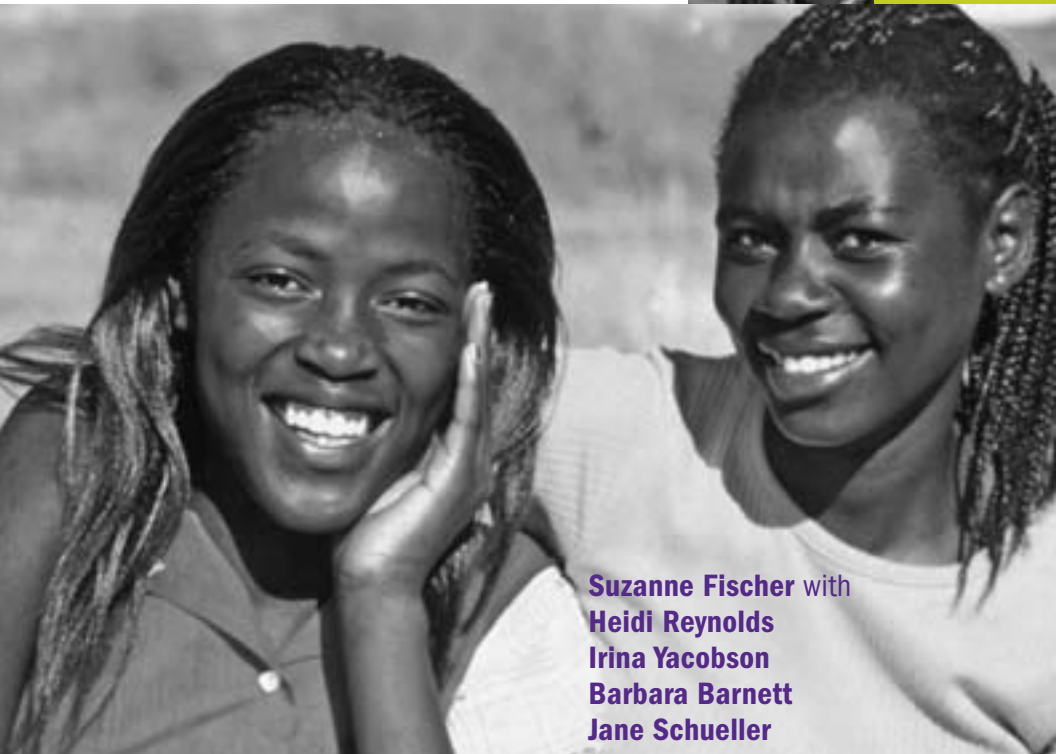


HIV Counseling and Testing for Youth



**Suzanne Fischer with
Heidi Reynolds
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A Manual for Providers



USAID
FROM THE AMERICAN PEOPLE



Family Health
International

Acknowledgments

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Introduction



At 1.5 billion strong, today's generation of youth is the largest in history. Among the many challenges young people face is the risk of HIV/AIDS. Youth account for as many as half of the five million new HIV infections each year — approximately 6,000 young people become infected every day. Although these statistics are sobering, with early detection of HIV through counseling and testing, more people can receive care and support and adopt healthy behaviors to improve their quality of life and avoid infecting others. In addition, HIV counseling and testing offers youth who test negative an opportunity to change behaviors that may put them at risk of infection in the future.

Integration of Services

HIV counseling and testing is a good time for young people to think about other issues related to sexual behaviors, including the prevention of other sexually transmitted infections (STIs) and unintended pregnancy. The counseling and testing process can be a powerful tool for helping young people deal with peer pressure and begin to adopt and sustain healthy behaviors that will benefit them the rest of their lives.

The connections between sexual and reproductive health and HIV/AIDS are now well recognized. Increasingly, the health services field is promoting the potential value of integrated clinical services. This integrated approach can be defined as offering two or more services at the same facility during the same operating hours, with the provider of one service actively encouraging clients to consider using the other services during the same visit, in order to make those services more convenient and efficient. Integrated services have the potential to offer greater dual protection against both HIV or other STIs and unintended pregnancy.

Models of HIV Counseling and Testing

The VCT model emphasizes pretest counseling, a risk assessment, and the voluntary seeking of the test.

The most widely implemented model of HIV counseling and testing is generally referred to as “voluntary counseling and testing” or VCT, where young people specifically seek the HIV test. In this model, young people receive counseling about their risks for HIV, obtain an HIV test, learn their HIV status, receive counseling on how to cope with the test results and implications, and develop a plan with a provider to minimize their risk of acquiring HIV or transmitting the virus to others.

The VCT model emphasizes pretest counseling, a risk assessment, and the voluntary seeking of the test. This type of HIV counseling and testing service has been commonly delivered in a stand-alone setting away from other health services or located in a youth center, a mobile clinic, or a health facility where access to other health services requires a referral system. Youth have usually obtained HIV counseling and testing in one of these types of locations.

International donors, including the U.S. President’s Emergency Plan for AIDS Relief and the World Health Organization (WHO), emphasize the need to expand the entry points to counseling and testing so that more people can know their HIV status. This approach includes the incorporation of counseling and testing into clinical settings, where the primary reason clients seek services is for other health concerns. WHO and others now use the term “counseling and testing” or “testing and counseling” to refer to this broader umbrella of testing locations and provider approaches.

Policy-makers and international experts are increasingly encouraging programs to integrate HIV counseling and testing into various settings including primary health facilities, tuberculosis and hospital facilities, STI clinics, family planning clinics, maternal and child health (MCH) clinics, antenatal clinics, and injecting drug treatment programs. Using an integrated service approach, HIV counseling and testing is often coupled with other routine medical tests.

Another emerging approach is a family-centered model, which enables members of families who are affected by HIV to receive care at the same clinic on the same day. Regarding counseling and testing, this model may appeal to young married couples, as well as to young adolescents who may go to a family-centered clinic with parents who are infected and receiving treatment. This approach might also encourage couples' counseling, which could in turn help prevent secondary infection if one partner is infected and the other is not — typically called a “discordant couple.”

Counseling and Other Essential Elements

The setting, available resources, cultural context, and the health priorities and needs of youth in a particular community should guide provider decisions about what level of HIV counseling and testing services is appropriate and feasible. In all settings, the following elements are essential, especially for youth:

- ◆ The test should only be administered after the client has given informed consent to be tested.
- ◆ Confidentiality must be assured.
- ◆ Test results must be available to clients.
- ◆ Counseling is needed to help youth understand what the test means, how to prevent transmission, how to change risky behaviors, and what types of services are available after getting their results.



- ◆ The counseling and testing service should be linked to youth-friendly services for care and treatment, contraceptive needs, and diagnosis and treatment of other STIs.

As medical providers, in particular, receive more pressure to incorporate HIV counseling and testing into the routine provision of health care services, they need to remember the principles of informed consent and client choice. Regarding counseling on contraceptive options, international guidelines emphasize that providers should always ensure that clients are making an informed choice. This key issue for family planning — informed choice — is analogous to ensuring that HIV testing is voluntary and informed.

Although testing should always include counseling, many clinical settings may only offer posttest counseling due to patient and workflow patterns. This approach poses a challenge to maintaining high-quality counseling. In clinical settings, HIV-infected clients and discordant couples may receive the most posttest counseling, in an effort to prevent secondary infection and to identify those who need antiretroviral treatment and other care and support services.

Youth are most likely to seek out a more traditional VCT model. VCT centers, community-based testing, and outreach models may better lend themselves to primary prevention, that is, prevention by those who test negative, as well as to more in-depth pretest counseling.



However, many youth do not seek testing, and others may lack access to testing services. Youth will increasingly have the opportunity for counseling and testing at STI clinics, antenatal clinics, and other clinical settings. These new counseling and testing opportunities mean that youth have more points of entry for a multitude of potential services, especially if they are HIV-infected.

How to Use This Manual

The materials presented here are a resource for providers in all service settings — a guide to best practices for offering HIV counseling and testing services for youth. The manual presumes that counselors have already received training in the technical aspects of administering the HIV test and, ideally, in how to provide youth-friendly services. Because this manual might be used in some clinical settings where providers have not had training in youth-friendly services, an overview of this topic is included in Chapter 1, with resources for further reference.

To strengthen youth counseling and testing services, this manual functions as:

- ◆ An easy-to-use reference tool on youth and HIV/AIDS
- ◆ A guide to counseling young clients about HIV testing, prevention, care, and treatment
- ◆ A reference tool on related services, including contraceptive options and other STIs
- ◆ A convenient place to record local referral networks

The materials presented here are a guide to best practices for offering HIV counseling and testing services for youth.

Chapter 1 summarizes where youth get information about sex and what factors put them at risk of HIV and other STIs, as well as unintended pregnancy. This chapter reviews the principles of counseling and testing with a focus on how they differ between youth and adults. It reviews important skills for counseling youth effectively. And, it summarizes approaches to youth-friendly services for providers, with resources for further training if needed.

Chapters 2 to 5 outline the counseling and testing process with a step-by-step guide. They provide basic information about prevention, treatment, and care of HIV and other STIs; contraception and prevention of unintended pregnancy; and selected life skills for young people.

Chapter 6 contains a chart for documenting local referral resources.

Although beyond the scope of this manual, other issues for program managers to consider include:

- ◆ Developing or acquiring youth-specific and youth-friendly information and educational materials
- ◆ Building community understanding of and support for counseling and testing in general and for youth specifically
- ◆ Creating awareness among youth about the need for HIV prevention, pregnancy prevention, and other reproductive health services
- ◆ Developing a plan for obtaining additional counselors and adequate space as more youth become aware of HIV services

This manual defines “youth” as people age 10 to 24 and uses the terms “adolescents,” “youth,” “young adults,” and “young people” interchangeably. Of course, this is a broad range, and the needs of a 10-year-old differ considerably from those of 24-year-old, as do age-dependent policies regarding confidentiality, parental notification, and other issues.

The World Health Organization and the U.S. President’s Emergency Plan for AIDS Relief increasingly use the term HIV “counseling and testing” or “testing and counseling” in referring to the broad umbrella of options. The term voluntary counseling and testing (VCT) refers to a specific model within this larger range of approaches. This manual also uses this vocabulary, with “counseling and testing” as the umbrella term.

Counseling Youth



Youth are a diverse population, often varying greatly in life circumstances and situations. Counselors may see youth who are in school or not, have not had sex or have been sexually active for several years, are married with children, or unmarried with several sexual partners. Some clients may be in the workforce or the military. Some may be young men who have sex with men. You may work with clients who are injecting drug users. One of your challenges is to assess your clients as individuals and tailor your messages to reflect their particular circumstances.

There are special considerations for those who counsel youth:

- ◆ Young people face barriers in receiving health services and tend to use services less than adults do. Their visits to places where HIV counseling and testing is offered may be their only chance to receive health-related information and services. In addition to counseling on HIV/AIDS, you might have the opportunity to address topics such as contraception and prevention of other STIs. It is important to know where you can refer your clients for services that are beyond the scope of your center.
- ◆ Confidentiality and consent issues are more complicated when working with adolescents. For adults, the choice to be tested is their own, and the process and results are confidential. For young

people, guidelines vary on the age at which they can decide for themselves to be tested, as well as on when, or if, their parents or guardians must be notified of the test and the results.

- ◆ Youth often have different terminology for, and understanding of, sexual terms.
- ◆ Establishing whether young people are *voluntarily* seeking counseling and testing may be difficult. Some may have been pressured, or even forced, to learn their status by employers, partners, parents, or others in the community.
- ◆ Unlike many adults who seek HIV counseling and testing, youth may be more interested in counseling and information than in being tested. Youth who may not have initiated sex might be seeking support in making informed decisions about their sexual and reproductive health.
- ◆ Youth may not always be candid about their sexual experiences out of fear of stigma and labels.
- ◆ Counselors might face personal ethical dilemmas when working with young people because their own values on sexuality may differ from those of the youth they counsel.
- ◆ Counseling adolescents often takes more time than working with adults, because young people often know less about their sexual health than adults do. This could be particularly true of younger adolescents, who might not have the life experiences that older clients do.
- ◆ The messages and the content of the counseling may vary depending on the age of your clients, their sex, their emotional maturity, developmental stage, family situation, and their knowledge, experience, and sources of information.

Unlike many adults, youth may be more interested in counseling and information than in being tested.

Factors that Put Youth at Risk

Many adults, including parents, are hesitant or ill-prepared to talk to youth about sex. Young people often turn to their peers and the media for information. Their friends may be equally uninformed, and the media tend to promote sexuality without a focus on responsibility and safety. As a result, young people often lack the information they need to make safe, healthy decisions. Surveys from 40 countries indicate that although many youth have now heard about the HIV/AIDS epidemic, half of the young people have misconceptions about how HIV is acquired and transmitted.

In addition to lack of accurate information about HIV/AIDS, many other factors put youth at risk of HIV infection:

- ◆ Early age at first sexual intercourse
- ◆ Risk-taking behaviors as part of the transition to adulthood
- ◆ A belief of being invulnerable (“it cannot happen to me”)
- ◆ Boys feeling pressure to prove their “manhood”
- ◆ Generally low levels of condom use
- ◆ Tendency of sexually active youth to have multiple sexual partners
- ◆ Vulnerability to sexual coercion and abuse
- ◆ Use of sex to ease loneliness, boost self-esteem, and gain respect
- ◆ Lack of skill in negotiating sexual decisions
- ◆ Exchange of sex for basic needs such as school fees, clothes, food, or shelter
- ◆ Cross-generational sex, typically — although not always — between young girls and older men
- ◆ Susceptibility of young women to gonorrhea and chlamydial infection because of a condition called cervical ectopy in which the cells that line the inside of the cervical canal extend onto the outer surface of the cervix — a normal condition that is present in most female adolescents and becomes less common with age

- ◆ High prevalence of STIs, which increase the likelihood of acquiring and transmitting HIV
- ◆ Improper treatment of STIs (or no treatment at all) when youth are discouraged from seeking help by clinicians who are not youth-friendly
- ◆ Experimentation with alcohol and drugs, which are associated with high-risk sexual behavior

Gender Norms

Consider the role gender plays in your clients' behavior. The term “sex” means the biological distinction of being male or female, whereas “gender” refers to the roles of men and women (or boys and girls) as determined by the society in which they live. Gender norms can influence adolescents' views on sexuality, their access to information and health services, and their ability to protect themselves from HIV, other STIs, and unintended pregnancy.

- ◆ In many cultures, premarital sex is accepted and expected of boys, who might be ridiculed by their peers if they have not had intercourse.
- ◆ The ideal of manhood promoted in many societies may discourage young men from showing affection, asking questions, seeking help, or expressing their doubts and fears.
- ◆ Girls are sometimes taught that premarital sex is unacceptable for “respectable” women and may not consider using or requesting contraception or other reproductive health services for fear of being thought of as sexually active or promiscuous.

- ◆ Gender norms can place girls at risk of sexual violence or sexual coercion. Some young people are raised to believe that it is the woman's duty to have sex; if a woman refuses, consequences might range from desertion to rape or domestic violence.
- ◆ Intergenerational sex is common in some societies, and high risks are associated with it, particularly for girls and young women. Data suggest that older male partners are many times more likely to be HIV-positive than young men are.

In counseling about HIV testing and related reproductive health issues, you may want to encourage young people to examine traditional gender roles and stereotypes. To generate a discussion about gender, ask some of these questions, if appropriate:

- ◆ Do girls have the right to refuse sex with a boy?
- ◆ Are boys manlier if they have several girlfriends?
- ◆ Some people think that there is something wrong with boys who wait to have sex. What do you think?
- ◆ Do you think it is a good idea to have a “sugar daddy” or “sugar momma”?



Special Populations

Providing HIV counseling and testing services to certain populations of young people can be especially challenging as they may require special care or a different emphasis in counseling.

- ◆ Mobile populations include youth whose work causes them to travel, members of the military, political refugees, street kids, and those displaced by civil conflict. These young people may lack a sufficient support network, access to ongoing health care, and, in some cases, even basic nutrition and shelter. They may not be able to return for additional counseling and support, so it will be important to cover as much information as possible during their first session without overloading them.
- ◆ Many orphans are caring for siblings and chronically ill family members, living in financially stretched households, or on their own. Some are HIV-infected themselves. Some orphans engage in high-risk behaviors to support themselves and their families. Orphans are more likely than non-orphans to face poor nutrition, lack access to basic health care, not be enrolled in school, face psychological and emotional difficulties, and lack support to deal with a positive test result and commitment to a healthier lifestyle. If your country or clinic has a policy requiring parental consent to test minors for HIV, in the case of orphans, find out if you can consult with a guardian or other adult allowed by law to grant consent, or decide whether your client is emotionally mature enough to provide voluntary consent.

You can make a lasting difference in the lives of your clients by promoting healthy behaviors and bolstering their hopes for the future.

◆ Youth who have mental disabilities might not be capable of providing voluntary consent. Try to determine if they have been coerced into being tested.

◆ If a rape victim comes to be tested, explore whether she (or he) has already received trauma counseling, emergency contraception (for girls), antiretrovirals (ARVs) as an HIV prophylaxis, and other medical care. Be sensitive to the possibility that your client has been a victim of incest; if this is the case, avoid talking to the parents, as this could add to your client's trauma. Let the laws of your country and the rules of your clinic be your guide about whether instances of incest and nonconsensual sex must be reported to the police. You may also need to consult a supervisor.

◆ Other groups of youth who may require special attention include those who may be infected from intravenous drug use, men who have sex with men, and ethnic or tribal minority groups. In such cases, counselors may need specialized training regarding the needs of the youth, the risks of infection, and the types of support and treatment services needed.

Despite these challenges, working with young people brings special rewards. You can make a lasting difference in the lives of your clients by promoting healthy behaviors, increasing their knowledge of HIV, and bolstering their hopes and health outcomes for the future.



Opportunity for Other Services and Education

HIV counseling and testing has the potential to provide clients with much more than an HIV test and its results. It can be an opportunity to offer other health services and education and an important way to begin encouraging youth to make informed decisions about their health. Although a few counseling sessions are usually not enough to affect long-term behavior change, HIV counseling can be a crucial first step.

Comprehensive HIV counseling and testing services and appropriate follow-up referrals have the *potential* to:

- ◆ Increase general awareness of HIV/AIDS
- ◆ Increase clients' understanding that they *are* vulnerable
- ◆ Reduce anxiety for those who test negative
- ◆ Ease acceptance of HIV-positive status
- ◆ Encourage both HIV-positive and HIV-negative youth to adopt safer behaviors, such as abstinence, faithfulness, and condom use as appropriate
- ◆ Encourage HIV-positive youth to seek proper care and, when necessary and available, appropriate treatment
- ◆ Offer compassionate support to reduce the stigma HIV-positive youth may face



- ◆ Reduce the likelihood of unintended pregnancy by discussing clients' desire for children and providing information about contraception and referrals as needed
- ◆ Help prevent transmission of HIV and other STIs
- ◆ Help reduce the transmission of HIV from mothers to their children
- ◆ Where appropriate, help couples discuss HIV-infection status, that is, in situations that could lead to greater faithfulness, reduced marital conflict, and less partner violence pertaining to testing and disclosure (but be cautious about couple counseling that could lead to greater partner violence)
- ◆ Help youth to understand that antiretroviral treatments may help a person feel better but do not cure AIDS and do not eliminate the risk of HIV transmission
- ◆ Encourage young people to seek other medical and support services as needed
- ◆ Help youth in planning their future
- ◆ Introduce other life skills, such as:
 - thinking critically
 - improving assertiveness
 - developing a supportive network of family, friends, teachers, and religious leaders
 - dealing with peer pressure, especially as it relates to sex, alcohol, and drugs

The number of youth seeking HIV counseling and testing services is increasing, and even more young people would use these services if they were available. The young people you work with may seek counseling and testing for a variety of reasons. Their motivation for seeking testing will likely affect your approach to counseling. Young people might:

- ◆ Simply want to know whether they are HIV-positive
- ◆ Be curious about HIV counseling and testing
- ◆ Want HIV counseling and testing as part of premarital counseling
- ◆ Be worried about having been exposed to HIV, either by their own actions, by the unsafe behaviors of a partner, or through the process of caring for ailing parents
- ◆ Suspect they are infected or have symptoms related to STIs
- ◆ Have an infected partner or child
- ◆ Be currently pregnant or planning to become pregnant
- ◆ Need to be tested as a requirement of study, immigration, or employment
- ◆ Have experienced the death of a partner, friend, or family member, either of AIDS or unexplained circumstances
- ◆ Be starting a new sexual relationship, considering having sex for the first time, or have recently begun having sex
- ◆ Be worried about their health and well-being after being raped
- ◆ Have been forced to be tested by a partner, spouse, or family member
- ◆ Want information about HIV/AIDS, but not necessarily testing

The young people you work with may seek counseling and testing for a variety of reasons.

Skills for Counselors of Youth

Your role as a counselor is vitally important in helping young people:

- ◆ Avoid acquiring HIV and other STIs
- ◆ Make positive, long-term changes in behavior
- ◆ Access other health-related and support services
- ◆ Avoid unintended pregnancy
- ◆ Plan for the future — for those who are HIV-negative to remain uninfected and for those who are HIV-positive to cope with HIV and prolong their lives
- ◆ Obtain correct information regarding HIV/AIDS





In many ways, counseling adolescents is similar to working with adults. Everyone wants to be treated respectfully, to have his or her concerns heard, and to receive accurate, up-to-date information. But young people often face more barriers to services than adults do.

A counselor who works effectively with youth has these qualities:

- ◆ The ability to build rapport with young clients and earn their trust
- ◆ Respect for the different life circumstances of the young people they counsel
- ◆ Excellent communication skills and ability to speak the language of youth
- ◆ Accurate knowledge of subject matter and local guidelines, laws, and customs

Building Rapport

When counseling young clients, try to remember how much courage they have shown in seeking your help. Think how many adults avoid talking about sex or are embarrassed to ask questions about their sexual and reproductive health. These fearful feelings are likely to be even stronger for many young people.

Help put adolescents at ease and demonstrate that you are trustworthy. They will be more likely to be open and honest about their feelings and experiences.

- ◆ Try to start on time. Waiting increases anxiety.
- ◆ If possible, set up a private, quiet counseling station.
- ◆ Introduce yourself in a warm, friendly manner.
- ◆ Explain and discuss issues of confidentiality. Depending on local laws or your agency's policies, you may need permission from a parent or guardian to conduct an HIV test. If this is the case, explain your obligation and offer to help your clients talk to their parents about the test. Be aware of any youth who might be exempt from parental notification, such as orphans, street kids, and "mature minors" (a phrase used in some country policies, see page 41 for a definition).
- ◆ Begin by asking general questions about their life and interests. You might ask about their friends and family, whether they are in school or working, and what kinds of hobbies they enjoy.
- ◆ Respect your clients' intelligence and life experiences. Ask them about their sexual knowledge and experience before giving them information they may already know.
- ◆ Show empathy; demonstrate that you understand your clients' thoughts and feelings.
- ◆ Be patient if your clients take a while to open up. If possible, allow enough time for the session so that young people do not feel rushed.

Respecting Your Clients' Life Circumstances

Social class, age, culture, marital status, ethnicity, race, religion, sexual orientation, sex, and occupation all influence young peoples' behavior and practices. Understanding how these factors affect their lives will help you provide personalized counseling and develop the most effective strategies for HIV prevention, care, and treatment.

- ◆ Assure your clients that you will not judge them. Try not to let any personal feelings or biases about how you think young people should behave interfere with your professional behavior. For instance, instead of saying, "What you're doing is wrong," or, "It's bad to have sex at your age," say, "Your behavior is exposing you to the risk of getting HIV and other STIs."
- ◆ Display a positive attitude about your clients.
- ◆ Treat each client as an individual. Do not stereotype or assume that one way of counseling will work with all young people.
- ◆ Ask questions about their beliefs and views and indicate that you understand them.
- ◆ Welcome all youth, regardless of their sex, age, or marital status and whether or not they are sexually active, have multiple sex partners, or have never been pregnant.
- ◆ Adjust your approach to account for your clients' developmental stage; assess their knowledge and experience instead of making assumptions based on age alone.

Instead of saying,
"What you're doing
is wrong," say,
"Your behavior
is exposing
you to
the risk of
getting HIV."

Communicating with Young People

Excellent communication is the key to positive interactions with your clients. This means effectively sharing information as well as *listening* to the young people who come for counseling and testing.

- ◆ Use simple language and short sentences. Avoid technical terms.
- ◆ Use nonjudgmental language. Avoid saying, “You should . . .”; instead say, “You can . . .” or “You may want to think about . . .”.
- ◆ Be aware of the language and slang adolescents use to discuss sexual issues. Be clear in your explanations and make sure your clients understand. For instance, when talking about “sex,”





clarify that sex includes oral, vaginal, and anal sex. Some youth engage in oral or anal sex because they do not consider it “real” sex.

- ◆ Use “active listening” by paraphrasing your clients’ statements and repeating them back. This confirms that you understand what your clients are saying. If a young person says he is concerned about HIV/AIDS, you can say, “It sounds like you want to learn how to prevent HIV, and you have some questions about protecting yourself and your partner.” This technique also gives your clients the opportunity to correct any misunderstandings.

- ◆ Ask open-ended questions that will lead to discussion rather than questions that require only a “yes” or “no” answer. For example, you might ask, “What do you know about protecting yourself from HIV?” rather than, “Do you know how to protect yourself from HIV?”
- ◆ Use appropriate eye contact, gestures, and verbal responses to show that you are listening. Nod your head or say “go on” to help assure young people that they are being heard.
- ◆ Learn to read body language. Be conscious of what your own body language is communicating by the way you stand, sit, or make eye contact. If you are frowning and sitting with your arms crossed in front of you, this could convey that you are angry or upset by what your client is telling you.
- ◆ Make sure young clients understand what you are saying to them. Do not simply ask, “Do you understand what I have said?” Clients may be too embarrassed to admit they do not. Instead, consider asking questions that will help you determine if the young person understands.
- ◆ Rather than giving orders, help youth develop steps they can take to protect themselves.
- ◆ Be genuine. Admit when you do not know how to answer a client’s question, and try to find the answer when you can.

Providing Accurate Information

Young people often receive misinformation from friends, the media, the Internet, and well-meaning adults. Your most important task is to provide your clients with accurate, science-based information in a clear and concise manner. This means that you should try to stay up to date on subjects that will be of interest to your clients, especially the topics addressed in Chapters 3 to 5:

- ◆ HIV/AIDS and other STIs
- ◆ Contraception and other reproductive health services
- ◆ Life skills, such as critical thinking and assertiveness

Making Services Friendly to Youth

Inconvenient hours or location, unfriendly staff, and lack of privacy and confidentiality are among reasons many young adults give for not using HIV prevention and reproductive health services. Since young people generally do not use existing services, special efforts have to be made to attract, serve, and retain young clients. Researchers and program planners are exploring the best types of interventions to provide reproductive health and HIV services to youth.

In providing HIV counseling and testing services to youth, ideally, providers would be sensitive to youth perspectives, and facilities would address the particular needs of youth. Many organizations have addressed this issue in various documents on “youth-friendly services,” ranging from advocacy and planning tools to provider training curricula, job aids, and evaluation tools.

As the options for offering HIV counseling and testing services to youth increase, more facility managers and providers may need basic information and training on youth-friendly services. Family Health International has compiled comprehensive background information about youth-friendly services on its Web site. The information includes:

- ◆ Characteristics of youth-friendly services (shown below)
- ◆ Evidence on effectiveness of clinic-based youth-friendly services
- ◆ Descriptions of possible approaches to youth-friendly services
- ◆ Research and program summaries

The Web-based resources include presentations from a global consultation meeting on youth-friendly services and an annotated bibliography of 16 useful tools with electronic links to these resources. Various organizations developed the tools, including the World Health Organization, EngenderHealth, Family Health International, Pathfinder International, and the Program for

Appropriate Technology in Health. The tools are grouped into these categories: advocacy, planning, and overview; assessment and implementation; provider training curricula; provider and program planner job aids; and evaluation. The background information and the annotated guide to resources are available online at: <http://www.fhi.org/en/Youth/YouthNet/ProgramsAreas/YouthFriendlyServices/index.htm>

Youth-friendly services in general have these characteristics:

- ◆ Providers are trained to communicate with youth and to understand the issues young people face.
- ◆ Providers have a respectful, nonjudgmental attitude.
- ◆ The facility has policies of confidentiality and privacy for youth.
- ◆ The facility has convenient hours and location for both in-school youth and those who work all day.
- ◆ The facility has a comfortable, nonthreatening environment.
- ◆ The fees are affordable.
- ◆ Youth participate in the policies and implementation of the services through an advisory board, as peer educators, and in other roles.

HIV Counseling and Testing



Youth can obtain counseling and testing in a variety of settings. Youth may seek out HIV counseling and testing at youth centers, community health centers, or other settings, or they may receive HIV testing as a routine part of services at primary health facilities, antenatal clinics, STI clinics, or maternal and child health (MCH) clinics. In the integrated service models, HIV counseling and testing is often coupled with other routine medical tests.

The setting, available resources, cultural context, and the health priorities and needs of youth in a particular community will affect decisions about what level of HIV counseling and testing services is appropriate and feasible. In all settings, the following elements are essential, especially for youth:

- ◆ The test should only be administered after the client has given informed consent to be tested.
- ◆ Confidentiality must be assured.

- ◆ Clients must be able to get their test results.
- ◆ Counseling is needed to help youth understand what the test means, how to prevent transmission, how to change risky behaviors, and what types of services are available after getting their results.
- ◆ The counseling and testing service should be linked to youth-friendly services for care and treatment, contraceptive needs, and diagnosis and treatment of other STIs.

Models for offering HIV counseling and testing follow four basic steps, as follows:

Step 1.

Offer the HIV test with varying degrees of counseling

Step 2.

Provide pretest counseling, which can vary extensively

Step 3.

Administer the HIV test, if the client decides to have one

Step 4.

Provide posttest counseling and support

Two Testing Models

In counseling and testing in clinical settings (see Figure 1), clients do not seek HIV testing per se but are in a situation where a provider may routinely offer it as part of other tests and services. A client may choose not to have an HIV test, which is being administered along with other tests. Counseling about preventive behaviors and other issues may come only after the test results are available.

In the traditional voluntary counseling and testing model (see Figure 2), the first step involves exploring the client's decision to seek testing. The second step involves thorough pretest counseling, including a careful discussion about how a client might cope with a positive test result.

HIV Counseling and Testing in Clinical Settings Model

Step 1: Offer HIV test routinely

Providers in clinical settings may approach HIV testing in quite different ways. They may offer HIV testing routinely along with other tests. In doing so, the provider should only administer an HIV test to a client who has given informed consent to be tested. In addition, the provider should explain the confidentiality policy of the clinic.



In some settings, everyone may be tested routinely for HIV as part of other tests unless a client expressly chooses not to be tested, which some refer to as choosing to “opt out.” In other settings, the test is routinely offered but the client receives the test only if they request it, that is, they “opt in” for the test. In either case, providers may choose to offer less counseling than they would in a traditional VCT setting except to get permission to administer the test.

Getting an HIV test can be traumatic under any circumstances, and without adequate counseling, the stress can be even greater. A young person may be particularly vulnerable under circumstances where providers do not work regularly with youth. Providers in clinical settings without any training in youth-friendly services should be aware of the needs of young people, should not be judgmental of their sexual behaviors, and should be aware of their needs for privacy and confidentiality. Moreover, the counseling component in this step, combined with knowing one’s test result later in the process, is critical for encouraging behavior change.

The discussion of Step 2 in the VCT model (see page 41) summarizes information useful for youth.

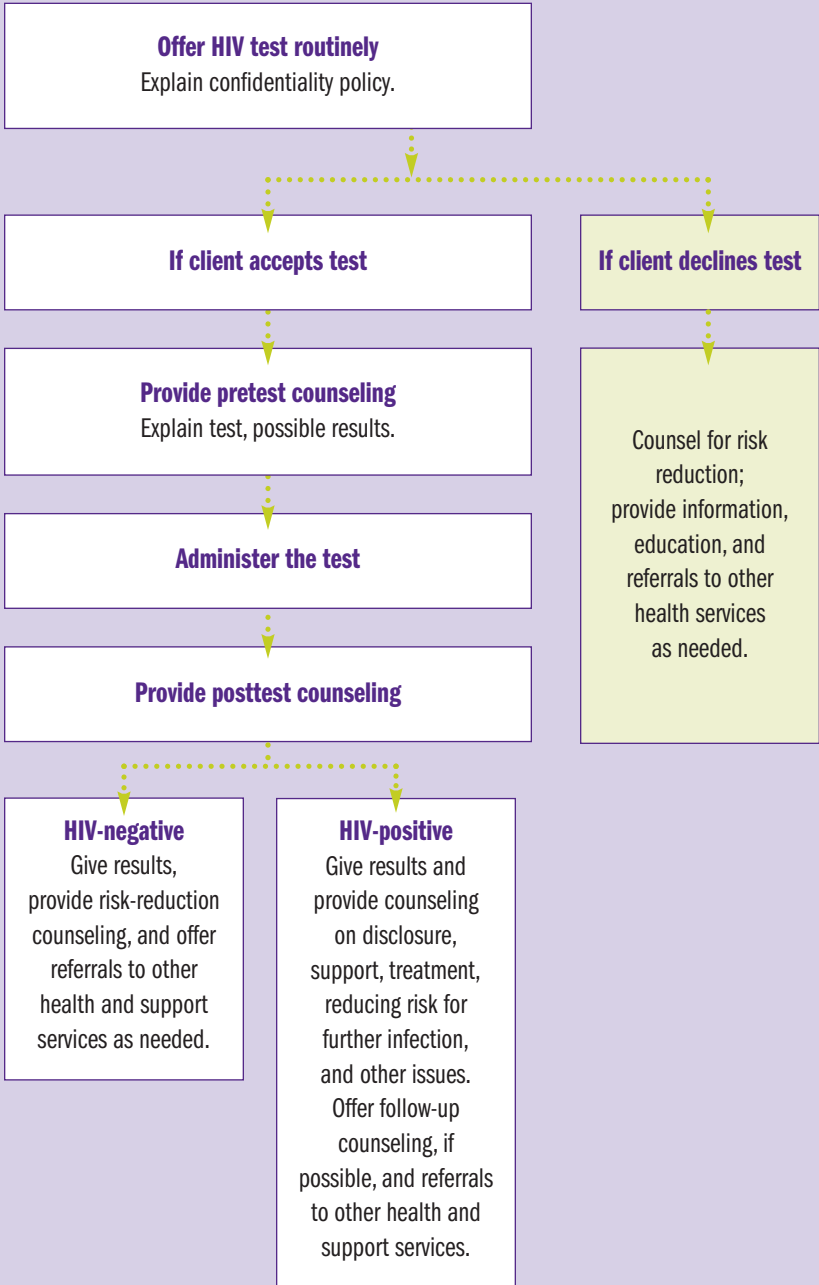
Step 2. Provide pretest counseling if your client accepts the test

In a clinical setting, providers will spend varying amounts of time with each young person who receives an HIV test. The discussion of Step 2 in the VCT model (see page 41), summarizes the type of information that would be useful for young people to discuss before being tested. Providers in clinics should incorporate as much of this information as possible in working with young people. See page 54 for a discussion of the type of counseling and information to provide to those who decline the HIV test.

Steps 3 and 4. Administer the test and provide posttest counseling

These two steps incorporate the same general information whether in clinical settings or in VCT settings. Steps 3 and 4 are discussed beginning on page 48.

Figure 1: HIV Counseling and Testing in Clinical Settings



HIV Voluntary Counseling and Testing Model

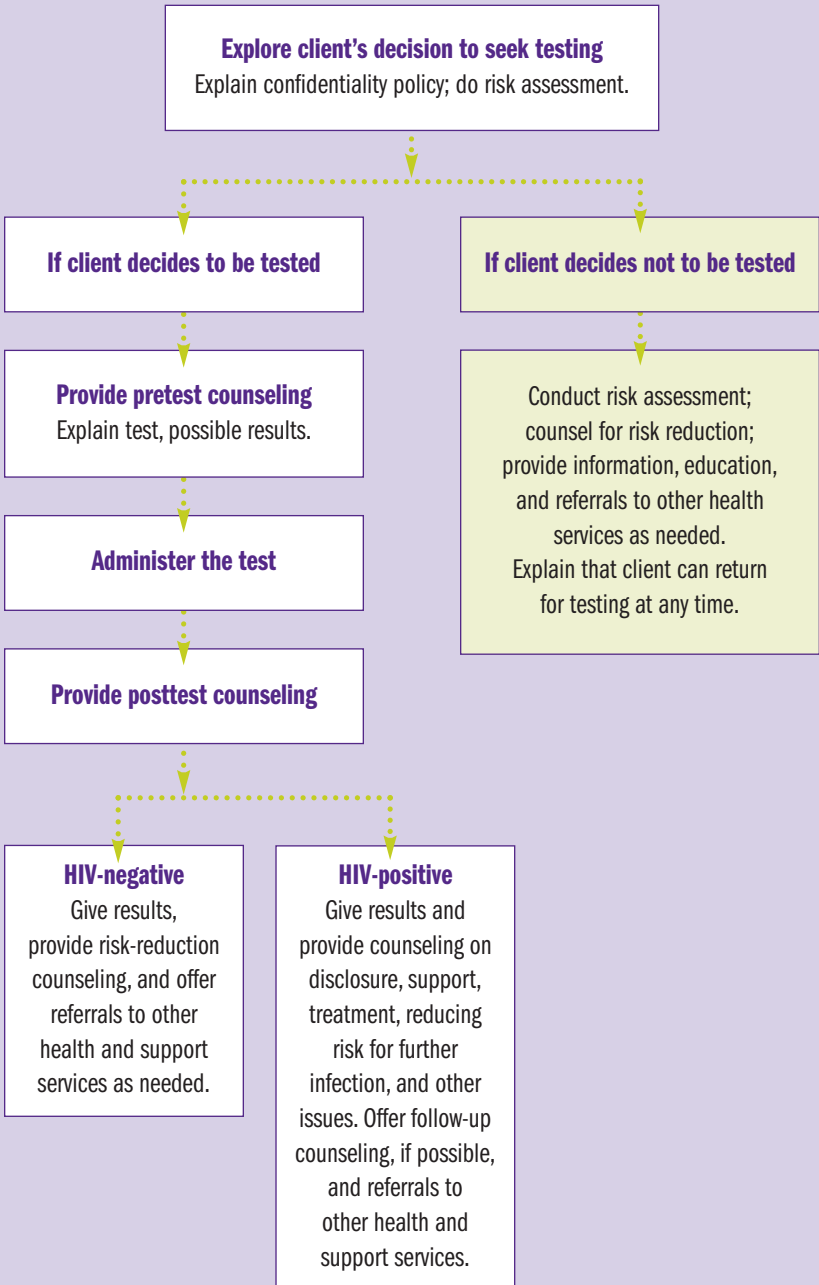
Step 1.

Explore client's decision to seek testing

If a young person has come with his or her parents or guardian, ask if you and your client can speak privately. Parents might not know or admit that their child is sexually active, and youth may hesitate to talk about their experiences in front of their parents. You might consider working with the parents, also, to help them accept their child's sexuality. You can encourage them to support their child instead of blaming him or her for being sexually active. Below are key issues in this step:

- ◆ Allow your clients to talk about why they want to be tested. A young person's decision to be tested for HIV may have been made without accurate information or under pressure from parents or a partner. Even if your clients have made an informed, independent choice, this step helps prepare them for the rest of the process.
- ◆ Establish a good relationship with your clients (as discussed in Chapter 1). Congratulate them for having the courage to come for testing and affirm their decision to look after their health.
- ◆ Explain your clinic's policies on confidentiality.
- ◆ Find out what prompted your clients to come for counseling and testing. Ask if they have any specific health concerns. Young people sometimes think they have symptoms of AIDS and have decided to come to the clinic to confirm their fears. The symptoms may be completely benign, but young people's fear that they are sick is one of the common reasons for them to visit a counseling and testing center.
- ◆ Find out whether or how your clients have been put at risk: through sex, by blood transfusions or other medical procedures, or through use of intravenous drugs. Try to explore the following issues without sounding like you are interrogating your clients:
 - Ask about their sexual history. Are they sexually active? Do they have a steady partner, a new partner, or multiple partners? Do they have older partners, exchange sex for money or gifts,

Figure 2: HIV Voluntary Counseling and Testing



or have same-sex partners? Do they use condoms (regularly? occasionally? correctly?) or other contraceptive methods?

- Ask if they have any history of blood transfusions or if they have had any other injections, tattooing, or medical procedure that could have exposed them to infection.
- Explore their current or past drug or alcohol use as well as that of their partner(s). Explain that you are not going to judge them, but that you are asking these questions because drug and alcohol use could be increasing their risk for unprotected sex, and injecting drug use itself is a means of transmitting HIV.

Based on their answers to these questions, you might find that your client has not been at risk for acquiring HIV and simply wants information. Or if he or she has engaged in any risky behaviors, you can use this information during counseling to develop a practical, personalized plan to help him or her change these behaviors. If your clients are sexually active, this is also a good time to ask if they are protecting themselves and their partners from unplanned pregnancy, as well. (See Chapter 4 for more information on preventing unintended pregnancy.)

- ◆ Try to rule out coercion. Explain that testing is voluntary but that they will be best served by knowing their status. Advise them to exercise good judgment about revealing their status. They are not required to tell their test results to anyone, although if they feel safe doing so, they should inform their partner(s).
- ◆ Explore their ability to deal with the results and their understanding of the possible implications. A positive test will likely be very traumatic. Do you sense that they might hurt themselves or others? Do they have support of family or some other trusted adult? If you strongly suspect that a client is not equipped to handle the test's results, you might suggest that he or she return for more counseling and bring a trusted friend or adult. Or, with your client's approval, work with his or her parents or guardian.

Step 2. Provide pretest counseling if your client decides to be tested

Young people who decide to be tested may be nervous and anxious. They may worry about the test itself, in addition to what its result will be. Acknowledge their fears and give them some time to express their concerns. If the client decides not to be tested, see page 54.

- ◆ Depending on the policies of your center or local guidelines and laws, you might need to get parental permission to administer the test. In some countries, policies are flexible enough to allow some called “mature minors” to decide for themselves to be tested. The term can refer to those younger than 18 years who are married, pregnant, parents, engaged in behavior that puts them at risk, or in other relevant situations (such as orphaned and head of a household). If parental consent is required, offer to talk to your clients’ parents or guardian.
- ◆ Discuss what HIV is, how it is transmitted, and what risky behaviors could lead to transmission. Explain what AIDS is.
- ◆ Explain how the HIV test is done. Young clients may be concerned that it will hurt or cause discomfort. Answer any questions they have about the test and its accuracy.
- ◆ Although HIV tests are very accurate, explain that the test’s reliability depends on the last time they may have been exposed to

In some countries,
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to be tested.

HIV and how quickly their body produces antibodies. It can take up to three or even six months after exposure to HIV — the “window” period — for it to be detected.

- ◆ Provide a clear explanation of what negative and positive test results mean.
 - A *negative* test result means that HIV antibodies — particles that are produced by the body in defense of HIV — were not identified in the person’s blood. This means that the person is either not infected, or that he or she has been infected so recently that HIV antibodies have not yet been produced and cannot be detected by the test. If your client has engaged in risky behavior in the past three months, it is possible that he or she may still become infected. Explain that in this case, your client should return for another test. Also explain that a person who tests negative is not immune; he or she can still become infected if he or she practices risky behavior in the future.
 - A *positive* test result means that HIV antibodies were detected in the person’s blood. It does not mean that he or she has AIDS but that your client is infected with HIV and could transmit the virus to others if he or she practices unsafe behaviors.

Talk with
your clients
about who
they will
turn to
for support.

- ◆ Talk with your clients about who they will turn to for support. Who will they tell about the test's results? What will a positive or negative result mean to them, their family, and their partner?
- ◆ Inform the client how long it will take to get the results. Most tests produce results almost immediately. Clients will often get the result soon after the test. Discuss whether they are ready to receive the results right away.
- ◆ If the results will not be ready right away, reinforce how important it will be for clients to know their status and, thus, return for the results. Try to get them to commit to do so by finding out when they will return and how they will get back to the facility. Talk to your clients about how they will handle nervous or fearful feelings during the waiting period. Stress the importance of practicing safe behavior while they are waiting to return, and help them develop a concrete plan for protecting themselves and their partner(s) during the waiting period. You might suggest they bring a trusted friend, parent, or other family member with them when they return to get their results.
- ◆ It may be appropriate to discuss HIV testing issues with a young person and his or her sexual partner. Knowing the HIV status of a partner is important, and pretest HIV counseling may provide a useful time for a couple to think about such issues, including secondary prevention if one partner does turn out to be infected. Counseling couples in this setting may also promote staying faithful to one partner and taking steps to prevent further infection.



Practicing Abstinence

A

Abstinence is the surest way to avoid HIV/AIDS, other STIs, and unintended pregnancy. If young people choose to remain abstinent or practice “secondary abstinence,” help them develop a strategy to do so. Secondary abstinence refers to choosing abstinence after previously engaging in voluntary or coerced sex. Review these strategies with your clients:

Be clear about why you want to wait.

- ◆ List your reasons. Talk them over with someone who supports you.
- ◆ Check your list from time to time to remind yourself.

Have a plan.

- ◆ Know what situations might make it hard to stick with your choice.
- ◆ Decide ahead of time what you will do to avoid or deal with difficult situations, such as leaving when you are being pressured to have sex.
- ◆ Instead of having a sexual relationship with someone you are interested in romantically, think of other ways to express your feelings.

Be impressed with yourself.

- ◆ It can be hard to go against the crowd and make your own choices.
- ◆ Give yourself credit. You deserve it.

Get support.

- ◆ Hang out with friends who know about and respect your decisions.
- ◆ Avoid people who might pressure you.
- ◆ If pressured, tell someone in authority.

Practice communication skills.

- ◆ Learn to say “No!” with conviction.
- ◆ Give a reason, such as, “I’m not ready.”
- ◆ Turn the tables: “You say that if I loved you I would have sex, but if you really loved me, you wouldn’t insist.”

Role-Play: Practicing Abstinence

You might help your clients practice what to say if someone is using the following arguments to pressure them to have sex.

If their partner says:

They can say:

“If you have sex, you will be more popular, beautiful, or manly.”

“That’s not true. Deciding not to have sex won’t make me less of a woman [or man]. It’s my own choice, no one else can make that decision for me.”

“If you do not have sex, people will think you are homosexual.”

“That’s crazy. Lots of people, gay and straight, want to wait to have sex.”

“Everyone in the movies and on television is having sex. Why can’t we?”

“Sure, the movies show how fun sex is, but they don’t show the consequences. They don’t show the girl who had to drop out of school because she was pregnant or the boy who got an STI.”

“You should have sex for the first time just to get it over with.”

“Why should I want to just get it over with? I want sex to be special, with someone I really care about.”

“There is no good reason to wait to have sex. You should do it now.”

“There are a lot of good reasons to wait. I don’t want to worry about getting pregnant or getting HIV or some other infection. I’m just not ready to have sex now.”

Adapted from *Abstinence Focus Poster No. R045*. Scotts Valley, CA: ETR Publishing, 2002; Grossman L, Kowal D. *Kids, Drugs, and Sex, Preventing Trouble*. Brandon, VT: Clinical Psychology Publishing, 1987.

Being *Faithful*

B If your clients are sexually active and wish to remain so, discuss the concept of being faithful to their partner. Having multiple, concurrent sexual partners puts young people at a much greater risk of acquiring HIV and other STIs. Help them think of other good reasons to be faithful:

- ◆ Ask them to recall why they chose their current partner. What did they like about him or her? What benefits does the relationship bring them? Security? Love? Companionship? Friendship?
- ◆ Have them consider how cheating could affect their partner and their relationship.
- ◆ Suggest they steer clear of situations and people who might tempt them to do something they would later regret.
- ◆ Explain the benefits of having both partners receive testing — that way, they can reduce anxiety and uncertainty about the risks of acquiring HIV or other STIs.



Using Condoms

C If your clients are sexually active and wish to remain so, emphasize that condoms provide dual protection against STI/HIV transmission and unintended pregnancy. Young people, especially women, may need strong negotiation skills for using condoms. You might help your clients practice what to say if one partner is pressuring the other not to use condoms.

Role-Play: Talking about Condoms

If their partner says:

They can say:

“I don’t like using condoms. It doesn’t feel good.”

“I’ll feel more relaxed, and if I’m more relaxed, I can make it feel better for you.”

“We have never used a condom before.”

“I don’t want to take any more risks.”

“Using condoms is no fun.”

“Unplanned pregnancy or getting an STI is much less fun.”

“Don’t you trust me?”

“I trust you are telling the truth. But with some STIs, there are no symptoms. Let’s be safe and use condoms.”

“Why should we use a condom? Do you think I have AIDS?”

“No, but I could have an STI. We need to protect both of us.”

“I will pull out in time.”

“I can still get pregnant or get an STI!”

“I thought you said condoms were for casual partners.”

“I decided to face facts. I want us to stay healthy and happy.”

“I guess you don’t really love me.”

“I do, but I don’t want to risk my health to prove it.”

“We’re not using condoms, and that’s it.”

“O.K. Let’s do something else, then.”

“Just this once without.”

“It only takes once to get pregnant, or get an STI, or get HIV.”

All HIV Counseling and Testing Models

Step 3. **Administer the test**

Depending on what type of test you use, clients may either wait 15 to 20 minutes (“rapid testing”) for the result or they might need to return several days later. If the results will be ready quickly, try to make clients comfortable while they are waiting. Give them educational materials, as appropriate, about HIV, STIs, and preventing pregnancy. If they need to come back another day, once again stress how important it is that they return for the result and posttest counseling.

When the test is positive, follow-up tests should be recommended to confirm the result. If a second test is negative, a client should return for another round of tests to clarify the HIV status. Procedures, time to wait for follow-up tests, and types of tests used vary depending on local practices and guidelines. The World Health Organization provides guidelines on testing procedures in a 2004 report available at: <http://www.who.int/hiv/pub/vct/en/rapidhivtestsen.pdf>

Step 4. **Provide posttest counseling**

Often, test results will be ready fairly quickly, but if clients have had to wait several days for the results, congratulate them for coming back.

Ask if they have any questions. It is usually best to present results fairly quickly, since clients are likely to be anxious. If you are required to do so, or if clients request, invite their parents or guardian to attend the session. They might also want a friend or family member present to provide support.

It is important to provide counseling to both HIV-negative clients, as well as those who test HIV-positive.

If the result is negative

- ◆ Acknowledge your clients' feelings of relief. Explain that a negative result means that HIV was not detected but emphasize that they could still become infected if they practice unsafe behaviors or that they might currently be infected if they practiced unsafe behaviors in the last three months. Suggest that if they have engaged in any risky behaviors — sex with multiple partners, sex with a partner who engages in risky behaviors, use of injecting drugs — in the last three months, they should return to confirm the results by taking another test in one to three months, depending on the date they may have been exposed to HIV.
- ◆ Encourage them to consider the benefit of being faithful to one partner and explain the risks of having multiple, concurrent partners (see page 46).
- ◆ Reinforce any healthy behaviors they reported in the pretest session — such as using condoms and being faithful to one partner — and help them develop a plan to change any risky behaviors and maintain their HIV-negative status.

Help youth
to develop a plan
to change
any risky behaviors
and maintain
their HIV-negative
status.

- ◆ Review information on HIV prevention, and, if appropriate, explain and demonstrate the correct use of condoms and provide some sample condoms. Discuss ways to negotiate condom use or overcome peer pressure and abstain from having sex. (See tips on pages 44–47.)
- ◆ Note the importance of using condoms consistently and correctly. Research involving HIV-discordant couples has shown that inconsistent condom use provided no more protection than not using condoms at all.
- ◆ If youth are aware of the new availability of antiretroviral (ARV) treatment in their area, help them realize that if they are not abstaining, they still need to practice safe sex. ARVs may help a person feel better, but they do not cure AIDS and do not eliminate the risk of HIV transmission.
- ◆ Review information on preventing other STIs as well (see details in Chapter 3). Provide services and make referrals as needed.
- ◆ Give clients information on preventing unintended pregnancy if appropriate (Chapter 4). Provide services and make referrals as needed.
- ◆ Refer clients as necessary for ongoing medical care, counseling, support, or development of life skills such as self-esteem, problem-solving, and dealing with peer pressure.

If the result is positive

You might find it very difficult to tell a client that he or she has tested positive for HIV. Try to deliver the news in a caring but not overly emotional way. Give clients the hopeful message that a person with HIV can remain healthy for a long time if they practice positive living habits.

- ◆ Review what a positive test result means. Explain that they have HIV infection, but that they have probably not yet developed AIDS — unless they are appearing with an opportunistic infection or other clinical signs that may suggest they have AIDS. Review the difference between HIV and AIDS.

- ◆ Allow your clients to express their feelings. Give them as much time as necessary. They might be angry, depressed, or afraid. They might feel betrayed by their partner or refuse to accept the test's result. Listen to them, reflect their feelings, offer empathy, and show that you care about what they are going through.
- ◆ Ask your clients whom they will tell about their test results. Help them determine if they will be safe sharing their HIV status. Some young people could face stigma or, even more seriously, physical abuse after sharing their results, so they might need to keep the information private.
- ◆ If they will be safe doing so, encourage them to tell their status to any sexual partner(s) they have had or — if appropriate — to anyone with whom they have shared a needle. Acknowledge their fears about doing so. Offer to role-play; try first acting as your client, so that he or she can learn how to explain his or her status. Then, allow your client to practice by pretending that you are the person they need to tell.
- ◆ Ask your clients to encourage their partner(s) to get counseling and testing.
- ◆ Encourage your clients to think about who they will turn to for support. Parents? Other family members? Religious leader? Trusted friends? Help them determine who would be most supportive. Again, you might help them practice how to talk to these people about being HIV-positive.
- ◆ Encourage clients to make a short-term plan. What will they do when they leave the counseling session? Who will they talk to immediately? What will they do to cope with the results over the next few days and weeks?
- ◆ Work with them to develop a long-term plan for practicing safe behaviors. Be practical and specific. Make sure the plan reflects what your clients can do, not simply what their parents or

friends think is best. Tell clients how to protect their current or future partner by either abstaining or by using a condom correctly every time they have sex. Even partners who are already HIV-infected need to be protected from being exposed to a different strain of HIV. The introduction of a new strain could further weaken an already-compromised immune system. Demonstrate correct condom use and provide some sample condoms.

- ◆ Ask them whether there is anything that could prevent them from making positive changes. They might need guidance on how to negotiate condom use or how to overcome peer pressure and abstain from having sex. (See tips on pages 44–47.) If they are injecting drug users, you could refer them to a needle exchange or substance abuse program.
- ◆ Review information about preventing other sexually transmitted infections (Chapter 3). Offer any appropriate educational materials, services, and referrals.
- ◆ Your clients or their partners may be at risk for unintended pregnancy. Discuss the clients' intentions about pregnancy and explain the risk of transmitting HIV to the baby. Offer information (see Chapter 4), services, and referrals, as needed.
- ◆ Discuss your clients' needs for care, treatment, and support.
 - Refer them to a doctor, even if they do not feel sick. Explain that they should tell the doctor about their status. Their doctor can evaluate whether they need any treatment at this stage and can provide advice on nutrition and other healthful lifestyle approaches that may delay the onset of AIDS and other opportunistic infections. The doctor might also recommend antiretroviral drugs, which can have a dramatic impact on the quality of life of people living with HIV/AIDS. Refer clients to health clinics in your area that are equipped to provide the services necessary for people who are HIV-positive.

- Emphasize the importance of maintaining their health. Drugs, alcohol, smoking, and poor nutrition all make the body weak and more susceptible to AIDS and opportunistic infections.
- If your client is pregnant, explain that treatment options exist that can dramatically reduce the risk of passing HIV on to her child. Make appropriate referrals.
- Have readily available a list of contacts and suggested support groups, youth clubs, additional counseling, and faith-based support (see Chapter 6). Very few people make long-term behavior change after one or two counseling sessions. For lasting, positive changes in behavior, your clients will need ongoing support and counseling.

If your client is pregnant, explain that treatment options exist that can dramatically reduce the risk of passing HIV on to her child.

If client declines the test or decides not to be tested

In a clinical setting, a provider should counsel about risk reduction while providing information, education, and referrals to other health services as needed.

In a VCT setting where a young person has sought out testing, the provider could note that although testing is voluntary, knowing one's HIV status is important, particularly if the client or partner has engaged in risky behavior. Even though your client decided not to take an HIV test, this is still a good opportunity to talk about healthy behavior; to provide information on avoiding HIV, other STIs, and unintended pregnancy; and to refer them to other services as appropriate.

- ◆ Make sure your clients understand how they are vulnerable or may become vulnerable to HIV. You might suggest they return for testing another time, when they feel more comfortable or when they think they may be at risk.
- ◆ Explain how clients can minimize their risk of acquiring HIV or other STIs — by abstaining from sex or, if they are sexually active, by being faithful to their partner, and by using a condom every time they have sex. (See tips on pages 44–47.) Demonstrate correct condom use and provide condoms to those clients who are sexually active. (See Chapter 3 for more information about other STIs.)
- ◆ If your clients are or may become sexually active, find out about their desire for children and offer information on preventing unintended pregnancy if appropriate (see Chapter 4). Make referrals as necessary.
- ◆ Refer them for other medical services, counseling, support, or education in life skills. Chapter 5 provides tips on a few selected life skills. Chapter 6 provides space for you to outline a referral network of resources in your community.

Sexually Transmitted Infections



Adolescents may think they are too young or too sexually inexperienced to acquire STIs. They may also think they are not at risk, because they incorrectly believe that STIs only occur among people who are promiscuous or who engage in “bad” behaviors. As a provider, you can play an important role not just in treating young people who contract STIs, but in helping them learn about prevention.

Young people are particularly vulnerable to STIs, including HIV, and consequent health problems because:

- ◆ They lack information about how to prevent STIs.
- ◆ They are less likely to seek proper information or treatment due to fear, ignorance, shyness, or inexperience.
- ◆ The risk of acquiring trichomoniasis, chlamydia, genital herpes, or human papilloma virus (HPV) is greater at first exposure to the STI.
- ◆ Adolescent females are more susceptible to infections than older women due to their immature cervixes.
- ◆ Early sexual experience can result in trauma to vaginal tissue, increasing adolescent women’s vulnerability to STIs.
- ◆ Adolescents who begin sexual activity early are more likely to have a greater number of sexual partners over the course of their lifetimes.

HIV — A Sexually Transmitted Infection

In an HIV counseling and testing situation, young people will be most focused on HIV, which is a sexually transmitted infection. Counselors using this manual should already have background information on HIV. A short summary of basic information on HIV transmission, prevention, and treatment follows. The rest of this chapter summarizes information on other STIs, which can have serious consequences and are very important to understand as well.

HIV is most commonly transmitted in one of three ways:

- ◆ Through sexual intercourse (semen and vaginal fluids)
- ◆ Through contact with infected blood (shared or reused needles, accidental sticks with needles, shared razors, body piercing, transfusions of infected blood)
- ◆ From mother to infant during pregnancy or delivery (vaginal fluids) or through breastmilk

HIV is not transmitted:

- ◆ Through the air, the way tuberculosis or colds are
- ◆ By insect bites
- ◆ Through saliva or kissing; “wet” kissing is considered safe if no cuts in the mouth are present
- ◆ Through touching or hugging
- ◆ Through food
- ◆ By sharing plates, cups, or glasses with someone who is infected
- ◆ Through swimming
- ◆ On toilet seats
- ◆ Through condoms (as has been rumored in some countries)

Sexual activities that increase the risk of HIV include:

- ◆ Vaginal sex without a condom
- ◆ Anal sex without a condom
- ◆ Taking semen in the mouth during oral-genital sex
- ◆ Any sexual act that causes bleeding

HIV infection can be prevented through abstinence, mutual monogamy with an uninfected partner, or using condoms correctly during each act of intercourse. Studies among HIV-discordant couples have shown that when male latex condoms were used consistently, even with regular exposure to infection, self-reported consistent condom users had a near-zero risk of HIV. However, among these HIV-discordant couples, inconsistent condom use carries considerable risk of HIV infection.

Among HIV-discordant couples, inconsistent condom use carries considerable risk of HIV infection.

Although there are drugs that can help to manage the symptoms and illnesses of HIV-positive patients, these drugs are expensive and are not widely available in developing countries. The regimens can be difficult to take because of side effects, and in some cases infection may become resistant to drugs. Long-term effects of these drugs on quality and duration of life remain unknown. For the vast numbers of those infected with HIV, the infection will eventually lead to death.

STIs Have Serious Consequences

Young people need to know symptoms that may indicate they have a sexually transmitted infection. Adolescents should be counseled to seek treatment as soon as possible if they have any of the following symptoms:



- ◆ Urethral discharge or painful urination in young men
- ◆ Genital sores or ulcers in young women or men
- ◆ Lower abdominal pain or tenderness in young women
- ◆ Unusual vaginal discharge or vaginal itching in young women
- ◆ Painful urination or painful intercourse for young women

People who contract STIs risk serious long-term health problems, including:

- ◆ Permanent infertility
- ◆ Chronic pain related to pelvic inflammatory disease (females)
- ◆ Cancer of the cervix
- ◆ Heart and brain damage (without treatment, can develop 10 to 25 years after initial exposure to syphilis)

Also, STIs are a risk factor for HIV transmission and acquisition.

STIs can be transmitted from mother to infant during pregnancy and birth. Infants of mothers with STIs may:

- ◆ Have lower birth weights
- ◆ Be born prematurely
- ◆ Be at increased risk of other disease, infection, and blindness

Sexually Transmitted Infections: Issues for Young Women

Generally, the long-term health consequences of an STI can be more numerous and severe for women than for men.

- ◆ A woman's risk of contracting an STI during a sexual encounter appears to be greater than a man's risk because women are biologically more susceptible to STIs.
- ◆ The surface of the vagina is larger and more vulnerable than the skin-covered penis.
- ◆ The amount of ejaculate deposited in the vagina during intercourse is greater than the amount of cervical and vaginal secretions to which a man is exposed.
- ◆ Young women often have a condition called cervical ectopy, in which the cells that line the inside of the cervix extend to the outer surface of the cervix. These cells are more vulnerable to infections such as chlamydia.
- ◆ Once they have an STI, young women are at greater risk of reproductive cancers and infertility. Other health problems can include pelvic inflammatory disease, ectopic pregnancy, and spontaneous abortion.
- ◆ Young women are less likely than men to experience symptoms, so some STIs go undiagnosed until a major health problem develops.

Because young women are especially vulnerable to STIs and their long-term consequences, one of the best ways to protect them is to encourage young men to practice responsible sexual behaviors. Counselors can:

- ◆ Encourage abstinence
- ◆ Encourage sexually active young men to use condoms
- ◆ Help young men learn and identify the signs of STIs
- ◆ Promptly treat STIs or refer young men to a treatment center
- ◆ Encourage young men with STIs to notify their sexual partners immediately
- ◆ Encourage young women to seek diagnosis and treatment promptly if their partners have an STI

Sexually Transmitted Infections: Key Issues to Discuss

Bacterial

Syphilis

- ◆ If untreated, long-term effects include damage to major organ systems, paralysis, deafness, blindness, insanity, spontaneous abortion, stillbirth, premature birth, and death.
- ◆ Women can transmit to infants during birth. Health workers should test all women during the prenatal period.
- ◆ Can be cured with antibiotics.
- ◆ Important to take medications as directed and to finish all medications.
- ◆ Genital ulcers can increase the risk of HIV acquisition, so client should be tested for HIV.

Gonorrhea

- ◆ Scarring of fallopian tubes can lead to infertility.
- ◆ Scarring can lead to sterility and urination difficulty in men.
- ◆ Newborns' eyes can be infected during birth.
- ◆ Can be cured with antibiotics.
- ◆ Important to take all medications as directed and to finish all medications.
- ◆ Can increase risk for HIV.

Chancroid

- ◆ Ulcers can cause a condition that results in an inability to retract the foreskin over the head of the penis among uncircumcised males.
- ◆ Can be cured with antibiotics.
- ◆ Important to take medications as directed and to finish all medications.
- ◆ Clients should see provider 3-5 days after treatment begins, then return weekly until infection is gone.
- ◆ Can increase risk for HIV.

Chlamydia

- ◆ Bacteria can infect urethra, cervix, or other pelvic organs.
- ◆ Scarring of fallopian tubes can lead to infertility or ectopic pregnancy.
- ◆ Newborns' eyes and lungs can be infected at birth.
- ◆ Can be cured with antibiotics.
- ◆ Important to take medications as directed and to finish all medications.
- ◆ Can increase risk for HIV.

Viral

HIV/AIDS

- ◆ No cure, so prevention is crucial.
- ◆ People with HIV may live with minimal symptoms or be symptom-free for many years. However, they may still infect others during this period.
- ◆ Drug therapies may reduce HIV levels in blood and semen, reduce symptoms, and delay onset of AIDS. However, treatments are expensive, have severe side effects, and are not widely available in developing countries.
- ◆ Can be transmitted to infant during pregnancy, childbirth, or breastfeeding.

Genital herpes

- ◆ Pregnancy loss and preterm delivery.
- ◆ Can be transmitted from mother to infant during vaginal delivery if symptoms are present.
- ◆ No cure.
- ◆ Medications can be given to relieve pain, reduce length of outbreak.
- ◆ Abstain from sex while ulcers are present.
- ◆ Can be transmitted even when symptoms are not present.
- ◆ Can increase risk for HIV.

Hepatitis B

- ◆ Long-term problems can include chronic hepatitis, cirrhosis, liver cancer, liver failure.
- ◆ Death possible.
- ◆ Can be transmitted from mother to infant.
- ◆ No cure.
- ◆ Symptoms can be treated.
- ◆ Preventive vaccine available in many industrialized countries.

Protozoan Trichomoniasis

- ◆ Premature childbirth, low birth weight, and risk of HIV acquisition.
- ◆ Can be treated.
- ◆ Return if not cured or problem recurs.

HPV (human papillomavirus)

- ◆ Very common.
- ◆ Usually causes no symptoms and goes away on its own.
- ◆ No cure.
- ◆ Some types cause cervical cancer. Vaccines for these types are available for young females in some countries.
- ◆ Other types cause genital warts, which can be removed by burning, freezing, or using chemicals.
- ◆ If possible, client should undergo Pap smears to detect.

The “good” news about STIs is that they can be prevented, and many can be cured.

The “good” news about STIs is that they can be prevented, and many can be cured. Preventive measures include abstinence, mutual monogamy among uninfected partners, or using male latex condoms correctly during each act of intercourse. Female condoms offer protection against bacterial and possibly viral STIs. Other barrier methods, such as diaphragms or spermicides, may offer some protection from bacterial STIs for women whose partners do not use male condoms.

STIs caused by bacteria can usually be treated successfully with antibiotics. These include gonorrhea, syphilis, chlamydia, and chancroid. Trichomoniasis, a protozoan infection, can also be treated. STIs caused by viruses cannot be cured, although the symptoms of some, including hepatitis B, genital herpes, and HPV, can often be managed so that the client’s quality of life is improved.

The chart on pages 60–61 outlines key STI counseling issues for providers working with young people. It is important to remember:

- ◆ Anyone at risk of STIs should use male latex or female condoms for protection. It is extremely important to use condoms consistently and correctly.
- ◆ Confidential notification of sexual partners is an important element of STI treatment and prevention. Sexual partners should be evaluated and treated, if necessary, to avoid reinfection. Adolescents may have an especially difficult time discussing STIs with sexual partners. You can help by volunteering to notify partners confidentially.
- ◆ Clients who are infected should abstain from sex until their infection is resolved or use condoms to protect their partners.

Pregnancy Prevention

As a service provider or program manager, you can play a vital role in helping young people prevent too-early and unintended pregnancies. You can:



- ◆ Educate young people about how their bodies function, what changes accompany puberty, and how pregnancy occurs.
- ◆ Inform youth that reproductive health is a lifelong process.
- ◆ Empower youth to delay sexual relations until they feel ready to accept sexual responsibility.
- ◆ Help young people develop decision-making skills and feel confident and empowered to follow through on decisions.
- ◆ Provide adolescents with information about the health, emotional, and socioeconomic risks of adolescent pregnancy.
- ◆ Provide referrals and help for young people who feel powerless to determine when they have sex and with whom.

- ◆ Inform about and offer access to safe, effective, and affordable contraception.
- ◆ Encourage sexually active youth to think about dual protection, using a combination of contraceptives to prevent unintended pregnancy and the transmission of HIV and other STIs.

As you begin to work with adolescents, you may find that your goals differ from the goals of the young people you serve. You may want to encourage adolescents to delay sexual activity. You may want couples to consider birth spacing, but young women and men may not want to use contraception until they have reached their desired family size. However, it is important to guard against letting personal biases influence professional behavior. You need to provide information but also to listen to, support, and encourage young people to make their own decisions and good choices for their future, based on their knowledge and reproductive goals.

When counseling youth about contraception, you should explain that adolescent pregnancy carries special health risks. Even when a pregnancy is wanted and planned, the risks are higher for adolescent mothers and their infants. You can explain that there are both health and socioeconomic reasons to delay childbearing until a woman is in her twenties.

You should explain that adolescent pregnancy carries special health risks.

Why Delay Childbearing?

- ◆ A young woman under age 16 has not reached physical maturity. If her pelvis is too small, she may suffer prolonged labor or obstructed delivery, which can result in death of mother or infant, hemorrhage, infection, or fistula. A fistula is an abnormal passage created between two internal organs or between an internal organ and a body surface. In prolonged or obstructed labor, fistulas may occur between the vagina and rectum or urethra, leading to incontinence and other health problems.
- ◆ Young women, especially those under age 15, are more likely than women age 20 and older to experience premature labor, spontaneous abortion, and stillbirths.
- ◆ First births are typically more risky than subsequent births. Women giving birth for the first time have a higher probability of developing hypertensive disorders, including preeclampsia and eclampsia, conditions marked by protein in the urine, high blood pressure, and edema.
- ◆ Infant death rates are typically higher for adolescent mothers than for older women.
- ◆ Delaying childbearing can give young women the opportunity to pursue formal education and work outside the home.
- ◆ Men who delay the start of their families can pursue educations and jobs without the pressure of providing for a family.
- ◆ Delayed pregnancy can mean smaller families and can offer economic benefits for the couple.



Contraceptive Methods for Adolescents

Although all methods are medically safe for young people, some are more appropriate than others. Sterilization is not recommended for young people because it is permanent and because the younger the client, the stronger the likelihood of regret. This chart offers information on contraceptive methods and their use by adolescents. The pregnancy rates shown are for “perfect use,” which refers to using a method consistently and correctly at every act of intercourse, and “typical use,” which usually has a pregnancy rate higher than perfect use.

Method/Pregnancy Rate : Appropriate and Safe for Adolescents? : Counseling Issues

Perfect Use/Typical Use

Abstinence

Yes, appropriate for those who have not yet begun sexual activity, as well as for those who have.

- ◆ Surest way to prevent pregnancy and STIs, including HIV.
- ◆ Requires high degree of motivation, self-control, and commitment from both partners.

Male condoms

2%/15%

Yes. Condoms are typically accessible, available, and affordable to young people. Protect against STIs/HIV.

- ◆ Must be used correctly and consistently with each act of intercourse.
- ◆ Can be used with other contraceptives except female condom.
- ◆ No systemic effects, although some individuals are allergic to latex.
- ◆ Clients should be instructed to use emergency contraceptive pills (ECPs) as a backup method when condom breaks or slips. ECPs can be given in advance.

Female barrier methods

female condom 5%/21%
diaphragm 6%/16%

Yes. Female condoms provide some protection from STIs/HIV.

- ◆ Must be used consistently and correctly with each act of intercourse.
- ◆ Can be used alone or in combination with other contraceptives, except the female condom with male condom.
- ◆ No systemic effects.

Spermicides
foaming tablets, foams, films, gels, suppositories, and creams
18%/29%

Yes, although they do not provide good protection from pregnancy and STIs. They should be used only when other methods are not available (better than no method at all).

- ◆ Must be used consistently and correctly with each act of intercourse.
- ◆ Not as effective as some other methods.
- ◆ Clients must follow directions about how to place high in vagina and how long to wait before intercourse can begin.
- ◆ New application of spermicide is necessary for repeated acts of intercourse.
- ◆ Must be left in place at least six hours after intercourse (douching or rinsing the vagina is not recommended).
- ◆ Can be used simultaneously with condoms, used as a backup for other contraceptives, or used when a couple changes from one method to another.
- ◆ Side effects include vaginal or penile irritation; switching to another type of spermicide can help. If used often, may increase risk of HIV infection.

Combined oral contraceptive pills (COCs)
(contain estrogen and progestin)
0.3%/8%

Yes. Do not protect against STIs/HIV.

- ◆ Must be taken daily to be effective.
- ◆ Fertility returns quickly when pills are discontinued.
- ◆ Clients need directions on what to do if pills are missed (see page 72).
- ◆ Possible side effects: nausea, headache, breast tenderness, bleeding changes.
- ◆ Noncontraceptive benefits: regular and less painful menses; reduced risk of ovarian cancer, endometrial cancer, ectopic pregnancy and symptomatic pelvic inflammatory disease.
- ◆ Not recommended for breastfeeding women.

Method/Pregnancy Rate Perfect Use/Typical Use	Appropriate and Safe for Adolescents?	Counseling Issues
Progestin-only pills (POPs) 0.3%/8%	Yes. Do not protect against STIs/HIV.	<ul style="list-style-type: none"> ◆ Must be taken daily to be effective; should be taken within three hours of the same time every day. ◆ Good choice for breastfeeding women because they do not contain estrogen. ◆ Fertility returns quickly when pills are discontinued. ◆ Clients need directions on what to do if pills are missed. ◆ Possible side effects: irregular menstrual cycles, spotting and bleeding between periods, amenorrhea.
Injectables <i>progestin-only and combined injectables (contain estrogen and progestin)</i> 0.3%/3%	Yes. Concerns exist about effects of progestin-only injectables on bone density when given during adolescence, but benefits generally outweigh risks. Do not protect against STIs/HIV.	<ul style="list-style-type: none"> ◆ Common side effects: irregular menstrual bleeding, prolonged bleeding, amenorrhea. ◆ Less common side effects: weight gain, headaches, dizziness, and mood changes. ◆ Noncontraceptive benefits: decreased risk of symptomatic pelvic inflammatory disease, ectopic pregnancy, and endometrial cancer. ◆ Pregnancy may not occur for up to nine months after discontinuation. ◆ Clients must remember to return for reinjections.

Subdermal implants
0.05%/0.05%

Yes. Do not protect against STIs/HIV.

- ◆ Offers three to seven years of contraceptive protection, depending on the product.
- ◆ Possible side effects: lighter, irregular bleeding or amenorrhea.
- ◆ Implant insertion and removal are surgical procedures requiring a trained provider.

Intrauterine devices (IUDs)
0.6%/0.8%

Yes. Appropriate for women in stable, mutually monogamous relationships. Women under age 20 who have not given birth appear to have greater risks for expulsions. Do not protect against STIs/HIV.

- ◆ Safe, effective, and requires little effort on the part of the user.
- ◆ Copper T IUD offers pregnancy protection for at least 12 years.
- ◆ Side effects of copper IUDs include heavier menses, cramping.
- ◆ User should check IUD strings monthly to make sure device remains in place.
- ◆ Clients should be told to come back immediately if they have abdominal pain, fever, chills, delayed menses, or missing strings.

Fertility awareness-based methods
4-5% (Two Day and Standard Days)/Not available

Yes, when regular menstrual cycles are established. Do not protect against STIs/HIV.

- ◆ Training is essential to help young people understand fertility and menstruation and to identify fertile and nonfertile times.
- ◆ Requires high degree of motivation, self-control, and commitment from both partners.
- ◆ Irregular menstrual cycles, such as in months following menarche or pregnancy, complicate use.
- ◆ Can be used alternatively with other contraceptives (such as condoms or diaphragms) during fertile days.
- ◆ Not as effective as some other methods.

Not available/25%
(other methods)

Method/Pregnancy Rate Appropriate and Safe for Adolescents? Counseling Issues

Perfect Use/Typical Use

Lactational

Amenorrhea Method (LAM)

0.9%/2% (for 6 mos. after birth)

Yes. Does not protect against STIs/HIV.

- ◆ Appropriate for women who are less than six months postpartum, fully or near-fully breastfeeding, and amenorrheic.
- ◆ 98% effective if women meet all three criteria.
- ◆ If any criteria change, client may not be protected from pregnancy.
- ◆ Client should discuss other contraceptive options before LAM criteria expire and receive chosen method in advance. (Breastfeeding women should avoid methods containing estrogen since the hormone can affect breastmilk production.)

Withdrawal

4%/27%

Yes. Does not protect against STIs/HIV.

- ◆ Can be used by a man at any age if he can predict ejaculation and ensure ejaculate will not come in contact with his partner's genital area.
- ◆ Requires a high degree of motivation, self-control, and commitment from both partners.
- ◆ Not as effective as some other methods.

Sterilization

Female: 0.5%/0.5%

Male: 0.10%/0.15%

No medical reason to deny sterilization to youth, but generally not recommended for people at the beginning of childbearing years. Does not protect against STIs/HIV.

- ◆ Not recommended for adolescents; young age and low parity are associated with high levels of regret.
- ◆ Any individual seeking sterilization should be counseled that it is a permanent method.

**Emergency
contraceptive
pills (ECPs)**

**POPs prevent 85%
95% of pregnancies if
used within 72 hours.**

**COCs prevent 57%
77% of pregnancies if
used within 72 hours**

(Either can be used
up to 5 days, but
effectiveness
decreases.)

Yes. Effective method of pregnancy prevention for couples who have unplanned sexual intercourse, who forget to use a method, or who experience condom breakage or slippage. Can be used by women and girls forced or coerced into sexual activity. Do not protect against STIs/HIV.

- ◆ Counsel about proper pill dosage.
- ◆ Possible side effects for ECPs: nausea and vomiting.
- ◆ Antiemetic drugs can help reduce nausea.
- ◆ Nausea and vomiting less common with progestin-only ECPs.
- ◆ Start within 120 hours (5 days) after unprotected intercourse. The earlier the method is started, the greater the effectiveness.
- ◆ Counsel to have a pregnancy test if menstruation is more than one week late.
- ◆ Counsel about the use of a regular contraceptive method.
- ◆ Clients can receive ECPs in advance and use them as needed.
- ◆ POPs are more effective as ECPs than COCs in preventing pregnancy.
- ◆ Specially marketed ECP products are available in many countries.

Source for pages 66–71: Contraceptive Effectiveness. In World Health Organization, Johns Hopkins Bloomberg School of Public Health, and U.S. Agency for International Development, *Family Planning: A Global Handbook for Providers*, 2007.

Contraceptive Methods: Other Issues

Several other issues dealing with contraception for adolescents are discussed below: abstinence, what to do about missed pills, and dual protection.

Abstinence

Saying no to sex can be difficult for many young people. There may be pressure from peers who claim “everyone” is having sex, or pressure from partners who argue that sex is the best way to prove love and affection, or pressure from older friends and relatives who say having sex is a way to show that you are an adult.

You can help youth develop “refusal skills” by counseling them about abstinence.

Adolescents may not feel they have many choices, but as a provider, you can explain to young people that they can say no to sex if they are not ready or if they have in the past had sex (voluntarily or coerced) and now want to be abstinent. You can help them develop “refusal skills” by counseling them about abstinence. One way to do this is to help them imagine situations in which they might find themselves and help them practice saying no. For some examples of how to help youth to choose abstinence, see pages 44–45.

What to Do about Missed Oral Contraceptive Pills

If a young woman forgets to take combined oral contraceptives (COCs), you can explain that the World Health Organization has provided guidance for the standard low-dose pill that is easy to follow. The key concept is: Just keep going. Whenever a woman realizes she has missed pills, regardless of



how many she has missed, she should take one as soon as she remembers —and continue taking a pill every day at the usual time. That may mean taking two pills at the same time or on the same day. Two additional points help round out the recommendation:

1. If she misses three or more pills, she should use a backup method (or abstain) for seven days.
2. If the missed pills occur in the third week of the cycle, she should skip the seven placebo pills and just go on to a new pack.

Even when women miss several pills in the middle of the pack, the probability of a viable ovulation is rather low. The risk increases if the missed pills are at the beginning or end of the 21 active pills, which in effect increases the vulnerable pill-free interval to more than seven days.

Dual Protection

Because many young people face the double risk of unintended pregnancy and STIs, dual protection may be recommended.

Dual protection is defined as the simultaneous prevention of STIs (including HIV) and unintended pregnancy. For example, a couple may use condoms to protect against STIs and oral contraceptives to prevent unintended pregnancy. Or they may use condoms as their primary means of preventing pregnancy and transmission of STIs, with emergency contraception as a backup to prevent unintended pregnancy if the condom breaks or slips. Practicing abstinence is also an option.

Although dual protection offers obvious benefits, its use can be problematic for adolescents. This is because both abstinence and consistent use of condoms require high motivation, and members of this age group may have difficulty using two methods consistently and correctly.

Negotiating Condom Use

You can help adolescents learn to negotiate condom use by:

- ◆ Encouraging young people to talk about contraception and STI protection before they have sex.
- ◆ Encouraging young men to take responsibility for protecting themselves and their partners by preventing an unintended pregnancy or STI.
- ◆ Helping young women learn the skills they need to insist on condom use.
- ◆ Helping young people overcome embarrassment in talking about condoms.

One strategy that is effective in helping young people negotiate condom use is role-playing (see page 47). In a one-on-one counseling session, you and your young client can pretend to be a couple discussing condom use. In a larger group setting during an education session, for example, you may ask two young people to volunteer to participate.

Life Skills



Life skills are practical behaviors needed to meet the demands of everyday life. Young people who are adept at life skills are better equipped to make healthy choices and avoid risky behavior. Some examples of life skills are critical thinking, being assertive, and developing good support networks.

If you have time, you can introduce these skills during pretest and posttest counseling. You can also refer clients to other services to learn more.

Developing Critical Thinking

Help young people learn to be wise “consumers” of information. Offer clients these tips to becoming critical thinkers:

- ◆ Do not accept everything you read or hear as truth. Look at the source of the information. Is the person who told you knowledgeable and reliable or might they just be repeating false rumors? Did you get your facts from a tabloid newspaper or a respected news source? What about the Internet? Did the site look professional, and was it sponsored by a reputable organization?
- ◆ Consider the goals of the source of your information. Is someone trying to sell you something? Are people who say they are your “friends” really looking for someone to engage

in risky behavior with them? If people have only their own best interests in mind, you would be wise to question their messages.

- ◆ Remember the saying: If something sounds too good to be true, then it probably is not true. Will having sex make you more beautiful, manly, or healthy? No. Will having sex mean he or she will love you forever? No. Will taking drugs solve all your problems and leave you carefree? No. Question anything that sounds like a quick and simple solution to a problem.
- ◆ Ask! If you read or hear something that does not seem true, ask a teacher, trained peer counselor, adult counselor, religious leader, parent, or other trusted adult.

Being Assertive

Being assertive means being confident, standing up for oneself and what one thinks is right, and believing in oneself. Assertive people are less likely to be influenced by peer pressure and more likely to make long-term positive behavior change. People who are assertive:

- ◆ Speak clearly and firmly, but politely
- ◆ Maintain eye contact when speaking to others (when culturally appropriate)
- ◆ Avoid arguments with people who disagree with you; simply state your opinion and agree to disagree
- ◆ Find role models who seem assertive — such as a teacher, relative, or friend — and watch how they act
- ◆ Remember that being assertive is not the same thing as being aggressive

Acknowledge that it is not always easy to be assertive, but suggest that practicing can help.

Developing Good Support Networks

Encourage your clients, whether or not they decide to be tested, to seek out people who support them. Supportive friends, family, and others can be a remedy for depression and loneliness and can encourage young people in their quest to lead happier, healthier lives.



Supportive people:

- ◆ Are honest and genuine
- ◆ Respect their friends
- ◆ Do not pressure their friends to do something that is dangerous or wrong
- ◆ Are trustworthy
- ◆ Do not tease, hurt, or abuse people
- ◆ Listen
- ◆ Maintain confidentiality
- ◆ Want what is best for the people they care about

Your clients may feel bad if they recognize that a certain “friend” or family member is not supportive. Acknowledge their feelings and encourage them to choose more positive friends.

Creating a Referral Network



Rarely can a single facility, agency, or community group deliver all the services that youth need. A well-established referral network is vital to meeting the needs of young people and maintaining contact with those who require on-going support. A good referral network should:

- ◆ Increase youth's access to needed services.
- ◆ Ensure confidentiality.
- ◆ Track referrals between organizations in the referral network.
- ◆ Document referrals and their outcomes.
- ◆ Solicit feedback from clients to see if the organization to which they were referred met their needs.

You can create a referral network for your clinic or program by using the following pages and by taking these steps:

- ◆ Create a referral book or a set of referral cards.
- ◆ List the names of other reputable organizations in your community that work with adolescents.
- ◆ List their address, telephone number, and the name of a person for young clients to contact. Try to ensure that this contact person has experience working with youth.
- ◆ Make this list available to all staff in your clinic or program.
- ◆ Regularly update your referral book to ensure that contact information, location, or hours of any of the organizations in your network have not changed.

For more information on developing an effective referral system, see “Establishing Referral Networks for Comprehensive HIV Care in Low-Resource Settings,” which is available online at <http://www.fhi.org/en/HIVAIDS/pub/guide/refnet.htm>.

Organizations/clinics that provide HIV-related services

Name of organization	Address	Telephone
1.		
2.		
3.		
4.		

Organizations/clinics that provide contraceptive services

Name of organization	Address	Telephone
1.		
2.		
3.		
4.		

Organizations/clinics that provide STI screening/treatment

Name of organization	Address	Telephone
1.		
2.		
3.		
4.		

Organizations/clinics that provide care for victims of sexual violence

Name of organization	Address	Telephone
1.		
2.		
3.		
4.		

Organizations/clinics that provide psychological or mental health counseling

Name of organization	Address	Telephone
1.		
2.		
3.		
4.		

Organizations that work with adolescents (YWCA, YMCA, scouts, youth groups, etc.)

Name of organization	Address	Telephone
1.		
2.		
3.		
4.		

Resources

Family Health International. *VCT Toolkit*. Arlington, VA: Family Health International, 2002-2004. Tools from this kit are summarized below, which is available at: <http://www.fhi.org/en/HIVAIDS/pub/guide/vcttoolkit.htm>

- ◆ Boswell D, Baggaley R. *Voluntary Counseling and Testing and Young People: A Summary Overview*, 2002. This 28-page booklet summarizes issues related to VCT and youth, including the relevance and rationale of VCT for youth, approaches and service models to consider, the diversity of young people, barriers to consider, advocacy messages, short case studies, and more.
- ◆ Sangiwa G. *A Guide to Establishing Voluntary Counseling and Testing Services for HIV*, 2002. This 11-page guide describes what a program establishing VCT services needs at the assessment, design, and implementation phases, and summarizes minimum staff, space, equipment, and supply needs.
- ◆ Sangiwa G, Kamenga C, Boswell D, et al. *HIV Voluntary Counseling and Testing: A Reference Guide for Counselors and Trainers*, 2004. This 125-page guide includes basic information on HIV/AIDS and other STIs, HIV testing issues, counseling concepts, strategies to promote behavior change, pretest and posttest counseling frameworks, care and social support issues, loss and bereavement issues, counselor support issues, monitoring and supervision issues, and ethical issues.
- ◆ Sangiwa G. *Voluntary Counseling and Testing for HIV: A Strategic Framework*, 2003. This short (nine-page, plus appendices) description of a strategic framework provides a conceptual approach to undertaking the various aspects of a VCT program.
- ◆ Walkowiak H, Gabra M, van Praag E, et al. *Commodity Management in VCT Programs: A Planning Guide*, 2002. Done in conjunction with Management Sciences for Health, this 39-page guide summarizes issues related to HIV test kits and other commodities at VCT services, with a case study from Zambia and recommendations.

Other Resources

Finger W. *HIV: Voluntary Counseling and Testing. YouthLens No. 3.* Arlington, VA: Family Health International/YouthNet, 2002.

<http://www.infoforhealth.org/youthwg/youthlens.shtml> (scroll to No. 3).

This four-page research brief synthesizes the research and programmatic directions on the issue of VCT and youth available at the time of publication, summarizing demand for services, impact of VCT on behavior, and programmatic challenges.

Horizons Program, Kenya Project Partners, Uganda Project Partners. *HIV Voluntary Counseling and Testing among Youth Ages 14 to 21: Results from an Exploratory Study in Nairobi, Kenya, and Kampala and Masaka, Uganda.* Washington, DC: Population Council, 2001.

<http://www.popcouncil.org/pdfs/horizons/vctyouthbaseline.pdf>

This report focuses on the attitudes and opinions toward VCT of youth in Kenya and Uganda who either have or have not taken a VCT test.

International Planned Parenthood Federation/South Asia Regional Office (IPPF) and United Nations Population Fund (UNFPA). *Integrating HIV Voluntary Counselling and Testing Services into Reproductive Health Settings: Stepwise Guidelines for Programme Planners, Managers and Service Providers.* London: IPPF/South Asia Regional Office and UNFPA, 2004.

http://www.unfpa.org/upload/lib_pub_file/245_filename_hiv_publication.pdf

This 77-page set of guidelines for integrating VCT into reproductive health settings is based on the experiences of four project sites who piloted VCT services into existing reproductive health services, two in India and two in the Ivory Coast. Staff and clients at these four sites contributed to the development of the guidelines. The guidelines

are designed to help reproductive health services planners, managers, and providers integrate VCT into their services.

McCauley A, Juma MA, Kirumira E, et al. *Attracting Youth to Voluntary Counseling and Testing Services in Uganda, Horizons Research Summary*. Washington, DC: Population Council, 2004.

<http://www.popcouncil.org/horizons/ressum/vctyth/vctythsum.html>

This eight-page report provides results from a program that established youth-friendly VCT services and a youth-centered media outreach campaign and measured the success of the intervention.

McCauley AP. *Equitable Access to HIV Counseling and Testing for Youth in Developing Countries: A Review of Current Practice, Horizons Report*. Washington, DC: Population Council, 2004.

<http://www.popcouncil.org/pdfs/horizons/vctythrvw.pdf>

This 18-page report reviews VCT programs for youth worldwide and gives recommendations for increasing access to such programs for youth in developing countries.

Revised guidelines for HIV counseling, testing: technical expert review of CDC HIV counseling, testing and referral guide. *MMWR Recommendations and Reports*. November 9, 2001/50(RR);1-58.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5019a1.htm>

This 51-page, online publication summarizes the findings of the U.S. Centers for Disease Control and Prevention (CDC) expert group that revised the VCT guidelines in 2001. It includes useful tables and charts on counseling and HIV testing issues.

World Health Organization. *Rapid HIV Tests: Guidelines for Use in HIV Testing and Counselling Services in Resource-Constrained Settings*. Geneva: World Health Organization, 2004.

<http://www.who.int/hiv/pub/vct/en/rapidhivtests/en.pdf>

These 48-page guidelines from WHO, done in collaboration with the U.S. Centers for Disease Control and Prevention, provide a valuable reference tool on the evolution of approaches to HIV testing and counseling, advantages of using rapid tests, testing strategies and practical considerations for rapid tests, quality assurance, and suggested protocols and checklists regarding counseling for negative and positive results.

Youth-Friendly Services programs area page on the Web site of the Interagency Youth Working Group.

http://www.infoforhealth.org/youthwg/prog_areas/youth-friendly.shtml

This site links to numerous resources including reports, tools and curricula by WHO, FHI, Pathfinder, CEDPA, IPPF, PSI, and others.

Notes

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