notes (or tape the papers) on the flipchart paper at the front of the room. (15 minutes)
5. Ask participants to read the notes that others have posted on the flipchart and then return to their seats. (5 minutes)
6. When participants are seated, review the ideas taped to the flipchart and use **Content: Reasons Why and Ways that Adolescents can be Vulnerable to Poor SRH** to supplement their observations. (10 minutes)

Content: Introduction to Vulnerabilities and Behaviors that Place Adolescents at Risk

In addition to understanding the biological, psychological, and emotional changes that adolescents experience, it is important for providers to understand young people's vulnerabilities and behaviors that may put them at risk. While adolescents tend to be healthy and resilient, they often find themselves in challenging situations where they are not adequately equipped with the skills, information, or services to protect themselves, or cannot do so because of the circumstances in which they are living. Adolescents, particularly young women, are influenced by and vulnerable to many external factors. For example, gender norms and stereotypes have a marked influence on adolescents' ability to make decisions and act on

those decisions, as well as on their socioeconomic independence, and emotional and physical health.

The increased vulnerability of adolescents coupled with their changing emotional and physical characteristics and developing cognitive skills may also lead to behaviors that put adolescents at risk for poor SRH outcomes. Not all adolescents intentionally take risks or behave in a risky way; however, during the period of adolescence, young people are more likely to test their limits and underestimate the risks involved. In addition, adolescents may feel invulnerable and act impulsively, which can lead to a lack of planning and to behaviors that put them at risk. This type of behavior is age-appropriate, but providers, family, and community members must help adolescents avoid life-changing consequences such as unintended pregnancy.

Content to supplement participant brainstorm: Reasons Why and Ways that Adolescents can be Vulnerable to Poor SRH

- Adolescents in a marriage or relationship may have little or no power and may not be able to assert themselves to protect their health and wellbeing.
- Adolescents are more vulnerable than adults to sexual, physical, and verbal abuse because they are less able to prevent or stop it.
- Adolescents may lack maturity and information about their bodies and reproductive systems that would allow them to advocate for themselves and their health.
- Adolescence is a time of rapid growth and development, which requires a nutritious and adequate diet. Adolescents who have poor eating habits or are unable to consume nutritious or adequate quantities of food may be more vulnerable to poor health outcomes.
- Adolescents may not yet have developed adequate assertiveness and communication skills, which limits their ability to articulate their needs and resist pressure or coercion from adults and peers.
- Repeated bouts of disease and infection can compromise physical and psychological development.
- Some adolescents may marry or enter into relationships at young ages for economic security, but may then find themselves facing other challenges such as inter-partner violence or control, poverty, or early pregnancy or motherhood. Other adolescents have no choice about marriage at an early age and then have limited ability to make decisions concerning their lives.
- Where female genital cutting is practiced, it can have significant physical and/or emotional effects for adolescent women, especially concerning SRH matters (e.g., painful menstruation, painful or harmful sex, and difficult or life-threatening childbirth).
- The physiology of the female genital tract makes women twice as likely to acquire HIV from men as vice versa.

- Sexually active adolescents are also more vulnerable biologically and socially to HPV (human papilloma virus) and most studies have demonstrated a six- to eightfold difference in HPV prevalence between younger and older women.[13]
- Irregular menstrual cycles can complicate adolescent women's understanding of fertility and pregnancy.
- Rapid changes in mood can increase due to hormones, physical changes associated with puberty, and changes in the social environment.
- Need for money increases during adolescence, yet adolescents have limited access to money or employment.
- Limited access to financial resources may result in adolescent girls engaging in transactional sex or early marriage for money, food, shelter, or other material goods. Transactional sex or early marriage may be sanctioned by the family and community.
- Poverty and economic hardships can increase health risks owing to poor sanitation, lack of clean water, and lack of access to health care and medications.
- Adolescents may face gender discrimination that affects their access to health care, ability to negotiate safer sex, and opportunities for social and economic wellbeing.
- Health services, specifically SRH services, typically address the needs of adult married women and often discriminate against adolescents (both unmarried and married).
- Community members, family members, and partners may not be supportive of adolescents' SRH and may stigmatize young women seeking SRH information, care, and services. Adolescent sexuality and sex outside of marriage is still considered unacceptable in many cultures, creating negative views of adolescent sexuality, which creates stigma and deters young people from seeking SRH services.

[13] Moscicki, A. (2007). HPV infections and adolescents. *Disease Markers. 23*(4), 229-234.

SESSION 3:

Youth-Friendly Postabortion Care Services

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
3.1 Explain why adolescents need tailored PAC services				
Brainstorming	PPT Slide 3.1A	None	• Review content sections. • Prepare two flipcharts: one labeled Personal Barriers and one labeled External Barriers.	40 minutes
3.2 Define YFPAC				
Trainer Presentation	PPT Slide 3.2A	None	• Review content section.	10 minutes
3.3 Discuss strategies for making PAC services youth-friendly				
Brainstorming and Trainer Presentation	PPT Slide Set 3.3C	3.3A, 3.3B, and 3.3C	• Prepare three flipchart papers labeled: Provider Characteristics, Health Facility Characteristics, and Program Design Characteristics. • Make copies of Participant Handouts 3.3A, 3.3B, and 3.3C	45 minutes
3.4 Explain national policies and guidelines that support PAC service provision for adolescents				
Trainer Presentation	None	None	• Become familiar with all relevant national policies and guidelines related to the provision of PAC services, including contraception, for adolescents.	20 minutes
			Total Time Required:	**115 minutes (1 hour, 55 minutes)**

RESOURCE REQUIREMENTS

- Pens, markers, flipchart paper, and tape
- Overhead projector and/or LCD

Learning Objective 3.1:
Explain why adolescents need tailored PAC services

Methodology
Brainstorming

Time
40 minutes

Brainstorming
The trainer should:

1. Present **Content: Introduction** below. (5 minutes)
2. Ask participants to think of reasons or barriers that make adolescents less willing and able to seek contraceptive/family planning services to prevent unintended pregnancy and unsafe abortion and/or less likely to seek PAC services in the case of an unsafe abortion. Have participants think broadly to include factors such as the health care system; legal and policy environment; community; and knowledge, skills, or vulnerabilities of the adolescent client. (15 minutes for steps 2 and 3).
3. As participants brainstorm, ask them to say whether the barrier they have suggested is a personal barrier or an external barrier. Write the barriers they suggest on flipcharts labeled appropriately (Personal Barriers on one paper and External Barriers on the other paper).
4. Supplement participants' brainstorm with the list in **Content: Barriers to Preventive Services and Care.** (5 minutes)
5. Present **Content: Reasons that Adolescents Often Seek Late, Cheaper, and Unsafe Abortions** (use PPT Slide 3.1A). (10 minutes)
6. Summarize by presenting **Content: Summary**. (5 minutes)

Content: Introduction
As we explored in Session 1, adolescents are different from adults because of their physical and psychological development, their cognitive abilities and skills, and their social status. In addition, we discussed adolescents' unique vulnerabilities and the potential SRH consequences of that vulnerability. Adolescents are also vulnerable because they are often less likely and less able to seek health services and often rely heavily on information from peers. As providers, it is important to understand why adolescents often do not use available services or seek services when they are in crisis. By understanding the barriers adolescents might face to preventive SRH services, it is easier to understand why adolescents may be delayed in seeking PAC services and how we might help to reduce those barriers.

Content: Barriers Adolescents Face to SRH Services and Care

Use the following content to supplement participant brainstorm:

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

Personal Barriers:

- Limited understanding of their bodies and conception/reproduction;
- Little knowledge of available services and their location;
- Religious values and teachings that may not support a positive attitude to sexuality and acting responsibly to be sexually healthy, such as by seeking SRH services;
- Belief that the services are not intended for adolescents;
- Concern that the staff will be hostile or judgmental (either verbally or non-verbally);
- Concern that services lack privacy and confidentiality and fear that their parents or communities might learn of the visit;
- Embarrassment at needing or wanting services;
- Shame, especially if the visit follows sexual coercion or abuse;
- Fear of contraceptive methods based on misconceptions or myths about future infertility;
- Lack of decision making power to seek health services (common when the adolescent is married or in a situation of economic dependence);
- Psychosocial development that may make them underestimate risk or feel that nothing bad will happen to them;
- Fear of poor quality services, infection, or other negative outcomes;
- Lack of necessary financial resources to pay for services or transportation.

External Barriers:

- National laws and policies restricting access to services based on legal age and/or marital status;
- Lack of appropriate services designed to meet the needs of adolescents, including lack of providers who are respectful and trained in YFPAC service provision;
- Inconvenient hours of facility operation;
- Lack of transportation;
- High cost of services;
- Providers' insufficient time available to spend with adolescents. (Heavy client loads and multiple responsibilities can mean that providers have limited time to spend with

adolescent clients, who may need more time to counsel because they lack prior SRH information and knowledge.)

- Religious or cultural beliefs of peers, partners, and families that restrict access to SRH services.

Content: Reasons that Adolescents Often Seek Late, Cheaper, and Unsafe Abortions
(use PPT Slide 3.1A)

- They deny the pregnancy.
- They are unaware they are pregnant.
- They fear the reactions of their parents/in-laws, partners, peers, and communities.
- They lack financial resources or transportation.
- They do not know where to go for a safe abortion, or there are no legal, safe abortion options. Or, if available, adolescents' access to the services is restricted due to age, marital status, or other structural factors such as provider attitudes.
- They do not know whom or how to ask for help.

Content: Summary

- Adolescents face many barriers to preventive services and care. Adolescents often seek late and unsafe abortion services. As a result, adolescents often end up with more serious complications (including death) than adults. YFPAC services should be designed to reduce these barriers and foster healthy adolescents.
- It is also important to recognize that many adolescents often present for the first time at health facilities when they are pregnant or when they are suffering from complications of an unsafe abortion. YFPAC services should capitalize on the PAC visit as an opportunity to address the comprehensive SRH needs of the adolescent client to avoid unintended pregnancy, HIV, and other STIs in the future.

Learning Objective 3.2:
Define youth-friendly postabortion care (YFPAC)

Methodology
Trainer presentation

Time
10 minutes

Trainer Presentation
The trainer should:

1. Present **Content: Defining YFPAC** (use PPT Slide 3.2A). (10 minutes)

Content: Defining YFPAC (use PPT Slide 3.2A)

In 2002, the PAC Consortium endorsed the Five Essential Elements of PAC:

1. Community and service provider partnerships
   - Help prevent unintended pregnancies and unsafe abortions.
   - Mobilize resources to help women receive appropriate and timely care for complications of abortion.
   - Ensure that health services reflect and meet community expectations and needs.
2. Counseling
   - Identify and respond to women's emotional and physical health needs and other concerns.
3. Treatment
   - Treat incomplete and unsafe abortion and potentially life-threatening complications.
4. Family planning and contraceptive services
   - Help women to practice healthy timing and spacing of pregnancy or to prevent an unintended pregnancy.
5. Referral for reproductive health and other services
   - Provide onsite care or referrals to other accessible facilities

YFPAC includes the five elements of PAC with the aim of reducing the barriers to care that adolescents face. YFPAC addresses both the quality of PAC services so that they better meet adolescent clients' unique needs and the access of adolescent women to these services. YFPAC can be defined as PAC services that attract, adequately and comfortably meet the health care needs of, and retain adolescent clients.

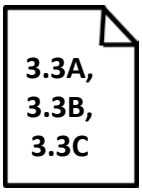
Learning Objective 3.3:
Discuss strategies for making PAC services youth friendly

Methodology
Brainstorming and trainer presentation

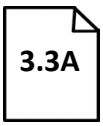
Time
45 minutes

Brainstorming and Group Work: Youth-Friendly PAC Services
The trainer should:

1. Ask participants to brainstorm characteristics of youth-friendly services. Put answers on flipchart under the following three headings: Provider Characteristics, Health Facility Characteristics, and Program Design Characteristics. Supplement with **Content: Characteristics of Youth-Friendly Services (use Participant Handout 3.3A).** (15 minutes)
2. Present **Content: Strategies for Making PAC Services Youth Friendly** (use PPT Slide Set 3.3C). (15 minutes)
3. Lead discussion with participants around these two questions (10 minutes):
    a. Do you think it is possible to tailor the PAC services offered in your facility so they are youth friendly?
    b. What challenges do you anticipate encountering in trying to make your PAC services youth friendly?
    c. How can you address these challenges?
4. Distribute the participant handouts **3.3A: Characteristics of Youth-Friendly Services, 3.3B: Youth-Friendly PAC Technical Guidelines,** and **3.3C: Youth-Friendly PAC Assessment Tool** as reference materials. Briefly present each handout and explain that these are useful tools for providers to take home and use to implement YFPAC in their facilities. (5 minutes)



Content: Characteristics of Youth-Friendly Services (use Participant Handout 3.3A)



The characteristics of youth-friendly services pertain to the providers, the health facility itself, and the program design. To successfully provide SRH services to adolescent clients, 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

All youth-friendly services, including YFPAC, should strive to achieve these characteristics. However, the following characteristics are essential minimum standards:

- Policies that do not restrict services based on age, marital status, gender, or parental/familial/partner approval
- Specially trained staff who are nonjudgmental and respectful
- Privacy and confidentiality ensured
- Availability of a wide range of SRH services and contraceptive methods with procedural considerations for adolescent clients
- Youth involvement in service design and provision of feedback

Content: Strategies for Making PAC Services Youth Friendly (use PPT Slide Set 3.3C)

For each of the five essential PAC elements, there are many strategies that providers, facility managers, young people, and communities can employ to make services youth friendly. These strategies are described in detail throughout the rest of the curriculum. Below is an overview.

PAC Essential Element 1: Community and service provider partnerships

- Include adolescents as partners in the design of the YFPAC services and develop mechanisms for community and adolescent input into the quality of PAC services.
- Create an enabling environment to support the provision of needed SRH information and services to young people by facilitating dialogues (through community discussion groups, mass media, community theater, etc.) around sensitive issues related to adolescent sexuality, sexual abuse or coercion, and prevention of unintended pregnancy.
- Build on existing youth programs with peer educators to improve peer educators' understanding of PAC and encourage referrals of adolescents in need of PAC services to the YFPAC facilities.

PAC Essential Element 2: Counseling

- Train providers to ensure appropriate and effective counseling that is tailored to the specific needs and characteristics of each young person since adolescents are not a homogeneous group. Differences in age, developmental stage, educational/literacy level, marital status, and living conditions all affect the counseling session, including what types of information should be provided and how to effectively communicate the information.
- Allocate more time and special care to counseling adolescent clients. This includes giving basic education on SRH issues such as fertility and pregnancy, ensuring two-way communication, exploring options and their consequences, and showing patience.
- Ensure respectful interactions, privacy, and confidentiality.

PAC Essential Element 3: Treatment

- Offer treatment in a separate space, if possible, and ensure privacy.
- Offer PAC in places that are convenient to adolescents and at low or no cost.
- Provide extra support to the youth client during the procedure or allow her to bring a support person, if desired.
- Clinical procedures for PAC are the same as for an adult client. However, lack of knowledge about what to expect and limited emotional support can lead to increased anxiety and pain. Pain management, especially for nulliparous women, should be given particular attention.
- Other procedural considerations include the following: Use a smaller speculum; perform examinations gently and slowly; explain what to expect before any action and repeat this information as necessary; and be aware that adolescents often wait longer to seek services and may have more severe complications than adult women.

PAC Essential Element 4: Family Planning and Contraception

- Explore the adolescent's reproductive intentions (e.g., does she have a desire to become pregnant again soon? Or further in the future? Or is she unsure?). Discuss healthy timing and spacing of pregnancy. Present characteristics of methods that match her fertility intentions and the considerations for successfully using specific methods.
- Remember that age is not a contraindication for any contraceptive method. Therefore, adolescent clients should be offered a range of methods that fit their fertility intentions and their readiness for successfully using a specific method, including long-acting reversible contraceptives like intrauterine devices (IUDs) and implants.While age is not a contraindication, permanent methods are usually not appropriate for adolescents and one should always consider medical eligibility criteria for contraceptive use in case the adolescent has other health considerations that might preclude certain methods.
- Emphasize dual protection to prevent both HIV/STIs and unintended pregnancy. Dual protection can be achieved through correct and consistent condom use or through dual method use, which means using condoms to protect against HIV/STIs and unintended pregnancy, as well as a second contraceptive method for better protection from unintended pregnancy.
- Help adolescents learn how to use their method successfully (e.g., linking daily activity to taking a pill). Be aware that adolescents may have different concerns than adult clients, such as weight gain or acne. In addition, adolescents may not have a safe place to keep a method (e.g., a packet of pills), so certain more discrete methods like injectables, IUDs, or implants may be more acceptable to them.

PAC Essential Element 5: Referrals for reproductive health and other services

- When possible, refer adolescents to facilities that offer youth-friendly services or to facilities or organizations that are receptive to adolescent clients.
- If an adolescent is being referred for contraceptive services because a particular method is unavailable at the place of PAC service provision, the adolescent should be supplied with a safe interim method that she is medically eligible for and finds acceptable for short-term use until she is able to seek services where she has been referred.
- Take the time to 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. If they have a good rapport with the provider, they may be reluctant to go elsewhere for services that are not available at the facility.

Learning Objective 3.4:
Explain national policies and guidelines that support PAC service provision for adolescents

Methodology
Trainer presentation

Time
20 minutes

Trainer Presentation
The trainer should:

1. Introduce the importance of the policy environment to YFPAC services using **Content: YFPAC Policy Environment.** (10 minutes for steps 1-3)
2. Ask participants to identify any local policies related to providing services to adolescents and record their suggestions.
3. Provide accurate information on existing policies and correct any misinformation.
4. Ask participants if these policies support or hinder the provision of health services like PAC to adolescents, based on the previous discussions around providing youth-friendly SRH services. (5 minutes)
5. Summarize by pointing out that when adolescent policies and guidelines exist, we must follow them. However, we must do everything in our power to ensure that adolescents are extended the same rights and quality of care as adult clients. Where policies do not exist or are restrictive, providers may be in a position to advocate with the government to ensure that positive and supportive policies are developed and implemented. (5 minutes)

Content: YFPAC Policy Environment
The 1994 International Conference on Population and Development Program of Action states that all women have the right to treatment of complications from unsafe abortion. In addition, this internationally agreed-upon statement supports the rights of adolescents to all SRH services, including PAC. Ethically, providers have an obligation to treat all clients, including adolescents.

At the national level, it is also critical that policies ensure that adolescents have unrestricted access to comprehensive SRH services, including PAC. Providers should be aware of national policies and procedures and should act in accordance with these policies. When national policies are restrictive toward adolescents, providers can play an important role in advocacy to change those policies. Sometimes, facilities restrict access to adolescents by requiring parental or partner consent or instate age requirements even when national policies do not require or

promote such restrictions. In these cases, providers should work with their facility managers to change their practices so they align with national and international policies.

There are a number of examples of youth SRH policies that can be found in the USAID PAC Global Resource Package (http://www.postabortioncare.org/) or at www.youth-policy.com.

SESSION 4:

Counseling Adolescent PAC Clients

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
4.1 Reflect on different perceptions of adolescent PAC clients				
Exercise and Facilitated Group Discussion	None	None	• Review Story 1 and Story 2 of exercise.	40 minutes
4.2A Describe key techniques for counseling adolescent clients				
Trainer Presentation	PPT Slide Set 4.2A	None	• Review content sections.	15 minutes
4.2B Describe key techniques for counseling adolescent clients				
Group Brainstorming	None	None	• Review content sections. • Prepare two flipchart papers labeled: Emotions of an adolescent seeking PAC *and* Good practices for counseling adolescents.	30 minutes
4.2C Describe key techniques for counseling adolescent clients (optional)				
DVD	None	None	• Watch DVD, *Enhancing Postabortion Care Counseling Skills – An Interactive Learning Tool.*	1 hour, 35 minutes
4.3 Understand and screen for sexual and gender-based violence among adolescent PAC clients				
Trainer Presentation and Discussion	PPT Slide Set 4.3A	None	• Review content sections and discussion questions. • Identify any SGBV services in the area where the training is taking place.	30 minutes

4.4 Demonstrate effective counseling techniques for adolescent PAC clients				
Role Play	None	4.4A and 4.4B	• Review role play scenarios and discussion questions.	1 hour, 30 minutes
			Total Time Required:	**300 minutes (5 hours)**

RESOURCE REQUIREMENTS

- Colored paper (two different colors), pens, markers, flipchart paper, tape
- Overhead projector and/or LCD
- Optional interactive DVD for PAC Counseling: *Enhancing Postabortion Care Counseling Skills – An Interactive Learning Tool.* Information on how to order the DVD is available at: http://www.intrahealth.org/page/enhancing-postabortion-care-counseling-skillsan-interactive-learning-tool

Learning Objective 4.1:
Reflect on different perceptions of adolescent PAC clients

Methodology
Exercise and facilitated group discussion

Time
40 minutes

Exercise – Reflection Scenarios
The trainer should:

1. Introduce the session and review the session learning objectives. (15 minutes for steps 1-5)
2. Explain that to begin the conversation about counseling, the participants will participate in an exercise that will help them better understand situations adolescents may face, as well as their own perceptions of and beliefs about adolescent PAC clients.
3. Distribute five sheets of colored paper to each participant (all should be the same color).
4. Read **Story 1** to the group
   Elizabeth is 17 years old and in form four (secondary school). It is midway through the first term and the students have just completed their exams. Over the summer holiday, Elizabeth dated Victor, who is at university. Their last night together before returning to school, Elizabeth and Victor had unprotected sex. A few weeks after returning to school, Elizabeth started feeling tired and nauseous—even vomiting in the mornings before class. She didn't get her period, but Elizabeth didn't think she could possibly be pregnant, since everyone knows you can't get pregnant the first time you have sex. Things didn't get much better and then she missed her next period too. Elizabeth talked to her best friend, Esther, about her situation and Esther told her that she was likely pregnant. Elizabeth panicked. All she could think about was getting sent home from school in disgrace because she was pregnant. Esther said she heard that there was a man in town who could help you abort. They visited the man. He gave Elizabeth some drugs, and also inserted an object into her vagina. Elizabeth took the drugs and returned to school, where she started bleeding heavily in the girls' bathroom. Esther was afraid and ran to call the school nurse. They loaded Elizabeth into a taxi and took her to the hospital up the road, where she was admitted for treatment.
5. Now, ask the participants to write down the first five things they thought of when the trainer read the story. Tell the participants they should not censor themselves—they should just write the thoughts that immediately came to mind. For example, the trainer might say that the first thing that occurs to him/her is that Elizabeth is too young to be having sex.
6. Collect the papers from the participants.

7. Now, distribute another five sheets of colored paper to each participant, using a different colored paper. (15 minutes for steps 7-11)
8. Read **Story 2** to the group:
   Anita is 14. Her father died of AIDS about five years ago, and her mother passed away about six months ago. She has been living with her aunt. Her aunt lives some distance from the school that Anita attends, so Anita has to walk a long way to and from school. Anita has complained to her aunt that she is harassed by some of the men she sees on the road. A few months ago, Anita came home in tears and shock. She had been raped by one of these men, who claimed Anita had been flirting with him and leading him on.

   Anita's aunt is terribly embarrassed by the situation and doesn't go to the police. She tells Anita to just forget about it and now grudgingly gives her bus fare to travel to school, complaining all the while that Anita is costing her a lot of money. But a couple of months after the rape, Anita realizes that she is pregnant. She is horrified and, given her aunt's reaction to the rape and her complaints about how much money Anita is costing her, she is certain she cannot go to her aunt for help.

   One of her friends tells her she can go to the market and purchase some herbs from the traditional medicine seller that will cause her to have an abortion. Anita saves her bus fare for a week and goes to find the woman in the market. She takes the herbs that night. In the morning, she wakes to find blood all over her bed. When her aunt comes to call her for school, she sees the blood and immediately takes Anita to the hospital.
9. Ask participants to write down the first thoughts that come to their minds on the colored paper. Again, tell the participants that they should not censor themselves. For example, the trainer might say that the first thing that occurs to him/her is that Anita must have been flirting with the men.
10. Collect the papers.
11. Post all the papers on the wall, and group the papers thematically according to whether or not the response is a negative one (e.g., she shouldn't be having sex, she is only getting what she deserves) or an empathetic one (e.g., the girl is vulnerable, she was raped, etc.).
12. Now, discuss as a large group. Ask the following questions (10 minutes):
    - Are our initial thoughts about adolescents PAC clients usually empathetic and understanding or judgmental and negative?
    - Do we have different responses based on the client's situation? In what way?
    - Do these responses affect how we communicate with adolescent clients? How?
    - How can health providers show empathy toward an adolescent who comes to the clinic or hospital for treatment of an incomplete abortion?
    - PAC clients, especially adolescents, are sometimes treated badly in health facilities to punish them. They may be forced to wait a long time or they are treated with a lack of respect. Does this behavior help prevent future abortions or unintended pregnancies? Why or why not?

Learning Objective 4.2A:
Describe key techniques for counseling adolescent clients

Methodology
Trainer presentation

Time
15 minutes

Trainer Presentation
The trainer should:

1. Present **Content: What is Counseling and What is its Purpose?** and **Important Considerations for Counseling the Adolescent Client** (use PPT Slide Set 4.2A) (10 minutes)

Content: What is Counseling and What is its Purpose? (use PPT Slide Set 4.2A)

Counseling is a person-to-person, confidential, two-way communication during which the counselor helps the client understand the PAC procedure and supports the client in making decisions to prevent future unintended pregnancies and other poor SRH outcomes.

Counseling during PAC is essential—it is the key to positive physical and emotional health outcomes.

PAC counseling is intended to:

- Provide adequate information to help the adolescent make an informed decision,
- Help the adolescent evaluate her feelings and opinions,
- Act as emotional support for the adolescent,
- Help the adolescent anticipate consequences of actions,
- Support the adolescent in making healthy decisions given her life circumstances, including the use of contraception to avoid another unintended pregnancy.

PAC counseling is <u>not</u> a way to:

- Provide solutions to the adolescent's problems,
- Make decisions for the adolescent,
- Give instructions,
- Promote a life plan that has been successful for the counselor,
- Express the counselor's judgment about the adolescent's behavior.

Content: Important Considerations for Counseling Adolescent Clients (use PPT Slide Set 4.2A)

Our behavior reflects our attitudes, feelings, and values, even when we do not realize it. It is important that providers understand their own attitudes and how to counsel adolescent PAC clients in a respectful and supportive manner.

When a young woman comes to a facility for treatment of an incomplete abortion, she has contact with many people, not just the health care worker treating her. She may encounter many different types of auxiliary staff as well as other patients in the waiting room. Remaining aware that these adolescent women are often under severe emotional distress in addition to physical discomfort, health care providers must serve as role models for other staff and patients in the facility. Each staff person who might interact with adolescents must understand these circumstances and feelings and must be prepared to assist in a helpful, nonjudgmental manner.

Providers should strive to foster a comfortable, trusting rapport with an adolescent PAC client so they are able to effectively counsel and support her before, during, and after the procedure. The more comfortable an adolescent client is, the more likely she is to open up about her concerns and play an active role in her treatment and follow-up. **All PAC counseling skills learned in previous PAC trainings are relevant and useful with adolescents. In addition, adolescents in many countries have identified their top three concerns for SRH as privacy, confidentiality, and positive provider attitudes.**

- **Privacy:** This characteristic relates primarily to the facility. It requires a separate space where counseling, examinations, and procedures can take place without being seen or overheard by others, and where the interaction is as free from interruptions as possible.
- **Confidentiality:** This characteristic relates to the provider and requires that she/he ensures that no discussions and matters pertaining to the visit will be shared with parents, partners, or others without the adolescent client's permission or consent.

  In accordance with national policies, the provider should make it clear that in some circumstances the provider may believe it necessary to share information with others (for example, to prevent further sexual abuse). In this instance, the provider should explain why it is important to share this information with others, and explain to the adolescent exactly when, how, and with whom the information would be shared.
- **Positive provider attitudes:** This characteristic involves the way that the counselor/provider relates to the adolescent. The provider must recognize the client's humanity, dignity, and right to be treated as someone who is capable of making good decisions. The provider must demonstrate respect. Respect assumes that one can be different and have different or alternative needs that are legitimate and deserve a professional response.

Learning Objective 4.2B:
Describe key techniques for counseling adolescent clients

Methodology
Group brainstorming

Time
30 minutes

Group Brainstorming
The trainer should:

1. Provide an introduction using **Content: Introduction to Emotions and Behaviors Clients Might Experience** and **Techniques for Counseling Adolescent Clients.** (5 minutes)
2. Ask participants the following questions and note their responses on flipchart papers labeled with each question (15 minutes):
   - What emotions might an adolescent seeking PAC experience?
   - What do you think are the best practices or good techniques for counseling adolescents, keeping in mind the range of emotions an adolescent might experience?
3. Supplement participant answers with **Content: Emotions and Behaviors the Adolescent Client Might Experience** and **Content: Good Techniques for Counseling Adolescents.** (10 minutes)

Content: Introduction to Emotions and Behaviors Clients Might Experience and Techniques for Counseling Adolescent Clients
It is important for providers to understand the complex emotions that many adolescent clients may experience and develop good techniques for respectfully and compassionately counseling them.

A number of factors may influence the client's emotional state, including her feelings about her pregnancy and the termination, fear that she might not be able to have children in the future, her beliefs about the procedure, her lack of familiarity with the clinic or hospital setting, the amount of time she has waited, or her fear that her family will find out. Acknowledging the adolescent's fears and concerns, responding empathetically, and, where possible, acting to calm her fears, are all part of the health worker's role and PAC counseling.

Even if you cannot help the client, you can still demonstrate care and concern for the client's problem. In these situations, it is important be clear when you cannot help with the problem and refer her to someone who can help.

Content: Emotions and Behaviors the Adolescent Client Might Experience

Supplement participant brainstorm with discussion of the following emotions and behaviors:

- Relief: The client had an unsafe abortion because she had an unintended pregnancy, so she might be relieved because she is no longer pregnant and she is receiving medical care.
- Isolation/loneliness: Sometimes, clinic or hospital protocols or transportation costs prevent family members, partners, or friends from accompanying the client, or the client may have come alone because she was afraid of telling anyone about the pregnancy and abortion.
- Fear: The client may be scared of the pain or possible complications from the procedure. She may also be afraid that others will find out and she will experience criticism or retaliation (from health workers, family, peers, or her partner) for seeking services.
- Embarrassment: The client could feel embarrassed or ashamed of getting pregnant and/or seeking an abortion. It might also be the client's first time in a health facility and she could be embarrassed about being unclothed or a provider examining her.
- Silence: Adolescents experiencing a range of emotions may be silent. This could be a sign of shyness, anger, or anxiety. It may also be the adolescent's way of processing the experience.
- Crying: Crying can be a sign that the client is emotionally distressed. It could mean that she is angry, scared, in pain, or worried. She may also be relieved.
- Refusal of services: An adolescent may refuse services because she is scared or does not understand the procedure. She may also refuse if she is very frightened or in a great deal of pain.

Content: Good Techniques for Counseling Adolescents

There are many different techniques to ensure that the PAC counseling experience is positive for adolescent clients and providers. Supplement participant answers with these listed below:

- Greet the client calmly and professionally—smile, tell her your name, and ask her for her name.
- Be sensitive and alert to the unique concerns the adolescent client might have, including her emotional state, fear of being seen, physical pain, and possible signs of infection. Respond to the adolescent's verbal and non-verbal communication.
- Assure the client that her visit and all information will be kept confidential.
- Demonstrate sincerity and a willingness to understand and help.
- Show that you are supportive of her decision to seek PAC.
- Depending on the situation, face the adolescent, sitting in similar chairs. For example, avoid having a desk between you and the client or standing over her.

- Begin by allowing the adolescent to talk freely before asking direct questions and allow a client's interests and needs to guide the flow, content, and timing of the session.
- Allow sufficient time for the adolescent client to become comfortable enough to ask questions and express her concerns. Give her some time to think, ask questions, and speak. Be silent when necessary, and follow the rhythm of the conversation.
- Avoid judgmental responses both in body or spoken language. Avoid questions that begin with the word "why" since the adolescent may think you are blaming her.
- Listen actively, nod your head, and periodically repeat what you have heard, confirming that you and the adolescent have a mutual understanding.
- Speak in an understandable way, avoiding technical terms or difficult words. Do not overload the adolescent with information. Provide information based on what the adolescent knows or has heard. Use language which is age appropriate (e.g., contraception instead of family planning).
- Where available, use visual or audiovisual materials such as pamphlets, posters, or videos to help the adolescent understand the information and to convey information in more concrete terms.
- Ask questions using a tone that shows interest, attention, and friendliness. Ask open-ended questions that permit or encourage the adolescent to respond with more than a "yes" or "no." Allow for explanations of feelings or concerns. Examples of open-ended questions might be: "How are you feeling?" or "What type of herbs/drugs did you take?"
- Avoid biased or leading questions that can direct the client's response or sound like you are blaming them. For example: "Have you heard that abortion can make you infertile?" Leading questions give answers to questions or imply what you want to hear. Sometimes these kinds of questions and statements begin with expressions like "Don't you agree that…" or "I hope you know that…."

Learning Objective 4.2C:
Describe key techniques for counseling adolescent clients (optional)

Methodology

Enhancing Postabortion Care Counseling Skills – An Interactive Learning Tool

Time

1 hour, 35 minutes

Interactive DVD for PAC Counseling

Note to the trainer:

The *Enhancing Postabortion Care Counseling Skills* DVD was made to be used as an interactive learning tool, but it also has very useful clips of positive and negative counseling behaviors. The DVD was filmed in Kenya and is widely applicable. If you would like to use this video (which can play on a computer or portable DVD player), please see: http://www.intrahealth.org/page/enhancing-postabortion-care-pac-counseling-skillsan-interactive-learning-tool

If this link does not work, please visit www.intrahealth.org and search for the "Postabortion Care Counseling DVD."

If you choose to use this methodology, do not conduct sessions 4.2A or 4.2B. Please follow the instructions that come with the interactive learning tool for this session.

Learning Objective 4.3:
Understand and screen for sexual and gender-based violence (SGBV) among adolescent PAC clients

Methodology
Trainer presentation and discussion

Time
30 minutes

Trainer Presentation and Discussion
The trainer should:

1. Present **Content: Introduction to SGBV** (use PPT Slide Set 4.3A). (10 minutes)
2. Facilitate a discussion by asking participants the following questions. Supplement with **Content: Supplemental Answers for Discussion Questions.** (15 minutes)
   - How common do you think rape, sexual abuse, and coercion are in your community?
   - Can you give some examples of the different types of sexual abuse or coercion that occur among girls and young women?
   - When a young person comes to the facility for PAC or because she suspects she is pregnant, do you consider the possibility that she may be in this situation because of abuse or coercion?
   - Do you discuss issues of abuse or coercion with all adolescent clients? Or only when a client tells you she has been abused or coerced?
   - What can you do as a provider to support these young women and help them cope with their situation?
3. Summarize by stressing the absolute need to keep all information confidential unless there is a legal responsibility to report the case to the authorities. If so, the provider should always explain the need to share the information with authorities to the client. (5 minutes)

Content: Introduction to SGBV (use PPT Slide Set 4.3A)

Gender-based violence "is derived from unequal power relationships between men and women… It includes, but is not limited to, physical, sexual, and psychological harm…."[14] For women, gender-based violence includes female infanticide, female genital cutting, sex trafficking, forced early marriage, rape, intimate partner violence, and honor killing.[15]

Sexual violence is an umbrella term that includes rape, attempted rape, sexual abuse, and sexual exploitation. It involves "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work."[16] According to international law, sexual violence includes any sexual act that is committed by force or coercion, against a person's will or without his or her genuine consent.[17] A person cannot give consent if s/he is a minor, is mentally impaired, or is under the influence of alcohol or drugs.

Sexual and gender-based violence may be physical, verbal, or emotional and is a violation that is perpetrated by a person who holds, or is perceived to hold, power over someone who is vulnerable. Often the perpetrator is known to the survivor and could be a parent, relative, partner or husband, neighbor, or teacher. In many, but not all, cases, the perpetrator is male and the survivor is female. Adolescent women are often at increased risk for SGBV because they lack power vis-à-vis adults and because they are female. SGBV can have a significant impact on an adolescent's health, mental state, and her life in general. It can cause serious future SRH problems.

Adolescent and youth programs and health care providers often assume that most adolescents engage in consensual or wanted sex. While hard data is limited, it is increasingly apparent that a significant number of young people are coerced and sexually abused. Young people who have been sexually abused often do not divulge that they have experienced SGBV, at least not initially, and have different health care needs than those who have not.

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[14] IGWG of USAID. (2006). *Addressing gender based violence through USAID's health programs: A guide for health sector program officers.* Washington, DC. Originally cited in United Nations Population Fund Gender Theme Group.

[15] USAID Gender-Based Violence Working Group. (2009). *A guide to programming gender-based violence prevention and response activities.* Washington, D.C.: USAID.

[16] Etienne, K., Dalhberg, L., Mercy, J., Zwi, A., and Lozano, R. (Eds.). (2002). *World report on violence and health.* Geneva: WHO.

[17] Global Justice Center. (n.d.). Overview of sexual violence in international law. Retrieved from: www.globaljusticecenter.net/media/4.%20Sexual%20Violence.pdf.

Content: Supplemental Answers for Discussion Questions

Use these answers to add to the participants' responses to the following questions.

How accepted do you think sexual and gender-based violence is in your community?
Because sexual abuse exploits the use of power, adolescents—especially young women and girls—are particularly susceptible. The level of acceptability of SGBV varies by community, but many forms of SGBV are often accepted across many communities and adolescent girls may suffer disproportionately.

Can you give some examples of the different types of SGBV that occurs in your community?

- Verbal abuse toward girls—yelling and name calling
- Unwanted touching or sex
- Rape (including within marriage)
- Forced early marriage
- Sexual abuse by a relative, teacher, etc.

When a young person comes to the facility for PAC or because she suspects she is pregnant, do we consider the possibility that she may be in this situation because of abuse or coercion?
Providers often assume that young people seeking PAC have had consensual, unprotected sex. As we discussed, however, this is not always the case. In fact, frequently young women seeking PAC are survivors of sexual violence.

Should we ask adolescent clients questions to determine if they have experienced SGBV?
It is important to address issues of SGBV with adolescent PAC clients as long as there is privacy, confidentiality, and appropriate referral services. Some adolescents may not feel comfortable telling a provider that they have been abused and others may not have experienced SGBV but could experience it in the future. Therefore, it is important to include in counseling. If an adolescent is under duress during pre-PAC counseling, wait and address SGBV in counseling after the PAC treatment. It is important to screen clients when they are fully clothed and there is privacy so that they feel as comfortable as possible.

What questions might be appropriate to ask to find out if an adolescent is experiencing or has experienced SGBV?
Standard screening tools should be developed. A good resource for such tools can be found in IPPF/Western Hemisphere Region's publication *Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries* (see resource list).

Some providers have had success with asking these questions:

1. Many of the adolescents I see have felt that someone their own age or older, sometimes a relative, pressured them into sexual activities. I'm talking to all my patients about this, so even if it's not happening to them, they might be able to help a friend in that situation.
2. There are lots of reasons why people have nightmares or fears. In some cases, it is because someone has sexually abused them. Is that a possibility with you?

3. Are you afraid that your partner or another person will cause you harm?
4. Have you ever been touched sexually against your will? Would you like to tell me more about this experience?

What can we do as providers to support these young women and help them cope with their situation?

Providers must establish trust with the adolescent client first before she will share this information. If a client reveals SGBV or you suspect that she has experienced SGBV, it is critical to express empathy and compassion without blame or judgment. Remember, such cases are complex and usually require a qualified person to handle them. SGBV often results in serious psychological trauma and a client who has experienced this type of abuse may need additional psychological support. In settings where SGBV services are onsite or where referral services are available, the provider should link the PAC client with these.

All PAC providers should be aware of some basic ways they can support a PAC client who has experienced SGBV. If a PAC client reveals that she has experienced SGBV, the provider should:

- **Provide psychological and emotional support.**
  - Practice active listening. Ask questions to show you care, for example—Is the abuse still going on?
  - Be understanding, but not pitying.
  - Validate her feelings. Tell her the way she is feeling is normal after what she experienced.
  - Help the adolescent not to feel guilty and tell her that the sexual or gender-based violence she experienced is not her fault.
  - Help her feel that she is in control of the situation. It is very important that she feels empowered to make decisions for herself, including whether or not she decides to access the services to which you refer her.
  - Help her identify a trusted adult that she can seek support from in an ongoing way.
- **Try to minimize additional trauma during the PAC procedure.**
  - A client who has experienced SGBV may find the physical exam and clinical procedure extremely traumatic. You can reassure the client that she has the right to ask you to stop at any point in the procedure and that you will stop (for a period of time).
  - Help the adolescent feel as comfortable as possible by taking extra care during exam and treatment. Help the client maintain privacy by covering up parts of her body that are not being examined and fully explain the steps you will take.
- **Refer her to HIV/STI services and SGBV services** including legal services and social work or counseling services. Explain why you are referring her and how she might benefit from these other services.

Learning Objective 4.4:

Demonstrate effective counseling techniques for adolescent PAC clients

Methodology

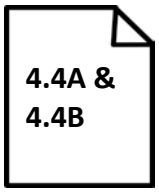
Role play

Time

1 hour, 30 minutes

Role Plays

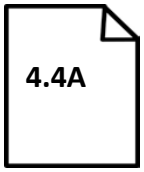
The trainer should:



1. Introduce the role play exercise. (10 minutes for steps 1-3)
2. Distribute **Participant Handout 4.4A: Scenarios for Counseling Role Plays** and **Participant Handout 4.4B: Observation Checklist for Counseling Role Plays.**
3. Review both handouts with the group, orienting them on the three scenarios in **Participant Handout 4.5A** and the observation checklist in **Participant Handout 4.5B**.
4. Ask participants to form groups of three people. For each set of three, ask participants to decide who will be the provider, who will be the client, and who will be the observer for the first role play. (5 minutes)
5. Ask each set of participants to select one of the three scenarios in **Participant Handout 4.5A.** (5 minutes)
6. Ask participants to act out the scenarios using positive counseling skills (with one person acting as the provider, another as the client, and the third as the observer). The observer can use **Participant Handout 4.5B** to guide his/her observation and provide feedback. (10 minutes)
7. Now ask the participants to select another scenario and rotate roles so that the person who was the provider is now the client, the person who was the client is now the observer, and the person who was the observer is now the provider. Repeat step 6. (15 minutes)
8. Then ask the participants to select a third scenario and switch roles so that each member plays the role they have not played yet. Repeat step 6. (15 minutes)
9. Bring the group back together and facilitate a discussion using the questions below. Ask respondents to refer to their observation checklists to facilitate discussion. (30 minutes)
   - When you were in the client role, what behaviors did you notice that were not comforting? What behaviors were comforting?
   - When you were in the provider role, what behaviors did you find came natural to you? What behaviors were not as natural or were more difficult?

- When you were the observer what were some of the positive counseling skills you observed? What were some ways that the providers could improve?
- For those who acted out Scenario 1, what counseling techniques did you find were most helpful? What types of questions did you ask?
- For those who acted out Scenario 2, what counseling techniques did you find were most helpful? What types of questions did you ask?
- For those who acted out Scenario 3, what counseling techniques did you find were most helpful? What types of questions did you ask?

Content: Scenarios for Counseling Role Plays
(use Participant Handout 4.4A)



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.

SESSION 5:

Postabortion Care Procedures for Adolescent Clients

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
5.1 Discuss important considerations for clinical treatment of adolescent PAC clients				
Group Work	None	5.1A, 5.1B, and 5.1C	• Review content sections. • Prepare flipchart papers labeled: #1: Procedural Considerations, #2: Strategies for Pain Management, and #3: Post-Treatment Considerations. • Review registration and national guidelines on use of misoprostol for PAC in your country.	40 minutes
			Total Time Required:	**40 minutes**

RESOURCE REQUIREMENTS

- Pens, markers, flipchart paper, tape
- Overhead projector and/or LCD

Learning Objective 5.1:

Discuss important considerations for clinical treatment of adolescent PAC clients

Methodology

Group work

Time

40 minutes

Group Activity—Three by Three

The trainer should:

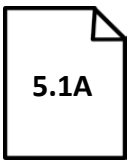
1. Prepare flipcharts labeled: #1: Procedural Considerations, #2: Strategies for Pain Management, and #3: Post-Treatment Considerations. Post them around the room.
2. Introduce the activity using **Content: Activity Introduction.** (5 minutes)
3. Ask the participants to count off numbers in order from one to three. All of the participants who called out "1" will go to flipchart #1, all who called out "2" will go to flipchart #2, and all who called out "3" will go to flipchart #3. (5 minutes)
4. Distribute **Participant Handouts 5.1A: Procedural Considerations, 5.1B: Strategies for Pain Management,** and **5.1C: Post-Procedure Considerations.**
5. Tell participants they will start out at the flipchart that they have been assigned to first. Each group will read the short content in the handout associated with their assigned flipchart (**Participant Handouts 5.1A, 5.1B,** or **5.1C)**. They should discuss in their group what they think are the two most important points about what they have just read, and then summarize those points on the flipchart paper. (20 minutes for steps 5-7)
6. After five minutes, the groups should rotate to a new flipchart station and read the handout related to that flipchart. They should write the two most important points they can think of that are not already written on the flipchart.
7. After five minutes, the groups should rotate to the final flipchart that they have not yet visited. The groups should read the handout related to that flipchart, write the two most important points they can think of that are not already written on the chart. (Note to trainer: It is a good idea to alert the groups when there is one minute remaining at each flipchart station.)
8. At the end, all the groups should walk around and look again at each flipchart to see what the groups who came after them wrote. (5 minutes)
9. Wrap-up: Review the key points from the handouts and answer any remaining questions. (5 minutes)

Content: Activity Introduction

Treatment for incomplete abortion can include using manual vacuum aspiration (MVA), misoprostol, electric vacuum aspiration (EVA), and—when other safe methods are not

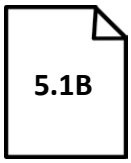
available—dilation and curettage (D&C). Clinical procedures are the same for both adult and adolescent clients; however there are some additional aspects that should be considered when treating adolescents. In this activity we will review the additional considerations for PAC treatment for adolescents, strategies for pain management, and post-treatment considerations.

Content: Procedural Considerations (use Participant Handout 5.1A)



- 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.

Content: Strategies for Pain Management (use Participant Handout 5.1B)

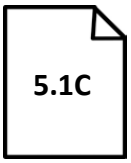


Lack of knowledge of what to expect and limited emotional support from family can lead to **increased anxiety and pain.** Pain management, especially for nulliparous women, may require additional treatment strategies. Extra support to the adolescent client during the procedure and attention to pain management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

Below are some strategies for pain management for adolescent clients:

- Understand all the options to treat and prevent pain during PAC, including the 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 procedure 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 are not).
- If the client wishes, she can have a supportive friend, partner, or relative at her side to draw her attention away from the pain.
- Put a relaxing picture on the ceiling of the room so the adolescent client can try to focus on something other than the procedure.

Content: Post-Procedure Considerations (use Participant Handout 5.1C)



- An adolescent may not be able to stay away from home or other obligations as long as an adult woman can. She may not have permission from her family or husband to leave her home or community and may be missed after a certain period of time. When it is clinically possible, an outpatient MVA or EVA procedure or misoprostol are preferable to facilitate timely discharge.
- 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.

SESSION 6:

Postabortion Contraception for Adolescent Clients

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
6.1 Review healthy timing and spacing of pregnancy and postabortion contraception				
Game	None	None	• Review questions and answers for game exercise.	25 minutes
6.2A. Explain the Postabortion Contraceptive Methods that are Appropriate for Adolescents				
Group Discussion	PPT Slide 6.2A	None	• Review content section, story, and discussion questions.	20 minutes
6.2B Explain the Postabortion Contraceptive Methods that are Appropriate for Adolescents				
Trainer Presentation	None	6.2B, 6.2C, and 6.2D	• Review content section and participant handouts.	15 minutes
6.3. Explain the Medical, Emotional, and Service Delivery Considerations Related to Postabortion Contraception for Adolescent Clients				
Exercise and Trainer Presentation	None	None	• Review content section. • Prepare three flipchart papers labeled: Medical/Physical Considerations; Behavioral and Social Considerations; and Service Delivery Considerations.	20 minutes
6.4A Respond to Misconceptions that Adolescents have about Contraceptive Methods				
Trainer Presentation	PPT Slide 6.4A	None	• Review content sections.	20 minutes
6.4B Respond to Misconceptions that Adolescents have about Contraceptive Methods				
Game and Discussion	PPT Slide Set 6.4B	6.4B	• Review content section and participant handouts.	20 minutes
6.5 Demonstrate Correct Male and Female Condom Use as Part of Dual Protection				
Demonstration and Return Demonstration	None	6.5A and 6.5B	• Review content sections. • Prepare condoms and penis and pelvic models for demonstration.	15 minutes

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
6.6 Demonstrate Appropriate Contraceptive Counseling Techniques				
Role Plays and Case Studies	None	6.6A	• Review role play case studies and participant handout.	60 minutes
			Total Time Required:	**195 minutes (3 hours, 15 minutes)**

RESOURCE REQUIREMENTS AND MATERIALS FOR TRAINERS TO PREPARE IN ADVANCE

- Colored paper (two-three different colors), PowerPoint slides, participant handouts, pens, markers, flipchart paper, tape
- Candy/prize for Learning Objective 6.1
- Ball for Learning Objective 6.4B
- For Learning Objective 6.5: female and male condoms; penis model, banana, or soda bottle; and pelvic model or small box (e.g., shoe box)
- Overhead projector and/or LCD

Learning Objective 6.1:
Review healthy timing and spacing of pregnancy and postabortion contraception

Methodology
Game

Time
25 minutes

PAC Contraception Review Game
The trainer should:

1. Divide participants into two or three teams.
2. Give each team a different colored piece of paper. They will lift the piece of paper to signal that their team has an answer.
3. Ask each of the questions in **Content: Questions for PAC Contraception Review Game,** one at a time. Each team should talk amongst themselves to come up with their answer. When the team has an answer, the team leader should raise the colored piece of paper. The team that raises their paper first is given the chance to say the correct answer. If the team gets it wrong, the second team to raise their paper is given the chance to answer correctly. If no team answers correctly, the facilitator can say the correct answer. (15 minutes)
4. Each team gets one point for each correct answer. The team with the most points at the end wins a small prize or candy.
5. When the game is over, the trainer should review the questions and the correct answers using the content below. (10 minutes)

Content: Questions for PAC Contraception Review Game
Question 1: How soon can all women, including adolescents, get pregnant following an abortion that occurs during the first trimester of pregnancy?

Answer 1: A woman, including adolescents, can become pregnant again in as few as 10 days.

Question 2: How soon can all women, including adolescents, get pregnant following an abortion that occurs during the second trimester?

Answer 2: Usually within four weeks.

Question 3: How soon after an abortion is it safe to try to become pregnant again?

***Answer 3*:** After a miscarriage or induced abortion, the World Health Organization currently recommends that the minimum waiting period before the next pregnancy is at least six months in order to reduce risks of adverse maternal and perinatal outcomes.

Question 4: How soon after a woman, including adolescent women, is treated for an incomplete abortion can she start using a contraceptive method?

Answer 4: A client should be counseled on contraceptive methods prior to discharge and the young woman's chosen method should be immediately provided prior to leaving the health facility. Nearly all methods can be provided before an adolescent is discharged, with very few exceptions. If the method chosen cannot be provided immediately due to medical eligibility criteria (e.g., an IUD when there are signs of sepsis or uterine perforation), the provider should tell the client should when she can return for the method and provide her with an acceptable interim method.

Counseling on a contraceptive method should not be conducted **during** PAC treatment procedures or **when the woman is in severe emotional or physical distress.** Wait until after the procedure has been performed and the client is calm and not in severe physical and emotional stress.

Question 5: Are there any methods of contraception that an adolescent cannot use?

Answer 5: **NO, age alone is not a contraindication for any method, including IUDs and implants,** therefore adolescents should be counseled on a range of contraceptive options. All adolescent clients should be told that **only condoms alone or condoms used with another method (dual method use) offer protection from both unintended pregnancy and STIs, including HIV.**

Note: It is recommended that women delay sexual intercourse until all bleeding has stopped and all complications resulting from the unsafe abortion have been resolved. While age is not a clinical contraindication for any method, sterilization is the only method that is considered contraindicated for most adolescent women due to their life stage and the permanent nature of this method. In addition, fertility awareness-based methods (e.g., standard days method) may not be the most appropriate for post-menarche adolescents due to the possibility of irregular menstrual cycles. Given these considerations, the WHO Medical Eligibility Criteria recommend that caution be taken when counseling adolescents on these two options. In addition, the WHO criteria state that fertility awareness-based methods are not recommended in the immediate postabortion period since regular menses have not yet returned.

Question 6: What is the goal of postabortion contraception counseling and information?

Answer(s) 6: There are many possible answers. Supplement the participants' answers with the following goals:

- Support the adolescent to understand the factors that led to the abortion (whether induced or spontaneous), in order to help her avoid repeating the situation.
- Explore the adolescent's fertility intentions to help tailor the contraceptive counseling to meet those intentions.
- Support each adolescent to decide if she wants to use a contraceptive method.
- Support her to choose an appropriate method, if she decides to use a contraceptive method.
- Prepare her to use the method effectively.

- Help her understand that it is important to protect herself from STIs and HIV, and that only male and female condoms can provide this protection.
- If she does not wish to use a contraceptive method and wants to become pregnant, counseling helps her understand the importance of spacing the next pregnancy by at least six months and of receiving antenatal care.
- If she indicates an interest in abstinence after receiving full contraceptive counseling, help her identify important skills and sources of support for abstaining.

Learning Objective 6.2A:
Explain the postabortion contraceptive methods that are appropriate for adolescents

Methodology
Group discussion

Time
20 minutes

Group Discussion—Implant Story
The trainer should:

1. Read the following story:
   Mary is a 15-year-old student who had induced abortion. During postabortion contraception counseling, Mary tells the provider she does not want to become pregnant before she finishes school, so she wants to get an implant (e.g., Implanon). She is in good overall physical health and takes no other medicines.
2. Ask participants the following questions:
   - Would you give her the method of her choice? Why or why not?
   - Are there any methods you would hesitate to give an adolescent client? If so, which ones and why?
3. Supplement participant answers with **Content: Implants** and **PPT Slide Set 6.2A**.

Content: Implants (use PPT Slide 6.2A)

- According to the World Health Organization, implants are safe and suitable for nearly all women, including adolescents.
- The implant is effective for three to five years. For young women who want to become pregnant, fertility returns immediately after the rods are removed.
- The implant is discreet and easy to use. Unlike pills, the implant does not depend on the user's regular compliance.
- Barriers to effective contraceptive use among adolescents include poor access to and transportation to a clinic; lack of personal funds to pay for a regular supply of contraceptives; little control and decision making power in relationships, especially if in a relationship with an older man; and family or community pressure to get pregnant. The convenience, ease, confidentiality, and long duration of the implant can help adolescents overcome many of these barriers.
- For more information see: Extending Service Delivery. 2009. *Implants for Adolescents: An option worth considering for healthy timing and spacing of pregnancy.* Washington, DC: ESD. (Available at: www.esdproj.org.)

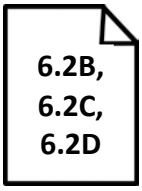
Learning Objective 6.2B:
Explain the postabortion contraceptive methods that are appropriate for adolescents

Methodology
Trainer presentation

Time
15 minutes

Trainer Presentation
The trainer should:

1. Present **Content: Contraceptive Methods for Postabortion Adolescent Clients**.
2. Distribute **Participant Handout 6.2B: Postabortion Contraceptive Methods for Adolescents.** Review each method with participants and emphasize the bolded items in the handout, which are most relevant to adolescents. Be sure to emphasize when each method may be initiated. Most methods can be initiated during the PAC visit.
3. Ask if there are any questions and distribute **Participant Handouts 6.2C: Medical Eligibility Chart** and **6.2D: Contraceptive Method Effectiveness Chart** for future reference.



Content: Contraceptive Methods for Postabortion Adolescent Clients
Postabortion contraception counseling may be the first time an adolescent is receiving counseling and choosing a contraceptive method. Therefore, it is important to comprehensively counsel on a range of contraceptive methods. Nearly all contraceptive methods can be used **immediately** after an abortion or PAC, as long as:

- There are no severe complications requiring further treatment.
- The provider screens for any precautions associated with using a particular contraceptive method in accordance with the WHO Medical Eligibility Criteria.
- The client receives adequate information and counseling.

Age alone is not a contraindication for any method, including IUDs and implants, therefore adolescents should be counseled on a range of contraceptive options. All adolescent clients should be told that only condoms alone or condoms used with another method (dual method use) offer protection from both unintended pregnancy and STIs, including HIV.

Note: It is recommended that women delay sexual intercourse until all bleeding has stopped and all complications resulting from the unsafe abortion have been resolved. While age is not a clinical contraindication for any method, sterilization is the only method that is considered contraindicated for most adolescent women due to their life stage and the permanent nature of this method. In addition, fertility awareness-based methods (e.g., standard days method) may not be the most appropriate for post-menarche adolescents due to the possibility of

irregular menstrual cycles. Given these considerations, the WHO Medical Eligibility Criteria recommend that caution be taken when counseling adolescents on these two options. In addition, the WHO criteria state that fertility awareness-based methods are not recommended in the immediate postabortion period since regular menses have not yet returned.

Learning Objective 6.3:

Explain the medical, emotional, and service delivery considerations related to postabortion contraception for adolescent clients

Methodology

Exercise and trainer presentation

Time

20 minutes

Participant Listing and Trainer Presentation

The trainer should:

1. Hang up the three prepared flipchart papers labeled: Medical/Physical Considerations, Behavioral and Social Considerations, and Service Delivery Considerations.
2. Present **Content: Introduction to Postabortion Contraception for Adolescents**
3. Ask participants to brainstorm issues that fall under each of the three areas which might impact an adolescent client's choice of contraceptive method.
4. Note responses on the flipchart. Use **Content: Considerations for Postabortion Contraception** to supplement as needed.
5. Make sure to emphasize the need to discuss dual protection during counseling on postabortion contraception as adolescents are at particularly high risk of contracting STIs, including HIV.

Content: Introduction to Postabortion Contraception for Adolescents

The period following the treatment of incomplete abortion offers the provider and client an opportunity to explore the client's contraceptive needs. In order to help an adolescent select the most appropriate contraceptive method, the individual assessment of each adolescent should include: her future fertility desires, her personal characteristics, her living situation/ marital status, her clinical condition, concerns she might have about side effects, the service delivery capabilities in the community where she lives, and where the services will be provided.

Content: Considerations for Postabortion Contraception

Use to supplement participant brainstorm.

While every woman will not experience all of these side effects, there may be **medical/physical considerations** that affect the choice of a method such as the following:

- Possible side effects (such as weight gain, complexion/skin changes, or changes in menstrual patterns) that may be more concerning to adolescents than adult women. Side effects can be uncomfortable, annoying, or worrisome and are a factor in discontinuation of contraceptive methods. It is important to differentiate between side

effects and complications and to offer clients sound technical and practical information, as well as effective advice about how to deal with side effects.

- Medical conditions that makes her ineligible for a particular method based on the WHO's Medical Eligibility Criteria. (Note- as adolescents are relatively healthy, it is rare for an adolescent to have a medical condition that would preclude a certain method.)
- Use of certain antiretrovirals (ARVs) that may reduce effectiveness of combined oral contraceptives (COCs) (see WHO Medical Eligibility Criteria).

There may be some **behavioral or social considerations** that affect the choice of a method.

- Previous method failure: If the adolescent was using a method when she got pregnant, assess why contraception failed and try to find out what problems she might have using another contraceptive effectively.
- Partner or family member disapproval: If the adolescent has a partner/family member who does not want her to use contraception, offer to talk with/counsel the partner/family member and the adolescent together. If she is unwilling to let you do this, discuss methods she can use without her partner's/family member's knowledge, such as injectables, implants, or IUDs.
- Desire for a pregnancy soon: If the adolescent wants to become pregnant again soon, advise her that she should wait at least six months before trying to become pregnant again and offer appropriate short-acting method options. Refer her for other reproductive health care services as needed.
- Desire to postpone pregnancy for a long period of time: Some adolescents may desire to postpone pregnancy for several years to allow them time to finish school, obtain a job, build a secure relationship, or allow their current child/children to get older. An adolescent seeking to delay pregnancy for several years should be counseled on all methods, including long-acting methods such as the IUD and implant, which may be preferable given her fertility intentions.

There may be **service delivery considerations** that affect the choice of a method. An adolescent's ability to use a method effectively is based, in part, on the resources in the community where she lives.

- Distance from facility: If an adolescent has traveled far from home for treatment of postabortion complications, it is important that PAC providers know what family planning services she will have access to when she returns home so they can help her choose an appropriate method that she can receive an adequate supply of (through public sector facilities, community-based distribution programs, or in pharmacies/chemist shops).
- Resupply of method: Provider- or supply-dependent methods such as pills or injectables may not be the best choice for adolescents who have **little or no access to ongoing facility-based care.** Adolescent clients with little access to an easy resupply of condoms or pills may find methods that do not require resupply (e.g., implants and IUDs) the most acceptable options.

- Cost of method: Providers should be aware of how much a contraceptive method will **cost** an adolescent**.** This is a key factor limiting the use of contraception. The high cost of services and methods can prevent adolescents from having access to contraceptives and often influences their ability and willingness to use them.

As discussed earlier, the PAC visit may be the first time that an adolescent has ever accessed SRH services and the adolescent seeking PAC has usually experienced an unintended pregnancy. Therefore, it is essential that she receives postabortion contraceptive counseling and services at the time of the PAC visit. The provider should treat all client concerns with patience, seriousness, and empathy and take their unique considerations into account during counseling. **Because young people often do not return to the facility for follow-up care, contraceptive methods should be made available to adolescent clients before they are discharged from the PAC facility.**

Learning Objective 6.4A:

Respond to misconceptions that adolescents have about contraceptive methods

Methodology

Trainer presentation and discussion

Time

20 minutes

Trainer Presentation and Group Discussion—Rumors and Misconceptions

The trainer should:

1. Introduce the section using **Content: Introduction Misconceptions Adolescents Have about Contraceptive Methods** and **PPT Slide 6.4A.** (5 minutes)
2. Tell participants you will read a short story and then the group will discuss it.
3. Read **Content: Story of Dr. X.** (5 minutes)
4. Ask participants to reflect on and discuss the story of Dr. X. (10 minutes)
   - Have they had similar experiences?
   - How did Dr. X respond?
   - How did you respond in similar situations?

Content: Introduction Misconceptions Adolescents Have about Contraceptive Methods (use PPT Slide Set 6.4A)

Rumors and misconceptions about contraceptives can play a big role in influencing adolescents' choices about methods because they are often uninformed about reproductive health and contraception and are eager to "fill in the blanks." People usually believe a given rumor or piece of misinformation because they are confused about or do not understand anatomy/physiology, pregnancy, or how contraceptives work.

Unfortunately, rumors and misconceptions are sometimes even spread by health workers who may themselves be misinformed about certain methods. For example, some providers believe that hormonal methods or the copper IUD should not be given to young woman until they have "proven their fertility." In the case of emergency contraceptive pills (ECPs), some providers believe that giving adolescents ECPs only encourages irresponsible sexual behavior, which evidence has demonstrated is not the case.

Content: Story of Dr. X

Dr. X went to work in a clinic in a small town. As an obstetrician-gynecologist, she was very interested in adolescent reproductive health. Dr. X was pleased to discover that her town had one of the highest pill acceptance rates among adolescent women in the province. But when she talked to the midwives and nurses, she discovered that they were extremely busy delivering teenagers' babies.

Dr. X decided to check the records of some of the young women who came to the clinic. She found that many of the adolescent clients who had accepted contraception and had been given COCs, were the same clients who were coming to the clinic for prenatal visits.

Dr. X decided to investigate the reason for this. She compiled a list of COC acceptors who had become pregnant while on the method. Then she asked several village health workers to interview these young women to find out how they had been taking their pills. The village health workers reported that some of the young women had taken the pill only after sleeping with their boyfriends or husbands.

Dr. X asked the village health workers to hold a series of health education classes about the contraceptive pills. The village health workers did this. They explained that the pills did not work unless taken every day and that it is necessary to have a certain level of hormones circulating in the blood to prevent pregnancy. The health workers also explained what to do when one or two pills were missed.

Over the next several months, Dr. X monitored pregnancy rates and found no change. She was very frustrated.

One day while she was doing a prenatal examination of a pregnant pill acceptor with preeclampsia, she asked the young woman how she had taken her pills. The young woman said that she had taken them only after having sex with her boyfriend. Dr. X asked why she had taken them that way. The young woman said that she didn't sleep with her boyfriend every day, so why did she need pills every day? Dr. X asked her how she thought the pills worked. The woman said she didn't know, but she supposed they killed the man's "seed."

Dr. X explained that pills don't kill the "seed," they only prevent eggs from developing in a woman's ovaries. The young woman said she didn't understand about eggs being in her ovaries; it was the first time she had heard anything like that—all she knew was that she was pregnant, even though she had taken the pill.

Dr. X began to suspect that the young woman did not have the medically correct idea about conception. She asked the young woman how she thought conception occurred.

The young woman said, "The woman is the vessel and the man plants the seed." Dr. X asked what the woman's role was. The young woman said, "She is merely the place for planting."

Dr. X then realized the underlying reason for the village adolescents' confusion and their subsequent failure to take the pills properly. They believed that they could become pregnant any time "the man's seed was planted" and that the pills worked only by killing the seed.

Dr. X began conducting classes for the health workers on counseling adolescent clients on the anatomy and physiology of reproduction. She also included information for them on how to counteract rumors and misinformation.

Questions for discussion with participants:

- Have you had similar experiences?
- How did Dr. X respond?
- How did you respond in similar situations?

Learning Objective 6.4B:

Respond to misconceptions that adolescents have about contraceptive methods

Methodology

Game and discussion

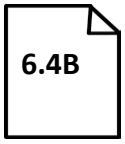
Time

20 minutes

Game—Counteracting Rumors and Misconceptions

The trainer should:

1. Ask participants to think of different rumors, myths, and misconceptions they have heard about different contraceptive methods. (5 minutes)
2. Present **Content: Strategies for Counteracting Rumors and Misconceptions** (use PPT Slide Set 6.4B) (5 minutes)
3. Have participants stand in a circle and hand one participant a ball. Explain the activity: the first participant to have the ball says a myth she/he has heard about a contraceptive method and then tosses the ball to another participant somewhere else in the circle. The participant who catches the ball should suggest how they might respond to that rumor. Then the participant tosses the ball to another participant who shares a myth they have heard. That participant tosses the ball to someone else who shares how they would respond to the myth. This pattern continues until about four myths and responses have been shared with the group. (10 minutes)
4. Use the information in **Participant Handout 6.4B: Fact and Realities about Common Rumors and Misinformation around Contraceptive Methods** to supplement with rumors and facts and realities to combat the rumors. Distribute **Participant Handout 6.4B <u>after</u>** the game.



Content: Strategies for Counteracting Rumors and Misconceptions (use PPT 6.4B)

- When a client mentions a rumor, always listen politely. Don't laugh.
- Take the rumors seriously.
- **Find out where the rumor came from** and talk with the people who started it or repeated it. Check whether there is some basis for the rumor.
- **Explain the facts** using accurate information, but keep the explanation simple enough for young people to understand.
- **Use strong scientific facts (using nontechnical language)** about contraceptive methods to counteract misinformation.

- Always **tell the truth**. Never try to hide side effects or problems that might occur with various methods.
- **Clarify information** by using demonstrations and visual aids.
- **Reassure the client** by examining her and telling her your findings.
- **Use good counseling** techniques to inform the client about methods of contraception.
- **Use visual aids** and actual contraceptives to explain the facts.

Learning Objective 6.5:

Demonstrate correct male and female condom use as part of dual protection

Methodology

Demonstration

Time

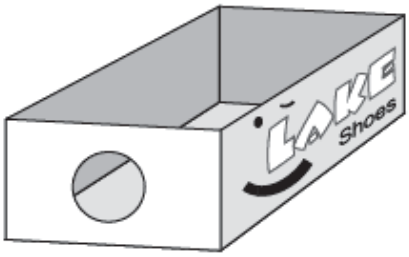
15 minutes

Demonstration

The trainer should:

1. Explain that all adolescents should select a dual protection strategy to prevent STIs, including HIV, and unintended pregnancies. Dual protection can be achieved by using either a male or female condom correctly every time you have sex or through dual method use, which means using both condoms and another contraceptive method. Providers should discuss the importance of dual protection and highlight that the most effective way of preventing unintended pregnancy as well as STIs/HIV is through dual method use. Providers need to be able to accurately demonstrate proper condom use and help adolescent clients negotiate condom use.
2. Correctly demonstrate proper male condom use on a penis model, banana, or soda bottle. Use **Content: Male Condom Use** to state aloud each step as you are demonstrating and ask participants to follow along using **Participant Handout 6.5A: Observation Checklist for Male Condom Use.** (5 minutes)
3. Demonstrate female condom use on a pelvic model or using a box (see *note to trainer* below), stating aloud each step as you go using **Content: Female Condom Use,** and ask participants to follow along using **Participant Handout 6.5B: Observation Checklist for Female Condom Use.** (5 minutes)
4. Ask if there are any questions or comments. (5 minutes)

Note to trainer: If you do not have access to a pelvic model to demonstrate female condom use, you can make a rough model by cutting a four to five centimeter hole in a small box (e.g., shoebox). Another way to demonstrate female condom use is by forming a loose fist and then inserting the condom through the opening that is made by the thumb and first finger.[18]

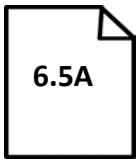


[18] Source: Callahan, K, Cucuzza, L. (2003). *Home care for people living with HIV/AIDS: The power of our community*. Washington, DC: The Center for Development and Population Activities.

Content: Correct Condom Use

- Condoms are only effective if they are used properly **every time** you have sexual intercourse.
- When properly used, a condom can provide protection against unintended pregnancy and HIV and other STIs. It is important that all adolescent clients know how to use condoms properly.

Content: Male Condom Use[19] (use Participant Handout 6.5A)



- Always use latex condoms because other kinds do not protect completely against HIV.
- How to use:
  1. Look at the condom packet to make sure that it has not expired and that it has not been damaged. (Make sure it is not sticky and there are 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.

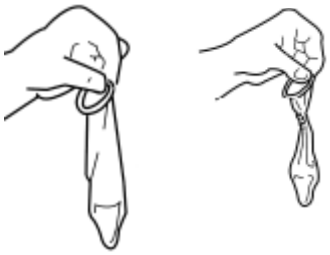
  4. Put on a condom only when the penis is erect.

  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.

[19] Source of illustrations: Burns, A., Lovich, R., Maxell, J., and Shapiro, K. (1997). *Where women have no doctor.* Berkeley, CA: The Hesperian Foundation, pp. 202-203.

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 condom must be removed while the penis is still erect to ensure that the condom does not slip off.

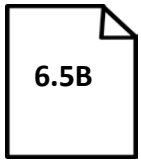


10. Tie the used condom in a knot to avoid spilling the semen and dispose of it in a latrine (not in a flush toilet because it may clog), or burn or bury it.

Remember:

- Put a new and unused condom on the penis for every act of sexual intercourse.
- If the condom tears at any time during sex, withdraw the penis immediately and put on a new condom.
- Do not use more than one condom at a time.
- Tips to help prevent condoms from breaking or leaking:
  - *Lubricants:* If lubricant is needed, use a water-based one (like K-Y jelly or glycerine). You can also use spit (saliva) for lubrication. Lubricants made with oil, like petroleum jelly (Vaseline), can cause condoms to break more easily. Tell people to never use petroleum jelly (Vaseline) with a condom.
  - *Storage:* Store condoms in a cool, dry, dark place, if possible. Heat, light, and humidity can damage condoms. It is not good to store a condom in your wallet or purse.
- Do not use condoms that are sticky, brittle, discolored, or damaged in any way. Throw them away.
- Keep condoms out of direct sunlight.

Content: Female Condom Use[20] (use Participant Handout 6.5B)



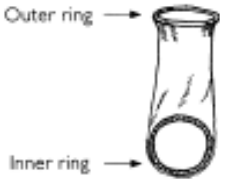
- Some women like the female condom because they do not have to rely on their partner to use a condom. However, female condoms need to be discussed and negotiated with a partner because they are visible.
- The female condom covers the whole inside of the vagina and the outer lips of the vulva. It can be put in any time before sex.
- It should be used only once.
- It should not be used with a male condom because both are more likely to tear due to friction.

[20] Source of illustrations: Burns, A., Lovich, R., Maxell, J., and Shapiro, K. (1997). *Where women have no doctor.* Berkeley, CA: The Hesperian Foundation, pp. 204.

How to use:

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, the condom 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.

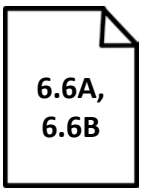
Learning Objective 6.6:
Demonstrate appropriate contraceptive counseling techniques

Methodology
Role plays and case studies

Time
60 minutes

Role Plays
The trainer should:

1. Introduce the role play activity and ask for eight volunteers who will be the actors. (5 minutes)
2. Break the eight volunteers into four pairs and give each pair one of the scenarios found in **Participant Handout 6.6A: Contraceptive Counseling Scenarios.** Ask the pairs to read their scenarios and decide which one of them will act as the provider and which as the adolescent PAC client. Give the pairs a few minutes to decide how they will act out their scenario in front of the group and then ask all the pairs to sit down. (10 minutes)



3. Distribute four copies of the **Participant Handout 6.6B: Contraceptive Counseling Checklist** to each participant in the room. Explain that the participants will use this checklist to help guide their observation of the role plays.
4. Invite the first pair up to act out Scenario 1 in front of the whole group. After the role play, lead the participants in a brief discussion of the strengths of the approach in the role play and what else the participants think should be added to the counseling session using the trainer's points in **Content: Contraceptive Counseling Scenarios** and **Participant Handout 6.6B: Contraceptive Counseling Checklist.**
5. Repeat this process for each of the four role plays allowing, about 5 minutes for each pair to act out and 5 minutes for discussion using **Content: Contraceptive Counseling Scenarios** and **Participant Handout 6.6B: Contraceptive Counseling Checklist.** (Total for all role plays and discussion 40 minutes)
6. At the end, draw conclusions and reinforce the key points from the role plays (e.g., listening skills, empathetic responses, ensuring privacy and confidentiality). (5 minutes)

Content: 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 decided not to 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 either. She is also worried about dealing with the pressure from her boyfriend because of his lack of interest in using condoms.

For the trainer—to be addressed in counseling:

- Ensuring privacy and reassuring client of confidentiality
- Myths and misconceptions about the pill and condom, specifically referring to future fertility
- Importance of using contraception to prevent another unintended pregnancy and avoid repeating this situation
- Information on range of contraceptive methods available
- Understand pressure from boyfriend and be aware of any signs of SGBV
- Concerns about infertility
- Skills for communicating her needs to her partners and negotiating condom and other method use. Consider inviting the partner to the counseling session.
- Risk assessment for STIs/HIV. Importance of dual protection and potential barriers to condom use
- Referral for voluntary counseling and testing (VCT) for HIV

Scenario 2

Aisha, 19, is a PAC client. She is married and has a six-month-old baby whom she is still breastfeeding. She is surprised that she got pregnant because 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 contraception to be sure she doesn't get pregnant again for a while.

For the trainer—to be addressed in counseling:

- Information on postpartum return to fertility
- Information on breastfeeding and lactational amenorrhea method (LAM) of contraception
- Appropriate contraception for postpartum breastfeeding mothers (copper-bearing IUD, progestin-only pills, DMPA/injecatables, implants). Since the baby is six months old, the mother could also consider COCs.
- Preventing another unintended pregnancy and/or spacing of intended pregnancies

- Risk assessment for STIs/HIV; and importance of dual protection and potential barriers to condom use.
- Communication and negotiation skills to overcome barriers to using condoms

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.

For the trainer—to be addressed in counseling:

- Importance of dual protection to prevent both unintended pregnancy and STIs
- Condom negotiation with partner(s)
- Discussion to determine most appropriate contraceptive method for Elsa (to be used in addition to the condom)
- Possible sexual abuse due to Elsa's age and possible engagement with more than one partner
- Adherence to treatment regimen for STI
- Referral for VCT

Scenario 4

Mary is 15 and a half and a secondary school student in form three. Her boyfriend told her 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. She attempted an abortion with a traditional healer and came in bleeding profusely. You are discussing the correct use of contraceptives and condoms with Mary, but she 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.

For the trainer—to be addressed in counseling:

- Discuss why Mary thinks she will not have sex again
- Skills necessary to abstain
- Correct use of condoms
- Other methods of contraception
- Communication with her boyfriend; including her boyfriend in follow-up counseling
- Risk assessment for STIs/HIV; importance of dual protection; potential barriers to condom use; communication and negotiation skills
- Referral for VCT

SESSION 7:

Referrals for Adolescent Postabortion Clients

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
7.1 Describe key considerations for referring adolescents to other health and psychosocial services				
Trainer Presentation	PPT Slide Set 7.1A	None	• Review content section.	15 minutes
7.2 Identify local services to which the provider can refer adolescents				
Brainstorming	None	None	• Prepare flipchart paper to be posted. • Develop list of locally available health and social services for adolescent PAC clients.	15 minutes
			Total Time Required:	**30 minutes**

RESOURCE REQUIREMENTS

- Pens, markers, flipchart paper, tape
- Overhead projector and/or LCD

Learning Objective 7.1:
Describe key considerations for referring adolescents to other health and psychosocial services

Methodology
Trainer presentation

Time
15 minutes

Trainer Presentation
The trainer should:

1. Explain that referral to reproductive health and other services is one of the five essential elements of PAC.
2. Present **Content: Referrals** (use PPT Slide Set 7.1A).

Content: Referrals (use PPT Slide Set 7.1A)

The PAC visit provides an opportunity to address the adolescent client's immediate health concerns, which are primarily to treat complications and help her avoid another unintended pregnancy. In addition, the PAC visit is often the first time a young person has attended an RH facility and the provider, through taking client history, physical assessment, and counseling, may uncover the client's other health and/or social needs.

As much as possible, such concerns should be treated onsite because adolescent clients are less likely than adult women to be able to go the referred facility.

If the provider or the other providers in the health facility cannot address the adolescent's needs during the visit or at the follow-up visit, she/he should be prepared to refer the adolescent client to other available services in the community**.** Clinics and health centers should establish a working relationship or develop a memorandum of understanding with these organizations to facilitate the referral process.

The following points should be taken into consideration if referral is necessary:

- If an adolescent needs referral for her preferred contraceptive method, provide her with an interim method of contraception that is acceptable to her because fertility returns quickly, often before she is able to complete the referral visit.
- When possible, refer adolescents to facilities that offer youth-friendly services or to facilities or organizations that are receptive and respectful 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. They are also less likely to complete referral visits due to financial, transportation, social, and other barriers.

- Referral cards or slips should note the adolescent client's name, age, and the location to which she is being referred. The referral slips can also be kept as part of record keeping between the primary site and the referral site. The adolescent's privacy should be protected—referral cards should not be required if the adolescent would prefer not to have one and the referral slip should not include treatment specific information.
- If possible, provide clients with easy to read and understand materials that:
  - Explain the services they will obtain at the referral site,
  - Describe the client's right to confidential services, and
  - 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 ongoing supply of condoms to exercise her decision to prevent future pregnancies and STIs, including HIV. This type of ongoing support may be more easily found through networks of peer providers or other adolescent and youth programs.
- Helping young people address their perceived and felt needs as well as their immediate needs for PAC is important in building and sustaining trust and rapport, and may ensure that the provider remains an important source of support and SRH care.

Learning Objective 7.2:
Identify local services to which the provider can refer adolescents

Methodology
Brainstorming

Time
15 minutes

Brainstorm
The trainer should:

1. Ask participants to brainstorm common health and social needs of adolescent PAC clients. Encourage the participants to be expansive in generating their lists. Write the list on flipchart paper. Supplement with **Content: Other Health Needs.**
2. After the participants have generated a list, ask them to identify to whom or where they might be able to refer young people to address these needs. Try to identify providers or places within the same health facility or as close by as possible. To the extent possible, generate names of contacts as well as addresses and phone numbers so that participants have a working list of potential referrals.
3. Supplement the list that participants develop with referral services that you have found in the area.

Content: Other Health Needs
Possible other health needs of an adolescent client:

- Sexuality and reproductive health education
- STI treatment
- SGBV services, including psychosocial or legal support for a client who has experienced SGBV
- VCT (if not offered at the time of PAC)
- ARVs for a client who is living with HIV
- Treatment or prevention of malaria
- Tetanus prophylaxis
- Tuberculosis treatment
- Nutrition services for a malnourished or anemic client

SESSION 8:

Closing Summary

Methodology	PPT Slides	Participant Handouts	Preparation	Time Required
8.1 Review key lessons learned in training				
Game	None	Trainer's Tool 8.1A (optional Feedback Form) 8.1A–Optional Post-Test	• Review content section.	30 minutes for game 30 minutes for optional Post-Test 15 minutes for optional Feedback Form
			Total Time Required:	**30 minutes (additional 45 minutes optional)**

RESOURCE REQUIREMENTS

- Two sheets of paper per participant, tape, pens
- Overhead projector and/or LCD

Learning Objective 8.1:
Review key lessons learned in training

Methodology
Game

Time
30 minutes

Game—Cabbage Game
The trainer should:

1. Give each participant two sheets of paper.
2. Ask them to spend 10 minutes thinking about the training and develop one or two review questions (depending on time and number of participants). The review questions should be on issues that the participants feel are important for their classmates to remember from the training. Participants should write one question on each piece of paper. (10 minutes)
3. Collect the questions and wad the questions up, wrapping them around one another, making a large ball of wadded paper. It should resemble a cabbage. It often helps to use a little tape to hold the cabbage together. (5 minutes)
4. When you have made the "cabbage" of paper questions, ask the participants to stand in a closed circle. Tell them you will be tossing the cabbage to a participant. After they catch it, they must peel back a layer of the cabbage and answer the question written on the piece of paper. If they do not know the answer, they make ask a colleague for help. After that the participant should toss the cabbage to another participant who should peel back a layer and answer the question. (10 minutes)
5. The game should proceed like this and the cabbage should be tossed until the last question has been answered. *It is fun to make the very center of the cabbage a note from the trainer that says, "Good job, team! You're finished."*
6. **Closing Circle:** While still standing in the circle, ask everyone to go around and name one thing that they will take away from the training (e.g., something they have learned or how they will do their job differently). You should participate in this activity as well. (5 minutes)
7. (Optional) Distribute **Trainer's Tool 8.1A: Optional YFPAC Supplemental Training Module Feedback Form** and allow participants 15 minutes to complete the form.
8. (Optional) Distribute **Participant Handout 8.1A YFPAC Supplemental Training Post-Test** and allow participants 30 minutes to complete the test. Use **Trainer's Tool 1.1C – YFPAC Pre-Test and Post-Test Answer Key** to score the post-test.