

**TRAINING MANUAL
FOR ADOLESCENT SEXUALITY**



**MEDICAL WOMEN'S
INTERNATIONAL ASSOCIATION**

2004

revised 2013



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PREFACE TO THE REVISED EDITION

The Medical Women's International Association (MWIA) is an international non-governmental organization (NGO). Women physicians in more than seventy countries make up the membership. The association was founded in 1919. Embodied in its mission is the objective to raise the health status of the communities in which the members work, especially the health of women and children in those communities.

In December, 2001, MWIA held a conference at the Rockefeller Study and Conference Center in Bellagio, Italy, under the Center's International Conference Program. The result was the development of a *Training Manual on Gender Mainstreaming in Health*, which has been successfully used at workshops throughout the world to educate physicians about the importance of incorporating a gender perspective into health care.

Following the success of the Gender Mainstreaming Manual, MWIA decided that a manual on Adolescent Sexuality was a logical offshoot. Sexuality is very closely related to the topic of gender mainstreaming in health as many of the issues are related to the socialization of men and women in various societies. Dr. May Cohen once again provided the expertise and Dr. Shelley Ross the logistical support.

To understand the connection between gender mainstreaming and sexuality, the following definitions are helpful:

Gender can be seen as the full range of personality traits, attitudes, feelings, values, behaviours and activities that society ascribes to the two sexes on a differential basis. It is a social construct, which varies from society to society and over time.

Sex is a biological description, which is determined by biology. However, even sex may not be wholly dichotomous as is made evident by inter-sexed individuals.

Sexuality refers to the capacity for sexual feelings and their expression – again this capacity is not necessarily dichotomous between men and women. (E.g. Heterosexuality, homosexuality and bisexuality.)

Sex and Gender are interactive. While sex and its associated biological functions are programmed genetically, gender roles and power relations vary across cultures and through time, and thus are amenable to change.

Gender roles are the particular economic, social roles and responsibilities considered appropriate for women and men in a given society. Gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationship between women and men, girls and boys.



Gender role socialization means that different societies have different ideas of what constitutes male and female behaviour. A fuller understanding of gender includes recognition of gender as a social construct, as a system of social stratification and an institution that structures every aspect of our lives because of its embeddedness in the family, the workplace, the health care system and the state as well as in sexuality, language, and culture. It is a primary way of signifying relationships of power. Each culture is deeply invested in its construction of gender roles and those who benefit from the existing system may strongly resist efforts to change, or even describe it.

Gender Mainstreaming in Health means applying these concepts to health and health care so that women and men receive care in accordance with their needs.

Gender analysis shows us how different cultural norms of masculinity and femininity influence sexual knowledge and behaviour.

The updated version of MWIA's *Training Manual for Adolescent Sexuality* continues to help physicians address the concerns, questions and problems that adolescents experience in dealing with their sexuality with inclusion of changes in generational thoughts and activities. Above all, its intent is to help physicians play an important role in teaching adolescents about "healthy sexuality." It uses cases to make the information understandable and relevant to physicians. The purpose of the manual is to improve clinical practice in this area and to facilitate and enhance physician input into policy development with respect to community health and education.

Healthy sexuality promotes the enhancement of life and of personal relations. The physician's role should not be limited to reproduction and sexually transmitted infections (STI) but should include counselling about the positive aspects of sexual health.

Many thanks go to Dr. Bettina Pfleiderer and the Scientific Committee of MWIA for updating and modernizing the manual.

Shelley Ross, M.D., C.C.F.P., F.C.F.P.
Secretary General, Medical Women's International Association



PREFACE

The Medical Women's International Association (MWIA) is an international non-governmental organization (NGO). Women physicians in more than seventy countries make up the membership. The association was founded in 1919. Embodied in its mission is the objective to raise the health status of the communities in which the members work, especially the health of women and children in those communities.

In December, 2001, MWIA held a conference at the Rockefeller Study and Conference Center in Bellagio, Italy, under the Center's International Conference Program. The result was the development of a Training Manual on Gender Mainstreaming in Health, which has been successfully used at workshops throughout the world to educate physicians about the importance of incorporating a gender perspective into health care.

MWIA decided to develop further training materials for physicians. Sexuality is very closely related to the topic of gender mainstreaming in health as many of the issues are related to the socialization of men and women in various societies. As indicated above, this topic is extensively addressed in the Training Manual on Gender Mainstreaming in Health. Very briefly, a few of the definitions in that manual are repeated here.

Gender can be seen as the full range of personality traits, attitudes, feelings, values, behaviours and activities that society ascribes to the two sexes on a differential basis. It is a social construct, which varies from society to society and over time.

Sex is a biological description, which is determined by biology. However, even sex may not be wholly dichotomous as is made evident by inter-sexed individuals.

Sexuality refers to the capacity for sexual feelings and their expression – again this capacity is not necessarily dichotomous between men and women. (e.g. Heterosexuality, homosexuality and bisexuality.)

Sex and Gender are interactive. While sex and its associated biological functions are programmed genetically, gender roles and power relations vary across cultures and through time, and thus are amenable to change.

Gender roles are the particular economic, social roles and responsibilities considered appropriate for women and men in a given society. Gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationship between women and men, girls and boys. Gender role socialization means that different societies have different ideas of what constitutes male and female behaviour. A fuller understanding of gender includes recognition of gender as a social construct, as a system of social stratification and an institution that structures every aspect of our lives because of its embeddedness in the family, the workplace, the health care system and the state as well as in sexuality, language, and culture. It is a primary way of signifying relationships of power. Each culture is deeply invested in its construction of gender roles and those who benefit from the existing system may strongly resist efforts to change, or even describe it.



Gender Mainstreaming in Health means applying these concepts to health and health care so that women and men receive care in accordance with their needs.

Gender is an important determinant of health. To obtain further information about Gender Mainstreaming in Health please refer to the MWIA's Training Manual for Gender Mainstreaming in Health, which can be found at www.mwia.net.

With the global community focusing on the adolescent, the MWIA decided that the logical next project would be to develop a Training Manual for Adolescent Sexuality.

Gender analysis shows us how different cultural norms of masculinity and femininity influence sexual knowledge and behaviour.

MWIA's Training Manual for Adolescent Sexuality has been developed to help physicians address the concerns, questions and problems that adolescents experience in dealing with their sexuality. Above all, its intent is to help physicians play an important role in teaching adolescents about "healthy sexuality." It uses cases to make the information understandable and relevant to physicians. The purpose of the manual is to improve clinical practice in this area and to facilitate and enhance physician input into policy development with respect to community health and education.

Healthy sexuality promotes the enhancement of life and of personal relations. The physician's role should not be limited to reproduction and sexually transmitted infections (STI) but should include counselling about the positive aspects of sexual health.

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(2004)



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Without financial backing, many good ideas never come to be. Due to the generous financial support of the United Nations Population Fund (UNFPA), the idea for this Training Manual has been allowed to grow and develop into the finished product.

The ideas contained in this manual are those of the Medical Women's International Association and do not necessarily represent the official policy of UNFPA.

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DISCLAIMER

This is not intended to be a textbook but is intended to provide guidelines to physicians in dealing with the topic of adolescent sexuality. There are a large number of textbooks on these various issues, which are readily available in many medical libraries.

A list of references and websites follows the didactic portion of the manual.



COURSE OBJECTIVES

After completing this workshop, participants should be able to answer the following questions:

- Can you acknowledge your own values and beliefs about sexuality?
- Can you accept the values of others about sexuality although they may not coincide with your own?
- Can you talk with adolescents about sexuality in a non-judgemental manner? Do you have the skills to talk about issues of sexuality?
- Do you have adequate knowledge about adolescent sexuality?
- Are you willing to deal with the adverse consequences which may result from adolescent sexual activity?



ADOLESCENT SEXUALITY

INTRODUCTION

The Beijing Conference in 1995 defined reproductive health as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. The definition goes on to speak of freedom to choose if, when and how often to reproduce and also the right to adequate methods of family planning. It also includes sexual health, the purpose of which is the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted infections (STI).

Sexual health has also been defined as the integration of the somatic, intellectual and social aspects of sexual being, in ways that are positively enriching and that enhance personality, communication and love.

And the Sex Information and Education Council of the United States states that sexuality refers to the totality of being a person. It reflects human character and the way humans interact with each other; it is a multi-dimensional concept and includes ethical, psychological, biological and cultural dimensions.

While sexual and reproductive rights are currently recognized as fundamental to maintaining and improving health, these rights are often at odds with ancestral traditions and customs.

However after the Cairo Conference (1994) on Population and Development, the Copenhagen Conference (1995) on Social Development, and the Beijing Conference, it has been accepted that sexual and reproductive rights must be addressed through a more integrated approach that includes people's rights to make free and responsible choices about sexuality and reproduction without being subjected to coercion, discrimination or violence.

This topic is very closely related to the topic of gender mainstreaming in health because many of the issues are related to the socialization of men and women in various societies. Gender analysis helps us to understand how fundamental cultural norms of masculinity and femininity influence sexual knowledge and behaviour.

WHY ADOLESCENT SEXUALITY?

Adolescence is a time of self-discovery along with physical as well as cognitive development. The World Health Association defines adolescence as the ages between 0 and 9, youth as ages 5 to 24 and young people as ages 0 to 24. The definition of adolescence strictly on chronological age is not always practical and the following definition by the Canadian Paediatric Society may be more practical: Adolescence begins with the onset of physiologically normal puberty, and ends when an adult identity and behaviour are accepted. This period of development corresponds roughly to the period between the ages of 0 and 9 years, which is consistent with the World Health Organization's definition of adolescence. (Canadian Paediatric Society. Age Limits and Adolescents. Paediatric Child Health 2003; 8(9).)



It is within this context that adolescent sexual development and behaviour occur. Becoming a sexual person is one of the roles of adolescence and presents difficulties for many young people in accomplishing these tasks in a responsible and healthy manner. The quality of their future lives depends to a great degree on the extent to which adolescents take advantage of opportunities for personal growth by going to school, and being employed, while avoiding potentially problematic outcomes of sexual relations. There is awareness of the concerns about pregnancies occurring too early in life, HIV and other STI's.

While the issues certainly vary in different societies, where cultural traditions, religious beliefs and ethnicity differ, there are many similarities between the needs of adolescents regardless of where they live. While the issues surrounding expression of sexuality become very important during adolescence, human beings are sexual throughout their entire lives although, at different points in life sexuality may manifest itself in different ways.

This manual is designed for use in interactive workshops, as there are a number of ways to think about these issues. The section on true and false statements is intended to provide an opportunity for exchanging points of view and providing information based on your own perspectives and experience and not meant to grade or judge anyone for their ideas. The answers to these true/false questions are at the end of the narrative section and are intended as a review of the material presented in the manual.

The following quotations reflect the basic concepts, which are further which are elaborated upon throughout the manual.

"Adolescents obtain their health information from a number of sources. Health care providers are high on the list of the most valued of these sources. Therefore, clinicians need to continue to develop their approach and communication skills with their adolescent patients. One of the challenges of adolescent medicine is helping your patients in finding a path to a healthy lifestyle they are comfortable with. It is essential for you to get the information you need to assess and diagnose health issues, and for the patient to get the information he/she needs to deal effectively with (these) health issues. Adolescents want very much to show they are mature and 'can handle things themselves', but at the same time, some of the medical and psychosocial issues they confront may require them to be more dependent. The health care provider must deliver information in such a way as to allow the patient to participate in their own care to the limit of their capabilities developmentally, physically and emotionally, whether they have a short term, chronic or life-threatening condition.

In addition to the young person who presents with a specific complaint, the physician has much to discuss with 'healthy' youth in the office. It is in fact during these adolescent years that behaviour such as eating habits, safe sex practices and physical activity regimens become established. It is also at this time that decisions concerning alcohol and substance use are often made." (Sacks D. An approach to interviewing adolescents. *Paediatric Child Health* 2003; 8(9):554)

"Becoming a sexual person often brings young people into conflict with their family, church, [and community]. These conflicts are compounded by factors including fear of disease, the need for acceptance from peers and lack of emotional maturity. The object of one's sexual attraction may become problematic if that person is someone from a different race or religion or if the attraction is to someone of the same sex.



Yet, within this context of conflict most adolescents do make judgments about their sexuality and sexual orientation not only with a paucity of accurate information but with an abundance of misinformation which includes myths and contemporary images of sexual intimacy." (Hughes J, McCauley A. Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries. *Studies in Family Planning* 998; 29:233-245.)

"Although social customs usually discourage sexual relations before marriage, available evidence from surveys suggests that premarital sex is common in many developing countries." (Although this survey was done in developing countries, the same is felt to be true in developed countries as well.) (Hughes J, McCauley A. Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries. *Studies in Family Planning* 998; 29:233-245.)

"In matters of sexuality, reproduction and marriage, the most important forces shaping modern day adolescence are each society's particular cultural values and institutions which to a considerable degree remain unchanged." (Hughes J, McCauley A. Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries. *Studies in Family Planning* 998; 29:233-245.)

"Cultural values regarding sexuality, gender roles, the power dimensions of adolescents' intimate relationships, and economic disadvantage exert powerful influences of how adolescents in developing countries make sexual and reproductive decisions". (Although this survey was done in developing countries, the same is felt to be true in developed countries as well.) (Hughes J, McCauley A. Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries. *Studies in Family Planning* 998; 29:233-245.)

"Current health [and education] programs are falling short of helping young people acquire the knowledge skills and behaviours they need." (Hughes J, McCauley A. Improving the Fit: Adolescents' Needs and Future Programs for Sexual and Reproductive Health in Developing Countries. *Studies in Family Planning* 998; 29:233-245.)

"Trends in adolescent sexual behaviour are changing and health professionals need to be aware of these trends to provide necessary medical care and education to this population." (Feldman J, Middleman A D. Adolescent Sexuality and Sexual Behaviour. *Current Opinion in Obstetrics and Gynecology* 2002; 4: 489-493.)

"One of the most glaring deficiencies in many countries is the complete absence of adolescent sexual and reproductive health services. Young people often find it difficult to get accurate and practical information on sexual matters from their parents, teachers or health professionals and are forced to rely on inaccurate or incomplete information circulating in their peer group" Commonwealth Secretariat and Maritime Centre of Excellence in Women's Health. *Gender Mainstreaming in HIV/AIDS: Taking a Multisectoral Approach* 2002; p 38)



"Adolescence is the optimum time to develop attitudes and behaviour and is the critical phase for intervention to ensure that high-risk sexual behaviour patterns do not become entrenched". (ibid p42)

"Teens aren't getting the information they need in time to protect their health and prevent unintended pregnancy and sexually transmitted infection. Information that is wrong, too little or too late can result in long-term and life-threatening consequences. Our young people need a responsible source to turn to in confidence and with confidence, not incorrect information from other teens or the media." (Cullin V. Study: Teens ask about sex first, worry about pregnancy prevention later. Contemporary Sexuality 2003; 37(2).)



These **TRUE AND FALSE** questions are to test your knowledge. The answers appear at the end of the narrative section as a review of the material presented in the manual.

1. Sexual feelings begin at puberty.
2. Having sex means having intercourse.
3. Adolescent males have a greater sex drive than adolescent girls.
4. The more knowledge adolescents have about their sexuality, the more likely they will engage in intercourse.
5. Adolescent males know more about their own and female sexuality than do females.
6. Males are responsible for the sexual satisfaction of their female partners.
7. Teaching an adolescent about his/her body and its sexual function is an important role for physicians.
8. Girls need love -boys need sex.
9. It is important for adolescents to learn about non-coital approaches to sexual gratification.
10. Uncertainty about his/her sexual orientation is an important concern for some adolescents and should be addressed.
11. Parents do not want physicians to discuss sexual topics with adolescents.
12. It is important for physicians to use medical terminology in discussing sexuality with adolescents in order to maintain a professional demeanour.
13. Physicians must be non-judgmental in discussing sexual behaviour with adolescents.
14. The sexual behaviour of adolescents is strongly influenced by the perception of his or her gender role.
15. The role for physicians in dealing with their adolescent female patients is only to prevent unwanted pregnancy and STI's.
16. Boys have a penis -girls have a vagina.
17. Sex is only for reproduction.
18. There are many myths about sexuality.



FOR DISCUSSION

Why should you as physicians address this issue?

What roles can you fulfill:

in your practice?

in your community?

as a policy advocate?

as an MWIA leader?

And finally--in a world in which gender roles, religious beliefs and cultural expectations may differ so significantly, how do we address adolescent sexuality?



WHAT DO WE NEED TO BE EFFECTIVE WHAT DO BOTH PHYSICIANS AND ADOLESCENTS NEED?

KNOWLEDGE

Knowledge is an important foundation for positive sexual health, since effective protection against HIV/AIDS and other STI's requires an understanding of disease transmission, prevention and prognosis. (Council of Ministers of Education, Canada. Canadian Youth, Sexual Health and HIV/AIDS Study 2003; page 55.)

1. Knowledge about anatomy, physiology and embryology of the sexual and reproductive organs
2. Gender role socialization as it influences sexual beliefs and behaviour
3. Knowledge about reproduction and contraception
4. Knowledge about STI's -their etiology, symptoms and prevention
5. Sexual myths, being sure to distinguish between myths and cultural traditions
6. Knowledge about options to intercourse
7. Impact of genital mutilation on sexuality and reproduction

1. Knowledge about anatomy, physiology and embryology

There has been a great deal of sex education in schools and other adolescent venues. However, this is usually limited to the anatomy and sometimes physiology or to the promotion of abstinence. What is missing is the acknowledgement of the legitimacy and universality of sexual feelings and pleasure that comes from sexual interaction. It is this feeling and how to empower adolescents to express these feelings in a safe and meaningful way that is absent. It does not give adolescents the knowledge, attitudes and skills to develop their own self-esteem and their own decision-making around their sexuality. Furthermore, they may be unaware of how to protect themselves from unplanned pregnancy or STI's if they do decide to engage in intercourse.

An important concept to understand is the development, structure and function of the genitalia in men and women and their common embryologic origin. Adolescents often do not know the analogous role of the penis and the clitoris. (See figure .) It explains why intercourse alone is not the only route to orgasm and indeed why a significant number of women are unable to achieve orgasm by intercourse alone. Clitoral stimulation in women is analogous to penile stimulation in men. In both sexes stimulation of these organs is usually necessary to achieve orgasm but this stimulation can be achieved in a variety of ways. Males often believe that their adequacy as lovers depends solely on an erect penis.

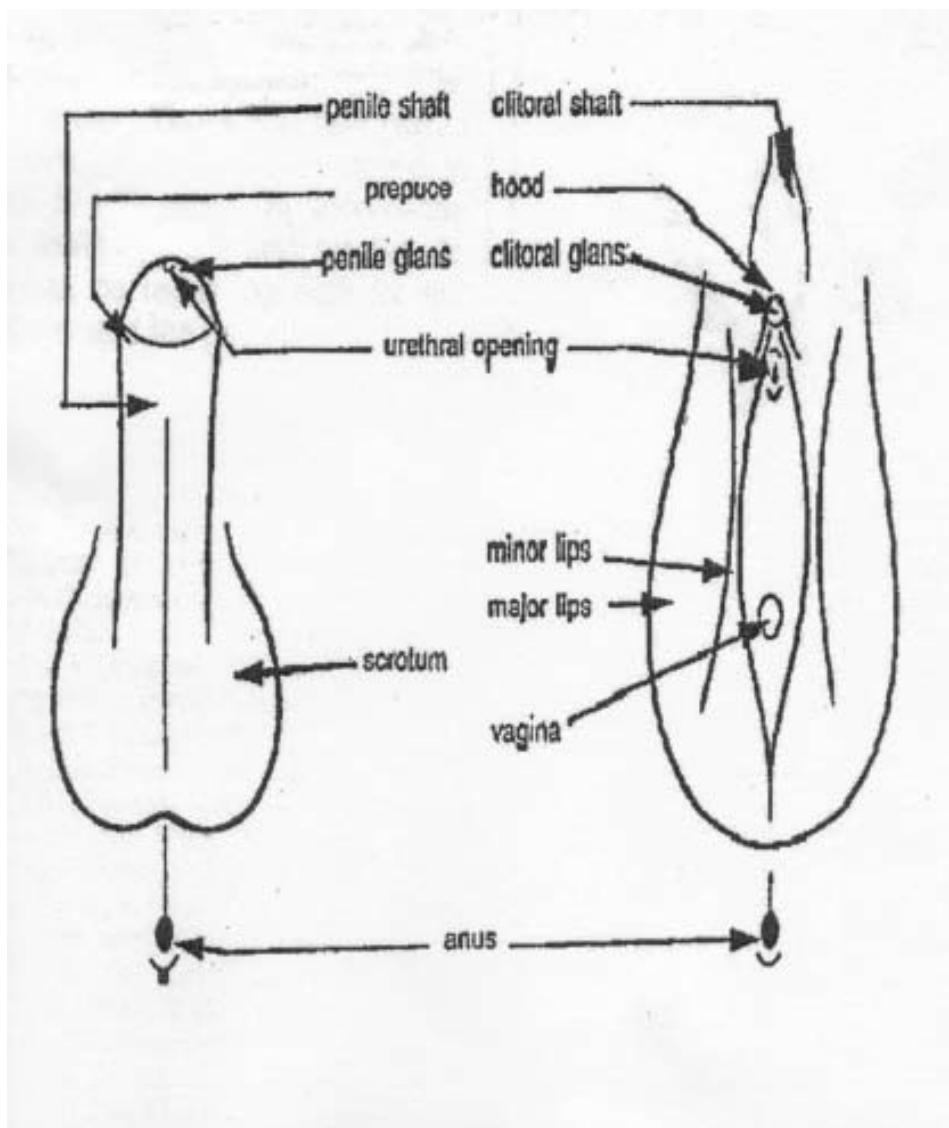


Figure 1: Analogous structures in male and female genitals.

(Reproduced with permission from Cohen G, Cohen M. The general practitioner as an effective sex counsellor. Australian Family Physician 1989; 8 (3):207.)

2. Gender role socialization.

Different societies have different ideas of what constitutes male and female behaviour. Society's expectation is that males initiate sex and know all about sexuality. This puts males in a difficult position if they wish to ask questions or admit that they do not know it all.

It is critical to understand the meaning of gender role socialization and gender, to be able to define it and to distinguish between gender, sex and sexuality.

Gender can be seen as the full range of personality traits, attitudes, feelings, values, behaviours and activities that society ascribes to the two sexes on a differential basis. It is a social construct which varies from society to society and over time.



Sex is a biological description which is determined by biology. However, even sex may not be wholly dichotomous as is made evident by intersex individuals.

Sexuality refers to the capacity for sexual feelings and their expression – again this capacity is not necessarily dichotomous between men and women e.g. Heterosexuality, homosexuality, bisexuality.

In many medical articles, as well as in the lay press, the terms sex and gender are often confused and used interchangeably. Some people use the word gender when they really mean sex, but feel it is inappropriate to use that word. This can be very confusing.

Differences between women and men need to be understood to result from the complex interaction between biology (e.g. Genetics, hormones physiology) and cultures, religion, hierarchical relationships, historical and geographic location and social roles.)

A fuller understanding of gender includes recognition of gender as a social construct, as a system of social stratification and an institution that structures every aspect of our lives because of its embeddedness in the family, the workplace, the health care system and the state as well as in sexuality, language, and culture. It is a primary way of signifying relationships of power. Each culture is deeply invested in its construction of gender roles and those who benefit from the existing system may strongly resist efforts to change, or even describe it.

Gender has many components both as a social institution and as an individual perception. From a social perspective gender is seen in terms of social status, distribution of labour, kinship, (family rights and responsibilities) sexual scripts, personalities (how one is supposed to feel and behave) social control, ideology and imagery. An individual's gender is constructed by the sex category to which the infant is assigned, gender identity, marital and procreative status, sexual orientation, personality (internalized patterns of behaviour etc) and gender beliefs systems.

Sex and Gender are interactive. While sex and its associated biological functions are programmed genetically, gender roles and power relations vary across cultures and through time, and thus are amenable to change.

Gender roles are the particular economic, social roles and responsibilities considered appropriate for women and men in a given society. Gender roles and characteristics do not exist in isolation, but are defined in relation to one another and through the relationship between women and men, girls and boys.

Nowhere is gender role socialization more clearly demonstrated than in sexual relationships.



3. Knowledge about reproduction and contracion

There are many methods to prevent pregnancy during sexual intercourse. Some methods are very reliable (such as the birth control pill), some are fairly reliable (use of condom in conjunction with spermicide) and others are very unreliable (withdrawal).

No matter which method is used, it is necessary to think of dual protection -the use of a condom along with another method to prevent sexually transmitted infections. Details on the following methods are included in Appendix I in a format suitable for photocopying for adolescents: birth control pills, Depo-Provera, IUD's, barrier methods, spermicides, withdrawal, Billings method of cycle awareness, emergency contraception and permanent sterilization.

There is much talk about "safe sex". However, preaching abstinence alone is not enough for most adolescents. It is also unrealistic in that it does not recognize that despite teachings that sexual intercourse must wait for a marriage, statistics from around the world show that a large percentage of adolescents engage in sexual intercourse long before marriage.

4. Knowledge about STI's

Adolescents must know the facts about sexually transmitted infections, how are they spread and how can they be treated.

Details on Chlamydia, gonorrhea, Herpes, HIV/AIDS, syphilis, genital warts, hepatitis B and C, Trichomonas in terms of how they are transmitted, signs and symptoms, treatment and potential complications can be found in Appendix 2. The format is suitable for photocopying for handouts for adolescents.

5. Sexual myths

Sexual myths are beliefs (often historical) often shared by large numbers of individuals which influence sexual attitudes and behaviours but which do not really have a factual scientific basis. The biggest myth of all is that there are no myths. Following are but a few of the many myths around sexuality:

- If a boy does not have sex by the time he is 8, the sperm will damage his testes and his penis will shrivel up and die.
- Having sex with a virgin will cure a man of HIV. You cannot get pregnant the first time you have sex.
- If you have sex with a younger boy, you cannot get pregnant.
- Arranged marriages at a young age will prevent unwanted pregnancies and STI's. AIDS stands for American Idea to Discourage Sex.
- Girls and boys believe that pimples occur because they do not have sexual intercourse as teenagers.
- One of the ways for a boy to identify a girl with any STIs is by pressing her lower abdomen to see if she experiences pain prior to sexual intercourse.
- After sexual intercourse a boy can prevent himself from contracting STIs by washing his private part with water immediately or take an antibiotic.
- STI's can be contracted through toilets.



- A boy that has a small penis should have sex with a girl to enlarge it.
- The number of girls a boy sleeps with is a measure of his sexual prowess.
- If a condom breaks during sexual intercourse it blocks the womb of the woman. If sexual intercourse is carried out during menstruation it brings bad luck.
- Taking a purgative after sex prevents unwanted pregnancy
- Sex is the only way a female can prove to man that she loves him
- Infections cannot be contacted by engaging in oral sex
- Being a virgin after adolescence/teenage hood shows that the lady is psychologically unstable
- When a man allows a woman to be on top during sexual intercourse it means he is weak.
- A shot of illicit gin after sexual intercourse stops contract HIV/AIDS and STI's. Any one that has TB or looks skinny has AIDS.
- HIV/AIDS is a punishment from God for immoral behaviour. Having oral sex protects you from STI's.
- You cannot get pregnant if the penis does not enter the vagina.
- Masturbation is taboo or at best acceptable only when a partner is not available.
- A girl can prevent herself from getting pregnant by douching with coca-cola after the boy has ejaculated inside her.
- Men need sex, women need love. Men need sex more than women do. Men must be the initiators.
- Men know it all.
- Men are responsible for the partner's sexual pleasure. Sex means intercourse.
- In this enlightened age, these myths no longer exist.
- If you take the birth control pill it will make you sterile forever. Vasectomy causes heart attacks and cancer of the prostate.
- Your most fertile time is during your menstruation.



6. Knowledge about options to intercourse

Although the word "sex" is often used synonymously with intercourse, there is much more to having sex than only intercourse. Sexual activity, which can be very pleasurable and may lead to sexual arousal and even orgasm, includes caressing, kissing, masturbation, mutual masturbation and oral sex. Adolescents need to learn about the alternatives to intercourse for sexual gratification, so as to avoid the negative consequences of engaging in sexual intercourse before they are physically and emotionally ready.

Even though the knowledge of these options is important at all ages, it is particularly important to adolescents who have strong sexual feelings and are struggling with how to express them appropriately("how far to go").

7. Impact of genital mutilation on sexuality and reproduction

Female genital mutilation or female circumcision is practiced mainly in sub-Saharan Africa. However, with widespread immigration from these areas, it is likely that physicians all over the world are encountering this tradition and its sequelae. It is not attributable to any one religion. It comes from the culture where the woman is dependent upon the man for her economic well-being and to be marriageable, it is a requirement. It ensures that the woman is not promiscuous and is a virgin before marriage. It takes away the woman's right to have sexual pleasure. For many women, the ability to have orgasm is related to clitoral stimulation. Even in the first degree of female genital mutilation (FGM or cutting), the hood of the clitoris is removed. With second degree it is the entire clitoris and in third degree or infibulation it is the clitoris, labia minora and fleshy part of the labia majora and fusion of the remaining labia that occurs, limiting any penetration. The procedure itself is excruciatingly painful and is prone to immediate dangers of hemorrhage and infection with morbidity in genital and urinary function and even mortality.

However, when it comes to pregnancy and delivery, it is wrought with hazards. So engrained in the cultures is this procedure, that it is often the woman herself who asks to be re-infibulated after delivery.

ATTITUDES

FOR THE PHYSICIAN

Awareness of one's own sexual values

Awareness and acknowledgement of a range of value systems and behaviours

Acceptance of one's own sexuality

Acceptance of the sexuality of others

Acceptance of the professional role in dealing with this area

Willingness to treat adolescents with unwanted consequences of sexual activity Acceptance of the ethical duties of the health professional in terms of maintenance of confidentiality



1. Awareness of one's own sexual values

You develop your sexual values from your youngest years on from multiple sources--parents, school, peers, religious institutions and media. When conflict arises, you often fall back on the values, which you have internalized. When the physician is unaware of his/her own values these may still become apparent through verbal and non-verbal behaviour. This behaviour will be quite apparent and may "turn off" the adolescent if these values are discordant with the needs or concerns of the adolescent.

2. Awareness and acknowledgement of a range of value systems and behaviours

As a professional, you have to realize that different persons, different cultures and religions and different generations have different values and accept different behaviours. Although they may not agree with your values, you must be aware that they exist and that you must not judge people solely against your own values or your own belief about appropriate sexual activities.

3. Acceptance of one's own sexuality

We are all sexual beings from birth to death with different ideas and needs about appropriate sexual expression and desirable activity.

4. Acceptance of the sexuality of others

We must realize that like different value systems, there are also different ways of expressing sexuality. Although these ways may not agree with our sexual repertoire, we must be non-judgmental in recognizing these differences. At the same time, we must be explicit in condemning sexual exploitation, physical and emotional coercion, or violence. Nor must we fail to identify behaviours that may pose a risk to the health and life of the adolescent.

5. Acceptance of the professional role in dealing with this area

Just as we deal with all aspects of health and disease, we must be willing to deal with issues around sexuality. This requires a willingness to initiate discussions about sexuality with the adolescent. Although there are a number of opportunities for adolescents to receive teaching about his/her body and its sexual function, there are studies that show that the adolescent does trust their physician as an accurate source of information and a reliable confidant, particularly when the physician acknowledges the importance of such a role.

6. Willingness to treat adolescents with unwanted consequences of sexual activity

Adolescents get pregnant, adolescents acquire sexually transmitted infections, and adolescents are victims of rape and incest and prostitution and need treatment. This is part of our professional responsibility both to treat and to educate. The commonest example of the professional dilemma is the physician who does not believe in abortion. As long as abortion is legal in their country, it is their professional responsibility to identify their values and not give false or inaccurate information but rather to refer the patient to a physician who will provide this option.



7. Acceptance of the ethical duties of the health professional in terms of maintenance of confidentiality

While the ethical physician must maintain strict confidentiality about what they hear in the course of caring for a patient, they must inform the adolescent that if they (the physician) perceives a risk to the life of the adolescent or to the life of others (e.g. threatened suicide or homicide). They will have to act on this information. The physician must also inform the adolescent about the legal obligation of reporting child abuse.

FOR THE ADOLESCENT

1. A belief in the future
2. Trust in the health professional
3. Acceptance of the ethics of the health professional in terms of respect for confidentiality

1. A belief in the future

With such events as the conflicts in Afghanistan and Iraq and with the daily news of doom and gloom, today's adolescent may feel that there is no hope for the future. If added to this an unhappy home or poor school performance the adolescent may feel that there is indeed no future. If the adolescent believes this, it is difficult to act on a way which shows a willingness to postpone present (immediate) gratification to avoid future consequences. Yet, adolescents must be empowered to look to the future. They should be helped to realize that they do not want to ruin their futures by infecting their bodies with STI's or experience the trauma of an unplanned and unwanted pregnancy or be forced into a date rape.

2. Trust in the health professional

The adolescent's trust will be gained if the physician demonstrates that they can discuss questions and concerns about sexuality in a knowledgeable, open, accurate and non-judgmental manner.

3. Acceptance of the ethics of the health professional in terms of respect for confidentiality

The physician must respect confidentiality. This includes not sharing information with parents without authorization by the adolescent patient. If this confidentiality is broken, the adolescent will not be willing to discuss sensitive issues with the physician.

However it is important to note the proviso described in the comment about item seven in the preceding section; namely that the adolescent must understand that if the physician fears that the adolescent will do something that might be life threatening to themselves or to others, the physician will be obligated to reveal this information to the appropriate parties.



SKILLS

FOR THE PHYSICIAN

1. Ability to communicate comfortably about sexual matters
2. Ability to transmit information using readily understood terminology, rather than medical jargon, while at the same time avoiding crass street language
3. Ability to check that you have been understood
4. Ability to educate and listen in a non-judgmental fashion
5. Ability to encourage parents to communicate openly with their adolescents about sexuality

1. Ability to communicate comfortably about sexual matters

The physician must be able to discuss issues of sexuality in the same way they are able to discuss any other medical topic. It is best to have a standard approach when doing a history that makes the adolescent feel that this is an acceptable topic, and that it is an integral part of overall health care. Ask questions by generalizing--for example, "many people your age worry about the changes happening to their penis and testicles or about having wet dreams. Are these things that worry you?" This helps the adolescent feel that their concerns or behaviour are not unique or abnormal. Avoid assuming that someone is heterosexual. If discussing a person's relationships, you may ask, "Are you in a close relationship? Are you sexually active and if so, is it with a man, woman or both?"

2. Ability to transmit information

The physician must regularly check that they are being understood. Talking in medical terms about coitus when the adolescent only understands the term intercourse (or other terms) will not take you far in the conversation. The adolescent, however, is not going to expect vulgar language to come from the mouth of a respected physician.

3. Ability to check that you have been understood

The physician needs to double back in the conversation and make sure that the adolescent is engaged in the conversation or at least understanding what is being said, and if necessary provide further clarification. The adolescent may sit with their head hanging, wanting to avoid eye contact, due to the sensitive nature of the conversation. A sensitive physician will acknowledge the adolescent's apparent discomfort and address this.

4. Ability to educate and listen in a non-judgmental fashion

The physician needs to employ not only proper verbal language but also body language that makes the adolescent feel that they are being respected when they ask questions or talk about their concerns and will not be humiliated or put down. Developing a good rapport will make the adolescent comfortable about returning with issues of sexuality as they develop.

5. Ability to encourage parents to communicate openly

Parents are often reluctant to discuss issues about sexuality with their children, leaving children to be educated by others. Religion and culture may influence the adult's comfort level in this area. It is necessary to recognize the important role that parents can play in preparing their children for the future and therefore physicians must encourage and help parents to discuss sexuality with their adolescents.



FOR THE ADOLESCENT

1. Ability to negotiate how, when and where to express one's sexuality. Ability to make own decisions re one's sexuality and sexual behaviour. Ability to communicate about their sexuality.
2. Ability to use contraceptives appropriately. Ability to prevent STI's.
3. Ability to express intimacy without sexual interaction.
4. Ability to discuss sexuality comfortably and without embarrassment. Ability to seek information about sexuality.

1. Ability to negotiate how, when and where to express one's sexuality

This is the area that is not covered in the usual sex education classes, which rather concentrate on anatomy and physiology. Peer pressure and lack of self-esteem and empowerment to make their own decisions are issues which need to be addressed with the adolescents.

In many African societies the woman is powerless to negotiate safe sex. An example of this is the false belief that if an HIV-positive man has sex with a virgin, he will be cured of his HIV. Another example is where girls may be seen as material objects of the family, often to be given as gifts to older males during their adolescent years. They therefore marry too young, reproduce too young and damage their bodies, only to be cast aside. A further example of this is the problem of obstetric fistulae, often due to too early childbearing in a body not fully grown or inadequate pregnancy and intrapartum care. As a result, the girl becomes incontinent of urine or feces, is evicted from the village and has no means of support.

2. Ability to make own decisions re one's sexuality and sexual behaviour

In order to make one's own decisions, the adolescent must have the knowledge base plus feel empowered to believe that they have the right to make these decisions.

3. Ability to communicate about their sexuality

If the physician introduces the topic of sexuality, the adolescent will know that this is an acceptable subject to discuss with the physician. The adolescent must also be able to communicate openly with their own peers with whom they have a relationship.

4. Ability to use contraceptives

The issue around contraceptives is complex. The knowledge may be readily available but access can be a problem. The adolescent is often fearful of letting their impending sexual activity be known. They fear that the family doctor will tell the family. The physician must realize that confidentiality is important if trust is to be developed. Family planning clinics and youth clinics are used frequently by adolescents seeking contraceptive advice. Cost can be a factor. The societal idea of the male being the initiator and the female being the passive partner makes it difficult for a girl to be the one to initiate or discuss contraception. Such issues as how to properly apply a condom to prevent breakage are often overlooked in the assumption that this is common knowledge.



5. Ability to prevent STI's

In the quest to prevent unplanned and unwanted pregnancy, the need to use dual protection in the form of a condom in order to prevent STIs can be overlooked. Adolescents are often unaware of the risk of oral sex in transmitting STI's.

6. Ability to express intimacy without sexual interaction

The media is a powerful role model for adolescents. With intercourse being shown as the norm in movies and television relationships, it is often confusing for adolescents to realize that it is intimacy rather than sexual activity that they are seeking. They may not understand the difference nor be aware of the many ways to share intimacy.

7. Ability to discuss sexuality comfortably

The attitude of others around them can help or hinder adolescents in feeling comfortable to discuss sexual issues. Role modeling by the physician of such comfort is a critical factor in enhancing and encouraging the adolescent's openness. The physician can go a long way in making the adolescent comfortable by making the topic an acceptable one in the office. So often, the adolescent will present to the office infrequently and when they do so it is for unrelated complaints such as acne. It is imperative that the physician develop the skill to introduce discussion about sexual issues when the adolescent does make an appearance in the office. This may be the only education they receive.

8. Ability to seek information about sexuality

Adolescents need to be aware of the availability of information about sexual issues. Although this information abounds, it is often not readily accessible. There are some excellent websites such as the one developed by the Society of Obstetricians and Gynaecologists (SOGC) of Canada.

CONCLUSIONS

The Medical Women's International Association is an international group and as such there are many differences in our traditions and culture. Nonetheless our differences should not allow us to opt out of our responsibilities as clinicians, community leaders and policy advocates. We must ensure that adolescents have the necessary awareness knowledge and skills so that they may express their sexuality responsibly, enjoy their right to sexual health and pleasure and avoid serious and indeed life-threatening problems--problems which concern us all. These are the problems of teen pregnancies, unwanted pregnancies, unsafe abortions, STIs, HIV and sexual abuse.



TRUE OR FALSE ANSWERS

1. Sexual feelings begin at puberty. **False.** Sexual feelings are present from birth. It has been shown that baby boys have erections and baby girls lubricate. Take the example of the young child who touches their genitals and finds the sensation pleasurable. Puberty is often a rite of passage in many cultures. In these cultures, a pre-pubertal girl is allowed to be a child, associating with boys on the playing field. However, when she begins her menstrual cycles, she is no longer allowed to associate with the boys. Sexual feelings become much stronger and more focused at puberty. This may be the reason that boys and girls are separated at this age.
2. Having sex means having intercourse. **False.** Although the word "sex" is often used synonymously with intercourse, there is much more to having sex than only intercourse. Sexual activity, which can be very pleasurable and may lead to sexual arousal and even orgasm, includes caressing, kissing, masturbation, mutual masturbation and oral sex. Adolescents need to learn about the alternatives to intercourse for sexual gratification, so as to avoid the negative consequences of engaging in sexual intercourse before they are physically and emotionally ready.
3. Adolescent males have a greater sex drive than adolescent females. **False.** This is a common belief but there is no evidence to support this. Females have just as much sexual drive as males but society's ideas of correct and incorrect behaviour see the male as the initiator and the female as the passive recipient. For example, a girl who carries a condom or who attempts to initiate sexual activity is thought to be sexually promiscuous. There is also a societal belief in many cultures that sexual activity is primarily a male imperative.
4. The more knowledge adolescents have about their sexuality the more likely they are to engage in intercourse. **False.** Many studies show that just the opposite is true. If well educated, adolescents are less likely to find themselves ill prepared for relationship development and sexual decision-making.
5. Adolescent males know more about their own and female sexuality than do females. **False.** Society's expectation is that males being the initiator do know it all. This puts males in a difficult position if they wish to ask questions or admit that they do not know it all. There has been a plethora of sex education in schools and other adolescent venues. However, this is usually limited to the anatomy and sometimes physiology or to the promotion of abstinence. It does nothing to acknowledge the legitimacy and universality of sexuality or give adolescents the knowledge, attitudes and skills to develop their own self-esteem, their own decision making around their sexuality. Furthermore, they may be unaware of how to protect themselves from unplanned pregnancy or STI's if they do decide to engage in intercourse.
6. Males are responsible for the sexual satisfaction of their female partners. **False.** This also goes back to society's expectation that the male is the initiator and has all the knowledge about his own and his partner's sexuality. Sexual satisfaction should be a mutual responsibility and depends on honest and open development of communication within the relationship.



7. Teaching an adolescent about his/her body and its sexual function is an important role for physicians. **True.** Although there are a number of opportunities for adolescents to receive such information, there are studies that show that the adolescent does trust their physician as an accurate source of information and a reliable confidant, particularly when the physician acknowledges the importance of such a role.

8. Girls need love- boys need sex. **False.** This is another myth about the differing sexual needs of females and males. Girls have as much sexual desire as boys. Boys are as much in need of intimacy and affection as girls.

9. It is important for adolescents to learn about non-coital approaches to sexual gratification. **True.** With the high prevalence of HIV/AIDS and other sexually transmitted infections, it is important that adolescents are knowledgeable about this. Such knowledge must include awareness that there are risks of transmitting STI's through oral sex.

10. Uncertainty about his/her sexual orientation is an important concern for some adolescents and should be addressed. **True.** Adolescence is a time when one's sexual orientation is often in question and at times the adolescent may be concerned about their preference for homosexual vs. heterosexual relationships. It is known that both gays and lesbians often have had heterosexual relationships before realizing that they are primarily homoerotic. The lack of acceptance of homosexuality by many societies is a source of great distress for and discrimination against people who are same-sex oriented. This influences the behaviour of the adolescent in "coming out" about their sexual identity and when they do so, of bearing the burden of possible rejection by family and society. This lack of acceptance by society may also include acts of violence against them because of homophobia.

11. Parents do not want physicians to discuss sexual topics with adolescents. **False.** Some parents are often reluctant to discuss sexual topics with their children and may welcome a trusted professional like the family doctor giving their children accurate and confidential information. Physicians should also encourage parents to talk to their children about sexual matters.

12. It is important for physicians to use medical terminology in discussing sexuality with adolescents in order to maintain a professional demeanour. **False.** The physician must use terminology that will be understood by the adolescent. The terminology does not have to be crass street language, but neither should it be medical jargon. It is also critical that, the physician check regularly during any discussion that they are being understood.

13. Physicians must be non-judgmental when discussing sexual behaviour with adolescents. **True.** Physicians must be aware of how their own attitudes may influence their discussions and possibly "turn off" an adolescent patient. Rather than being judgmental, physicians must provide accurate information by ensuring that their own knowledge is correct. Being non-judgmental does not mean standing back and approving of behaviour that will be risky to the health of adolescents, but rather explaining why it is risky and providing alternatives. This also brings up the issue of the skill in talking to adolescents about sexuality.



Often if the adolescent does not ask questions or voice concerns about their sexuality or sexual behaviour the physician can initiate a discussion, which is age and situation appropriate. This demonstrates a recognition by the physician of the wish by many adolescents to have or need such information but are reluctant or uncomfortable to raise these issues by themselves. There are ways of asking questions that make the adolescent feel comfortable to discuss such topics with you. A generalizable statement preceding a question is more likely to lead to increased comfort and openness. (For example "Many people your age are concerned about how to decide when to start having intercourse. Is this a concern for you?") It has been shown that if you make the adolescent aware that this is an acceptable topic, they will return to you when they do have questions about their sexuality or are prepared to discuss them.

14. The sexual behaviour of adolescents is strongly influenced by the perception of their gender role. **True.** Most societies strongly influence the perception of boys and girls about their appropriate gender roles. From early childhood, children are exposed to messages from parents, schools, media, friends and religious institutions about how they are expected to behave as males and females in their society. In these roles boys are expected to be strong, aggressive, to take leadership and to be sexually knowledgeable and experienced whereas girls are expected to be passive, weak, followers and sexually naive. It may be stressful for girls or boys to step out of this role, particularly in their sexual interactions.

15. The role for physicians in dealing with their female adolescent patient is only to prevent unwanted pregnancies and STI's. **False.** This is only part of the role for physicians. Girls need to know that it is permissible for them to have sexual feelings to the same degree as their male counterparts. They need to be empowered to make decisions about their sexuality and sexual behaviour such as whether or not they wish to engage in sexual intercourse but not to do so just to please their partner. These decisions should be based on knowledge, personal values and self-esteem.

Knowledge of how to prevent unplanned pregnancy or STI is just the tip of the iceberg in the total fund of knowledge that they require in order to promote their self-esteem, their comfort with their own sexuality and their ability to make their own decisions with respect to sexual activity.

16. Boys have a penis-girls have a vagina. **This is both true and false.** Although this is anatomically true, the correct analogy is that the sexually functional female equivalent of the penis is the clitoris. For some women, orgasm is possible only with clitoral stimulation.

17. Sex is only for reproduction. **False.** While sexual intercourse is necessary for reproduction, sexual relations are also important for enhancing intimacy, for pleasure and for cementing relationships. We do acknowledge that some religious and cultural teachings do promote the belief that sexual relations must include the possibility of reproduction, but we also recognize that this belief precludes any sexual activity that does not have such a potential. (Examples include mutual masturbation, self masturbation, oral sex, gay sex, sex with post menopausal women or sex in couples who do not wish to have children.)



18. There are many myths about sexuality. **True.** The biggest myth of all is that there are no myths. Some of these myths are:

1. If a boy does not have sex by the time he is 8, the sperm will damage his testes and his penis will shrivel up and die.
2. Having sex with a virgin will cure a man of HIV.
3. You cannot get pregnant the first time you have sex.
4. If you have sex with a younger boy, you cannot get pregnant.
5. Arranged marriages at a young age will prevent unwanted pregnancies and STI's. f. AIDS stands for American Idea to Discourage Sex.
6. Girls and boys believe that pimples occur because they do not have sexual intercourse as teenagers.
7. One of the ways for a boy to identify a girl with any STIs is by pressing her lower abdomen to see if she experiences pain prior to sexual intercourse.
8. After sexual intercourse a boy can prevent himself from contracting STIs by washing his private part with water immediately or take an antibiotic.
9. STI's can be contracted through toilets.
10. A boy who has a small penis should have sex with a girl to enlarge it.
11. The number of girls a boy sleeps with is a measure of his sexual prowess.
12. If a condom breaks during sexual intercourse it blocks the womb of the woman. n. If sexual intercourse is carried out during menstruation it brings bad luck.
13. When a man allows a woman to be on top during sexual intercourse it means he is weak.
14. A shot of illicit gin after sexual intercourse stops contract HIV/AIDS and STI's.
15. Any one that has TB or looks skinny has AIDS.
16. HIV/AIDS is a punishment from God for immoral behaviour. s. Having oral sex protects you from STI's.
17. You cannot get pregnant if the penis does not enter the vagina.
18. Masturbation is taboo or at best acceptable only when a partner is not available.
19. A girl can prevent herself from getting pregnant by douching with coca-cola after the boy has ejaculated inside her.
20. Men need sex, women need love. Men need sex more than women do. Men must be the initiators.
21. Men know it all.
22. Men are responsible for the partner's sexual pleasure. Sex means intercourse.
23. In this enlightened age, these myths no longer exist.
24. If you take the birth control pill it will make you sterile forever. Vasectomy causes heart attacks and cancer of the prostate.
25. Your most fertile time is during your menstruation.



CASES

The following cases are based on true-life examples. They give the physician the issues to be covered. Not every case will be suitable for all parts of the world.

The cases are well suited for role-playing to develop the skills of using the appropriate language and techniques with which to communicate with adolescents. Sample dialogues between the patient and the physician are included with some of these cases, as examples of possible role-plays. These dialogues are not intended to be followed as an absolute script but are provided to demonstrate the way in which the physician can be non-judgmental, explore the adolescent's thoughts and feelings, comment without being directive and provide information.

When discussing questions of sexual uncertainties, the physician should remember the following points:

1. The patient must be comfortable and feel she/he can say whatever she/he likes to the physician. This may not be fully understood by a young person who is not used to discussing anything with a physician.
2. The physician must emphasize that she remains non-judgmental and everything is said in full confidence including no communication with teacher or parent unless the patient gives definite permission.
3. As time constraints may prevent full discussions in one office visit, ensure that return appointments are made.
4. Make sure that the patient understands the medical and colloquial terminology used.
5. Many of the solutions assume full medical, laboratory and pathological facilities to be available. Advice should start from the basics as in many countries there is no such availability.
6. Both the girl and the boy are equal partners in a relationship. The physician will often be the only person to advise them about the variety of ways of showing intimacy and about contraception and prevention of STI's.

The cases are provided without answers to allow workshop participants to think through their own answers first before seeing the answers provided.

**Case 1**

Laura, a 17-year-old-grade student comes into your office to talk about her acne. You spend time talking about the treatment of what appears to be very minor acne. When you are about to leave the examining room, you sense that she really wants to talk about something else. She breaks into tears and you find out that for the last six months she has been dating her first boyfriend, Jason, who is in grade 12. Jason wants sex and she is afraid to say no in case she loses him, yet she does not feel that she wants to become sexually active.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 2

Jane or John comes to your office to get a certificate of good health so that she/he may play soccer. As her/his physician, you know that she/he rarely comes to see you and you want to ensure that she/he is doing well physically, emotionally and is aware of behaviours, which can be detrimental to her/his health and well-being.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 3**

Carly comes into the office very distraught. She is in first year-university and has recently become sexually active. Two days ago she developed severe vulvar pain and when she looked with a mirror, she found that she really didn't know what she was looking at, but it sure didn't look normal. There were blisters and redness and swelling and the pain was not getting better. You examine her and find that she has obvious primary Herpes genitalis.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 4

Megan, age 13, is brought to your office by her mother who is concerned about her mood. Life has not been easy for the family these past few years. Megan's mom has separated from her dad, who was an alcoholic and abusive to Megan and her two brothers. Her mom has found some happiness with a new partner, Tom, who works days and so is able to help keep an eye on the children while Megan's mother works the evening shift. The two younger boys go to bed early and Megan and Tom often watch TV together in the evening. Megan discloses that Tom has been touching her with his privates and she does not know what to do. She is so upset that she can't concentrate at school, can't eat, and can't get her proper sleep and feels like killing herself.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 5**

Robert is 16 and comes to the office not feeling well. Examination shows no physical problems but he seems anxious. Upon further questioning, he tells you that he is afraid that he is gay. All his life, his family has made fun of gays and he has no one to talk to.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 6

Inderpal comes to you for her first prenatal visit. She is from Mumbai, where her family is still living. Her husband has been in Canada for the last seven years and speaks good English, but her English is very basic. Her husband, Ranerjit, answers all the questions you ask, often speaking to her in Hindi to get the correct answer. Upon examination, it is impossible to do a vaginal exam due to vaginismus.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 7**

You are on call and the hospital emergency calls to say that Linda, your 17 year old patient, has been brought to hospital following a rape. She was out at a concert with some girlfriends, but as she was not enjoying the music, she decided to head home on her own. On her way home, she is attacked and gang raped by a group of boys.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 8

Greg is 19 and still a virgin. He has been raised in a strict family where sex was not discussed. He has taken a liking for Christine who has recently broken up with a fellow classmate. He knows that Christine and this classmate have been sexually active. He is afraid that she will think he is immature but he really doesn't know much about this sex thing and he wants to look like a macho guy.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 9**

Sandra, age 16, comes in to see you regarding treatment for her acne, which is very minimal. You talk about the various topical treatments, but you see her hesitating. She finally gets up her nerve and tells you that her friend went to see her doctor about her acne and the doctor suggested she go on the birth control pill. You explore the situation delicately and find out that she has been having unprotected intercourse. Her last period was six weeks ago and her acne has gotten worse in the last two weeks.

You suggest a pregnancy test, which you can do in your office, and it is positive. You talk about her options and she is not sure whether she wants to terminate the pregnancy or continue with the pregnancy.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 10

Aisha is brought into your office by her mother as at the age of 16 she has not yet started periods. Mother does all the talking and Aisha sits tight-lipped hunched over in her chair. Aisha was originally from Nigeria, where she was the product of her mother's fourth pregnancy. All other pregnancies ended in early miscarriage, but with this pregnancy, her mother was given some special medicine to keep the pregnancy going. You suggest that you should examine her, but she refused to get up on the examining table.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 11**

Chitan is a 9-year-old girl in Mumbai who is being married next month to a 20 year old boy from Hyderabad. She has only met her future husband once even though her marriage has been arranged since she was 2. She is not happy about the upcoming marriage but is worried because the husband's family is demanding more and more money for her dowry. Her father is a rickshaw driver and has put aside all the money he can for the dowry, but it is not enough. She sits and cries.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 12

Rozmin is a 15 year girl who presents to the fistula hospital in Addis Ababa. She became pregnant with her first child soon after her father gave her as a gift to his friend, a man of 50. She was in labour for 4 days before she delivered a dead baby. She never seemed to heal down below after she had the baby and could not control her urine. She smelled so badly that she was thrown out of the village. It is only by luck that she heard of the fistula hospital, which is so kind to girls like her.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 13**

Barbara is 16. She started menstruating at age 12. Her periods are regular. Her breasts started developing at age 10 and she wears a 38D bra. She will not wear the latest styles that are clingy as she is self conscious about the large size of her breast. It becomes even more obvious when she is with her best friend, Sharon, who wears a size 32AA and looks like she has no breasts at all. Both Barbara and Sharon feel that they are freaks and cannot bear to change in the locker room for gym class.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 14

Maria, who is 14 is brought to emergency beaten and bruised. She is from the Philippines and was told that if she came to Canada she would get a job as a nanny and make good money. When she got here, she found out that she was not going to work as a nanny, but was forced into prostitution. She was one of many girls who found themselves in the same predicament. They tried to protest but were given drugs repeatedly until they became submissive and did what they were told. They had no family or friends in Canada and were at the mercy of the pimp. Maria was working the streets tonight and when she got into a car for a trick, the guy started verbally abusing her. She tried to get out of the car but he sped away and took her to the outskirts of town where he first had sex with her, then beat her and threw her out of the car. If it had not been for some hikers passing by, she would still be lying in the bush unconscious.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 15**

Nonhlanhla age 14 was brought to the local health clinic by her mother as she was not well. As the story unfolded, she had been raped by her uncle, who was HIV positive. He was of the belief that if you had sex with a virgin, it would cure you of HIV. Nonhlanhla was tested and found not only to be HIV positive herself, but also having Chlamydia and Herpes.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 16

Susan, age 15, found herself pregnant and decided to continue the pregnancy and keep the baby. In grade 10 she realized that she must finish high school if she was to have any future for her and the baby. Her boyfriend dropped her when she would not have an abortion. Her family is supportive, but her mother and father both must work to pay expenses and therefore cannot baby-sit the baby while Susan attends school. Luckily, Susan found a high school that has babysitting arrangements for teen parents and has secured herself a spot for the next term. She now comes to the doctor for her postpartum check.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 17**

Laura is 18 and finished school. She had a learning disability and graduated with a modified high school diploma. She is a very personable girl, but has a pervasive disorder and does not always appreciate the difference between right and wrong. She got a job as a cashier at the donut shop but lost the job as the manager thought it took her too long to make change and she made too many mistakes. She has recently started dating Tom, who is 20 and working at the gas station, pumping gas. He too was slow in school and his last girlfriend left him when she became pregnant and had an abortion. Laura's mother comes into the office asking about birth control.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 18

Mara is a timid girl of 24 who has never done well in school. She is finally in a training program to learn to be a data entry clerk and has been doing well. She went out with Rob and he talked her into having intercourse, even though she told him she did not want to do so. He did not wear a condom but told her not to worry. She comes to the office feeling awful, unable to concentrate, feeling used and having failed her midterm exam.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 19**

Martha, 16 years old, comes to your office very distraught. She was sent by her parents abroad for one year of high school to a school for girls only. She had sex with her roommate and now she is confused, alone and without her parents. She seeks your professional help.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 20

Patrick, age 17, comes to the office looking quite anxious. With great difficulty, he tells you that he is dating his first girlfriend. They have had intercourse twice now. His worry is that his penis is very small and that he is scared that he can't satisfy her. He is afraid that she doesn't like sex with him. He wants to know if you can help him.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

**Case 21**

Meghan comes into the office for a routine check-up as she is now 15 and has not been to the office for 3 years. She is a healthy teenager, currently in grade 10 and plans to go to university when she finishes high school. She thinks she would like to train in the health care field either as a nurse or physiotherapist. She is currently involved in sports, playing on the school volleyball team and also plays the saxophone in the school band. She makes friends easily and has a good group of friends, but no steady boyfriend.

On taking the medical history, other than the occasional cold and flu she has no complaints. She started her periods at age 12 and they are no problem. Physical examination shows a healthy teenager.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?

Case 22

Michelle and Justin are in grade 2. They have had casual dates with others before but this is the first serious relationship for both of them. They come to the office to talk to you about sex. You delivered Michelle and have looked after her all her life, but do not know Justin.

What are the issues that need to be addressed in dealing with this case?

How would you talk with your patient about these issues?

What might you, as a respected community member, do outside your office and in the community to deal with similar issues or to help prevent similar problems?



DISCUSSION OF THE CASES

The following cases are based on true-life examples. They give the physician the issues to be covered. They are well suited for role-playing to develop the skills of using the appropriate language and techniques with which to communicate with adolescents. Sample dialogues between the patient and the physician are included with some of these cases, as examples of possible role-plays. These dialogues are not intended to be followed as an absolute script but are provided to demonstrate the way in which the physician can be non-judgmental, explore the adolescent's thoughts and feelings, comment without being directive and provide information.

In each dialogue, A stands for Adolescent and P stands for Physician.



Case 1

Laura, a 17-year-old-grade student comes into your office to talk about her acne. You spend time talking about the treatment of what appears to be very minor acne. When you are about to leave the examining room, you sense that she really wants to talk about something else. She breaks into tears and you find out that for the last six months she has been dating her first boyfriend, Jason, who is in grade 12. Jason wants sex and she is afraid to say no in case she loses him, yet she does not feel that she wants to become sexually active.

General Statements

It is important to point out that discussing this concern gives permission to the adolescent to speak to the physician about these issues. Ask open-ended questions to help her make her own decisions.

Often the issue of sexuality arises outside the context of the apparent problem for which the appointment was booked. One very possible problem that physicians might have is that there may not be time to enter into this discussion at this moment in a busy practice. We need to help develop language to deal with this without making the adolescent feel brushed off. For example, "I am really glad that you felt you could discuss this with me. It is a very important issue and I would like to have enough time to discuss this with you carefully. Would you be willing to make an appointment in the next few days so we can spend some time together?"

Issues

The major issue here would be how to talk to an adolescent about "how far to go." It would require exploration of her own feelings and self-respect and also careful probing about a boyfriend who might not respect her wishes. It would also involve some teaching about the fact that the boy probably has very strong sexual feelings, but that there are a number of non-coital ways (both together and by himself) of addressing these needs. It would lead into a discussion of birth control and protection against sexually transmitted infections. All these discussions would lead to empowerment of the adolescent. It is important for the physician to inform the adolescent that each person has the right to their own value system and to make their own decisions about the type of sexual activity they wish to engage in that are in keeping with their value system.

First relationships are special, exciting and new. Healthy relationships occur when both partners grow together and make decisions that they are both comfortable with.

The dialogue may proceed as follows:

P: You're crying. You must be upset about something.

A: There is something I want to talk to you about. You won't tell my mom, will you?

P: Anything we talk about will be confidential and will stay in this room and not get back to your parents. So, please go ahead.



A: I have been dating Jason for the past 6 months and I really like him and I think he likes me. But lately he's been telling me that if I really loved him I would be willing to go all the way with him.

P: What do you mean "go all the way."

A: He wants me to have intercourse with him. P: How do you feel about that?

A: I don't really want to because I believe I should wait until I am married. I feel strongly that he is the person I plan to marry.

P: Have you talked to him about this?

A: Yes, but he says that everyone is doing it. He needs it, because he gets so excited when we're together. I don't want to lose him.

P: Does he understand your feelings? What does love mean to you?

A: It means having him care for me and consider me his girl. I couldn't bear to have him dump me because I would not come across. When we get kissing and touching, he tells me that he wants to have sex with me. He tells me that I can't send him home without some relief.

P. Many people your age are not aware of other ways to give him sexual relief without having intercourse. There are such ways as masturbation or mutual masturbation.

A. We never talked about those methods.

P: Do you believe that you have the right to make your own decisions regardless of what other girls decide to do?

A: I guess so.

P: Do you believe that if he really loves you he will respect your own decisions? A: I guess so.

P: Do you really believe he would leave you if you don't come across and what does it say about your relationship if he does break up with you?

A: Yes, I am afraid he will break up with me.

P: Are you able to talk and make him understand your feelings?

A: He doesn't ask me about my feelings. He is more interested in getting me to have sex with him.



P: How do you feel about that?

A: It makes me sad but I try not to show him my feelings because I want the other girls to see what a handsome boyfriend I have. He is the quarterback for the school football team, you know. He tells me that all the other girls do "it."

P: Remember that having intercourse must be your decision as well as his. If you do decide to have intercourse, you need to protect yourself against getting pregnant and also against getting a sexually transmitted disease. Please feel comfortable to ask me for birth control before this happens.

Although this sounds like a cliche, you must remember that you always have the right to say "no." Your first time is something you will always remember, so make a decision that is right for you, not just right for Jason. And for Jason, if this relationship is right, then this doesn't mean no forever, just for right now, until you both find a time that is perfect.

P: I am really glad that you felt you could discuss this with me. It is a very important issue and I would like to have enough time to discuss this with you further and give you a chance to think about what we have talked about. Would you be willing to make an appointment in the next few days so we can spend some time together?



Case 2

Jane or John comes to your office to get a certificate of good health so that she/he may play soccer. As her/his physician, you know that she/he rarely comes to see you and you want to ensure that she/he is doing well physically, emotionally and is aware of behaviours, which can be detrimental to her/his health and well-being.

Issues

The issues here are that adolescents are generally very healthy and rarely visit the physician. This visit provides the opportunity to monitor the adolescent's health and development and provide health education even in the absence of any specific or immediate problems or complaints. In approaching the topic of sexuality, ask age appropriate questions such as-- how are things going? Do you have any close friends? Is your best friend a girl or a boy? How close are you to this friend? Are you physically close? What do you mean by physically close-kissing, petting? Do you sometimes feel that you want to go further? What do you mean by going further—are you talking about intercourse? Do you know how to take care of yourself to prevent pregnancy and sexually transmitted infections?

This is also a good opportunity to talk about substance abuse, safe driving and smoking.

The dialogue might proceed as follows:

P: John, it is good to see you, as I have not seen you in many years. Your examination shows you to be in good health and I can certainly sign the certificate allowing you to play soccer.

A: Thank you, doctor. I am rarely sick. P: How is school?

A: Good.

P: How are things at home?

A: Fine. My mom and I sometimes fight because I think she is too strict but things are mostly okay. I get along really well with my dad.

P: Do you have many friends?

A: Quite a few, mostly ones in my class.

P: Do you have a particularly special friend? A: Well, yes.

P: Is it a boy or a girl?

A: A girl.



P: Do you spend a lot of time with her?

A: Not too much. We sometimes go out after school for a coke.

P: Your body is changing so rapidly now. Do you have any questions for me?

A: Not particularly.

P: Some guys your age have concerns about wet dreams or masturbation or about getting intimate (very close) with their special friend.

(Depending on the answer, one could talk about nocturnal emissions, the normality and universality of masturbation then go on to question and then go on to question whether he and his friend might soon become physically intimate and in what way).

It would become necessary to inquire if he knew about STI's and how to prevent pregnancy.)

P: Can you talk to anyone about these issues?

A: The guys at school often talk but I don't know whether I should believe them. P: I'll be glad to answer any questions that you have either now or at a later time when you can come back to see me. Please feel free to do so. In the meantime I can suggest some reading material for you or some websites.



Case 3

Carly comes into the office very distraught. She is in first year-university and has recently become sexually active. Two days ago she developed severe vulvar pain and when she looked with a mirror, she found that she really didn't know what she was looking at, but it sure didn't look normal. There were blisters, redness and swelling and the pain was not getting better. You examine her and find that she has obvious primary Herpes genitalis.

Issues

The mains issues to discuss are: diagnosis and treatment of her Herpes the need to check for and teach her about STI's in general and Herpes in particular (see Appendix 2), the need to teach her about prevention of pregnancy, as she is appropriately distressed even before and especially after she finds out she has Herpes, there is a need to talk about how to help her deal with her fear, guilt and shame, and how to deal with future sexual encounters.

This is a difficult case emotionally but an opportunity to check for other sexually transmitted diseases and initiate discussion about safe sex. Decisions you make can affect you your whole life and fortunately, many outbreaks of herpes can be controlled symptomatically with medications. (Refer to Appendix 2)

If she states she used a condom, believe her. Condoms don't always protect from herpes, especially if the sore is more exposed. Encourage her to continue to use condoms. And although she may be ashamed or embarrassed in future relationships, she needs to inform her sexual partners, and act responsibly. It has been shown that use of condoms plus daily use of antiviral therapy decreases both the clinical reactivation of Herpes 2 lesions and the subclinical transmission of virus shed by persons seropositive for Herpes Virus type 2 by decreasing the amount of SHV-2 shed on genital mucosal surfaces. (Corey L. Once-Daily Valacyclovir to Reduce the Risk of Transmission of Genital Herpes. The New England Journal of Medicine 2004; 350:11-20.)

All of this discussion may be overwhelming at the first visit. It is important to schedule a follow-up visit to review the information and answer subsequent questions. She has been given a sign that she needs to take charge of her health, and as a health professional, you are to help her do so.

In the parts of the world where they are available, support groups are often useful. Many times these patients feel they are the only ones with this condition. The groups reveal they are not alone and help with learning ways to initiate discussions with potential sexual partners about herpes.

The dialogue may proceed as follows:

P: Carly, this may be difficult for you to hear, but your problem is a Herpes infection. The first time a person has a Herpes infection, it is often very painful like this.



A: I don't know much about Herpes, but I'm worried that my life is now ruined. I know I won't be able to have sex again without spreading the Herpes. I know I probably won't be able to have children.

P: Your life is not ruined, but you will need to learn some more about Herpes and sexually transmitted diseases in general, as I want to see you take control of your health. You acquired this infection through intercourse. People are most infective when they have a Herpes lesion, but there is a small chance of spread even when you do not have an active sore. You need to protect yourself by having your partner use a condom or something that might be new to you is the idea of a female condom. It is hard to tell right now how often you will be troubled with outbreaks of Herpes. Some people find it a frequent occurrence and others may go many years without seeing another lesion. You mentioned having children and there is certainly no reason that you cannot have children because you have Herpes. When you are pregnant, the doctor will put you on suppressive medicine the last month of your pregnancy to stop the chance of an outbreak around the time of delivery. If an outbreak does occur at that time, you will have a Caesarean Section.

A: If I have Herpes, how do we know that I have not acquired some other sexually transmitted disease as well?

P: I can take swabs to check for Chlamydia and Gonorrhoea and will send you for blood tests to check for such infections as hepatitis, syphilis and HIV, both now and a repeat in a few months.

A: I feel so awful. I should never have had sex.

P: The decision to have sexual relations is a decision everyone has to make. You need to feel that it is the right decision for you and that you are not agreeing just because your partner wants to do so. You also need to make sure that you look after your own health. This includes physical health like preventing STD's and pregnancy and mental health like empowering yourself to have an equal say in a relationship.

A: Not only am I upset, but I am feeling so sick and miserable right now.

P: This is an upsetting time for you. I am going to give you some medication to help with your immediate problems and then I want to see you back in a week, so we can talk some more.



Case 4

Megan, age 13, is brought to your office by her mother who is concerned about her mood. Life has not been easy for the family these past few years. Megan's mom has separated from her dad, who was an alcoholic and abusive to Megan and her two brothers. Her mom has found some happiness with a new partner, Tom, who works days and so is able to help keep an eye on the children while Megan's mother works the evening shift. The two younger boys go to bed early and Megan and Tom often watch TV together in the evening. Megan discloses that Tom has been touching her with his privates and she does not know what to do. She is so upset that she can't concentrate at school, can't eat, and can't get her proper sleep and feels like killing herself.

Issues

The advisable approach is to ask the mother to leave the room and wait in the waiting room. If there is anything the adolescent wishes to discuss, the presence of the parent may inhibit them.

The dialogue may proceed as follows:

P: Your mom thinks you are upset about something.

A: Yah.

P: Can you tell me a bit more? A: OK.

P: How are things going at school? A: OK.

P: Do you have friends? A: Yah, they're ok.

P: How about at home? A: Makes a face.

P: What's wrong?

A: Well, Mom works nights and I don't like that.

P: Why?

A: Her partner, Tom, stays home with us and after my brothers go to bed at night he always sits with me to watch television.

P: Tell me more about that.

A: He's always touching me.

P: What do you mean?



A: He hugs me and kisses me and touches me all over.

P: Does he touch your private parts?

A: Yes, and he puts his fingers inside of me.

P: Have you told your mom?

A: No and he told me never to because she wouldn't believe me anyhow and he's make lots of trouble for me.

P: Would you like me to talk to your mom? At this point, the mother could be involved. It is important to point out that this is illegal and that you must notify Children's Aid or the police.

It is also necessary to be sensitive to the issues for both Megan and her mother. In addition to the notification of the Children's Aid Society, these cases often require referral to those specializing in the management of families in which incest occurs.



Case 5

Robert is 16 and comes to the office not feeling well. Examination shows no physical problems but he seems anxious. Upon further questioning, he tells you that he is afraid that he is gay. All his life, his family has made fun of gays and he has no one to talk to.

Issues

There is a need for a great deal of teaching. There is no relationship at all between physical build and appearance or interest in sports and sexual orientation. There is not an absolute dichotomy between heterosexual and homosexual orientation. One may be primarily one or the other but that may not preclude an interest in either the same or the opposite sex at times. A single or even a few same-sex encounters or fantasies do not necessarily mean a person is gay. There must be awareness of the risk of HIV and if the individual is a female the risk of unwanted pregnancies, if she has engaged in heterosexual intercourse. Homosexuality is not a life-style choice, a sin or a moral failing. About 5 to 0% of the population is gay. Some of the myths about homosexuals are that they are pedophiles or that they can make others become gay. Homophobia or fear of homosexuals is hurtful or indeed dangerous but many societies are becoming more accepting of homosexuality. Robert needs to be asked with whom he can share this information. He needs to be informed about support groups. He needs to be offered help if he wishes to talk to his parents or about "coming out."

The dialogue may proceed as follows:

P: Why do you think you might be gay?

A: Well, as you can see I am not very big or muscular and I don't like football and other team sports, so the kids at school are always teasing me and calling me "fag."

The following questions should be asked by the physician. The order in which the questions are asked is important as one goes from less sensitive to more sensitive questions.

P: Who are your friends? Do you have a particularly close friend-a boy or a girl? Do you date? Do your activities with your close friends include physical touching, caressing or hugging? Have you been having intercourse or thinking of having intercourse? Have you had sexual activities with strangers? Did anyone ever force you to have sexual activities with them?

Keep an open mind and avoid any judgemental statements. Allow the patient to express in his own terms how and why he feels he is gay. Some patients will state they knew it all their life, other adolescents may be more confused about their sexuality. Sexual orientation for some individuals is an evolving process and sexual experimentation with either males or females may not define their primary sexual orientation. Some patients equate childhood molestation by a person of the same sex to defining their sexual orientation, as they had no other experiences with which to compare.



Assure him that he should not be "afraid" of his sexual orientation. He has done nothing wrong.

This is a part of him and he is not doing something to hurt anyone. Do not attempt gratuitous reassurance that he is heterosexual. This might cause him even more distress.

It is important to remember that 30% of all teenage suicides are committed by troubled homosexuals. Be aware of depression.

Listen, listen, listen.....if you are the first person the patient has told this to, he will feel a sense of relief. He no longer carries the burden of this knowledge alone. He is not alone, he has you to talk to. In time, when he is ready to let his parents/family/friends know (i.e. to come out) you can help here too. For example, he might say, "I know I've been distant this last while, mom/dad. There's a part of me that I haven't been honest about and I need to talk about it so that we can help each other."



Case 6

Inderpal comes to you for her first prenatal visit. She is from Mumbai, where her family is still living. Her husband has been in Canada for the last seven years and speaks English well, but her English is very basic. Her husband, Ranerjit, answers all the questions you ask, often speaking to her in Hindi to get the correct answer. Upon examination, it is impossible to do a vaginal exam due to vaginismus.

Issues

One of the main issues is that the husband is the authority figure and yet is providing the translation. As a general rule, if a patient requires a translator, it should not be a family member or friend who could stop the patient from saying what she wanted to say. In addition, even if the patient did speak her mind, the non-objective translator might translate the information to convey their point of view.

Empowerment of the woman is a major issue in this case. Even if her English is basic, at some point in the visit, I would ask the husband to leave and thus give the patient the opportunity to express herself. She may not be comfortable to do this at the first visit, but it may be made a routine gesture at follow-up and at some point, she may divulge concerns she may not otherwise be able to do in her husband's presence. There is often a greater agenda here, not just vaginismus. She is likely afraid of something, of many things.

Another issue is that of vaginismus. The vaginismus may be situational, in the doctor's office, as she is in a strange land, away from customs she has known and never having had an internal exam before. On the other hand, the vaginismus may be present in her relationship with her husband. In that case, the sexual relationship between Inderpal and Ranerjit must be very stressful. Intercourse must be very painful or impossible. This must be very discouraging for the couple. They require sexual education.

Vaginismus is a very difficult problem to treat and may require a specialist in sexual medicine. However the physician can make some preliminary enquiries and provide some education about possible causes of vaginismus, about the pelvic musculature and how spasm of these muscles plays a role in this condition.

Vaginismus may indicate some previous unpleasant or painful sexual encounter or fear of pain because of myths she has heard or because of an attempt by her husband to rush into intercourse without adequate lovemaking and lubrication. These questions should be asked of her when her husband is out of the room.

The issue of antenatal care and delivery must also be addressed.

Because of the vaginismus, it would be advisable to perform only an external exam at this visit. Ultrasound will help with gestational age. PAP and cultures can be done later without consequence to the pregnancy. Provide her with a handout about the importance of PAP and cultures in pregnancy and inform her that this will be done later in the pregnancy. It can be presumed that she will require lots of prenatal education as well.

No dialogue is provided as the issues are clearly outlined



Case 7

You are on call and the hospital emergency calls to say that Linda, your 7 year old patient, has been brought to hospital following a rape. She was out at a concert with some girlfriends, but as she was not enjoying the music, she decided to head home on her own. On her way home, she is attacked and gang raped by a group of boys.

Issues

Linda must be reassured that the rape is not her fault.

One of the issues is that of avoiding risk situations. In today's society, it is often not safe for a young woman to be alone on the street after dark.

Another issue is prevention of unwanted pregnancy with the use of the morning after pill and checking for STI's.

Another issue is dealing with the emotional trauma including post traumatic stress disorder.

Legal issues must also be considered. Have the police been notified? Does Linda wish to press charges?

Should she be referred to a sexual assault centre for a sexual assault examination? There is a need to talk about the sexual assault examination to gather evidence and the fact that the evidence obtained during the examination can be stored if Linda wishes to think about whether or not she wishes to press charges.

The dialogue may proceed as follows:

P: Linda, I am so sorry this has happened. How are you doing?

A: Doctor, I feel awful. What did I do to make these guys want to rape me? I had never seen them before in my life.

P: Linda, this is not about what you did. This was a vicious attack and you happened to be in the wrong place in the wrong time. We are going to talk later about how to protect yourself.

A: These guys were scary looking. What am I going to do if I get pregnant or if I have a sexual disease?

P: Linda, I am going to give you the morning-after pill right now and again in 2 hours. It is very successful in preventing pregnancy. I am going to check you now and again later for any sexually transmitted disease and I am going to give you some antibiotic right now that will attack the commonest STD.

A: I think I am going to go crazy thinking about this. Already, I feel that I cannot go out in public again. I am sure I cannot face school.



[NOTE: There is a need to enquire about home support and does she wish to call her parents or some other support person.]

P: Linda, once I am finished my exam, I am going to ask Susan, our counsellor, to come in and talk to you. We are going to arrange some follow-up visits to help you deal with this traumatic event. We want to make sure that you get back to your normal activities and that you manage okay with your schoolwork and social life. We are here to support you as you work through this. I am going to make you a follow-up appointment before we finish today



Case 8

Greg is 19 and still a virgin. He has been raised in a strict family where sex was not discussed. He has taken a liking for Christine who has recently broken up with a fellow classmate. He knows that Christine and this classmate have been sexually active. He is afraid that she will think he is immature but he really doesn't know much about this sex thing and he wants to look like a macho guy.

Issues

Greg knows little about sexuality and needs education. He needs to know that not all young men at his age have had intercourse and that this is okay. He also needs to know that it is a myth that men have to have intercourse at a young age to prove that they are real men. He should be complimented for having sought information and assured that men do not automatically know everything there is to know about sex.

There is an issue around communication. Christine may well have been sexually active with her previous boyfriend but it is not known if this was her choice or if she was coerced by him and that was perhaps the reason for the break-up.

His concerns about his immaturity have to be further explored to clarify what he means by this and whether this concern applies to other areas in his life.

The dialogue may proceed as follows:

P: Greg, good to see you. You look a bit upset. Is there something I can help you with?

A: Doctor, I don't know if I should be bothering you with my problem, but I did not know where else to go.

P: I want you to feel that you can approach me with any problem and if I can help you with it, I shall do so and if I cannot do so, I can often point you in the right direction.

A: There is a girl at school, named Christine, whom I would like to ask out on a date. I have been talking to her in the hallway ever since she broke up with her boyfriend and I think she likes me too. Her last boyfriend was the school quarterback and I heard him boasting how he and Christine were having sex. I've never had sex and I don't want to look immature to Christine when I do take her out.

P: Do you mean intercourse? A: Yes.

P: Have you had a close relationship with any other girls?

A: No



P: I am glad that you came to talk to me about this. You are not alone in never having had intercourse at your age. If Christine broke up with the quarterback, it may have been that she didn't want to have a relationship that included intercourse. Also, if Christine is finding you attractive, you should ask her out and let your relationship develop. As you get to know each other better, talk will turn to what you want from a relationship. Should it include sexual intimacy, there are many ways to develop that part of your relationship. This can include a whole range of things like kissing, hugging, caressing each other, mutual masturbation, oral sex and intercourse.

Different couples may choose different ways to express their love and closeness for one another. I have an excellent book for adolescents discussing this topic and will give you a copy. Please remember that should you become very intimate that you must act responsibly in the prevention of unplanned pregnancy and also sexually transmitted disease. You must wear a condom.

A: Thank you for your advice but what if she thinks I am immature compared to the quarterback?

P: What makes you think that you are immature?

A: I don't drink or smoke or do street drugs. I am on the honour roll at school and play in the band rather than on the football team.

P: I certainly do not find those qualities equating to immaturity. I would like to see you back in the office to discuss things further.



Case 9

Sandra, age 16, comes in to see you regarding treatment for her acne, which is very minimal. You talk about the various topical treatments, but you see her hesitating. She finally gets up her nerve and tells you that her friend went to see her doctor about her acne and the doctor suggested she go on the birth control pill. You explore the situation delicately and find out that she has been having unprotected intercourse. Her last period was six weeks ago and her acne has gotten worse in the last two weeks.

You suggest a pregnancy test, which you can do in your office, and it is positive. You talk about her options and she is not sure whether she wants to terminate the pregnancy or continue with the pregnancy.

Issues

The immediate issue is the unplanned pregnancy. She needs information about options termination, continuing the pregnancy and giving the baby up for adoption or having the baby and finding a school that provides daycare while she continues her education.

The next issue is knowledge about adequate contraception upon completion of this pregnancy.

She must be tested for and educated about STI's.

This case provides an excellent opportunity for role-playing to practise discussing options.

The dialogue may proceed as follows:

P: We have talked about the topical treatments for your acne, but you look like there is something else you want to ask me.

A: Actually, I heard that the birth control pill is a better way of treating the acne.

P: This is certainly a possibility. Usually, we try some of the topical treatments first, but if there is a need for birth control right away, there is nothing to stop us from discussing that possibility. You know that what we discuss is confidential, so let me ask you a few questions. Have you been having intercourse or are you planning to have intercourse?

A: I only had sex once and that was about six weeks ago. I am so scared because my last period has not come yet. I am hoping it is just nerves that have made it late.

P: I shall do a pregnancy test in the office right here in the office.A: Okay.

P: I have to tell you that your pregnancy test is positive. I know this is very upsetting for you, but we need to talk. Now that you are pregnant, you have to make some decisions. Although it is unplanned, do you want to be pregnant?



A: I have been giving that question some thought because I had this dread in the pit of my stomach that I might be pregnant. I really love my boyfriend, but we are both in grade and hoping to start university once we graduate. I would love a baby but I am not sure that this is the right time in my life. What options do I have?

P: You actually have a number of options. If you wish to continue with the pregnancy, you have the option after delivery of keeping the baby or giving it up for adoption. Should you wish to keep the baby, you will need to look into a high school that has daycare facilities for single parents, as well as other means of assistance to help you raise the baby. Should you wish to terminate the pregnancy, you have the option at this early stage of either a medical or surgical termination. I can refer you to the appropriate facility. With the medical termination, it is a matter of taking medicine and having a miscarriage on your own, with follow-up with your doctor. Should you wish a surgical termination, it will require an operation done through the vagina and into the uterus from below. That can be done either with local anesthetic or general anesthetic. There are risks to any method and well as risks to being pregnant, so we can talk more about those risks once you make your initial decision.

P: Does your boyfriend know anything about this? A: Not yet.

A: I am so confused and upset. I thought you could not get pregnant the first time you had sex. How am I going to tell my parents?

P: If you want, I can help you tell them. I see that your mother came into the office with you today. Do you want that we call her into the room or do you prefer to tell her yourself afterwards? I respect your confidentiality and would not tell her without you being present.

A: Thank you. I think I would like to have you help me break the news to my mother. Let us bring her into the room.

[NOTE: At some point in the conversation it would also be necessary to find out whether or not the boyfriend knows about her worry about pregnancy, how he might react when he learns that she is pregnant and what role he might play in supporting her and her decision. This might have to wait for a next visit when she might even want to bring him along. She has enough on her plate for this visit just coping with the news and informing her mother.]



Case 10

Aisha is brought into your office by her mother as at the age of 16 she has not yet started periods. Mother does all the talking and Aisha sits tight-lipped hunched over in her chair. Aisha was originally from Nigeria, where she was the product of her mother's fourth pregnancy. All other pregnancies ended in early miscarriage, but with this pregnancy, her mother was given some special medicine to keep the pregnancy going. You suggest that you should examine her, but she refused to get up on the examining table.

Issues

One issue is to educate Aisha and her mother as to what is the normal range of age of menarche. The physician should also enquire about other manifestations of puberty (breast development, axillary and pubic hair and body shape changes.) As well it is advisable to enquire about the mother's age of menarche.

Another issue is how to make the adolescent feel comfortable enough to be examined.

Another issue is how much gynaecological examination to do in the office and how much needs to be done after imaging investigations, perhaps under anesthesia.

Coming from a developing country, her mother may very well have had DES when she was pregnant with Aisha, resulting in structural abnormalities in Aisha's reproductive system. Aisha may have other endocrine based abnormalities that require investigation.

The dialogue may proceed as follows:

P: Aisha, I am pleased that you have come to the office, although I know doing so is difficult and embarrassing for you.

Your mother says that she is concerned that you are 16 and have not started menstrual periods. Different girls start their periods at different ages. As a matter of fact, the age can range from 9 to 16. So, you are reaching the stage where you are getting to the older end of the common range and still do not have your period. Your mom tells me that you have grown quite tall in the last year or so and that you have noticed some development of your breasts and hair growth. If you will allow me, I would like to examine you.

A: No.

P: Why don't we just take your blood pressure and listen to your heart and lungs to start with?

A: I am too shy.



P: That is understandable. Any examination can wait until you know me better. In the meantime, I would like to get some blood tests done and I would like to get picture of the organs in your pelvis by way of an ultrasound. It does not hurt and once you have that done, I am going to ask you to come back and we can talk some more.

A: Okay, I'll do the blood tests and the ultrasound.



Case 11

Chitan is a 19 year old girl in Mumbai who is being married next month to a 20 year old boy from Hyderabad. She has only met her future husband once even though her marriage has been arranged since she was 12. She is not happy about the upcoming marriage but is worried because the husband's family is demanding more and more money for her dowry. Her father is a rickshaw driver and has put aside all the money he can for the dowry, but it is not enough. She sits and cries.

Issues

One issue is that there is a move away from arranged marriages in India. In addition there is now a law preventing girls from marrying before age 20. This is to stop adolescent pregnancy and to empower the girl to get education and a career. The old custom of dowry is still present but less so in modern times.

It is important to ascertain if this is the only reason she is unhappy.

There is an issue of the feelings of Chitan and of her fiance, which have not been taken into account.

[NOTE: No matter how the physician feels about arranged marriage, absence of sexual knowledge or progression of sexual activity in adolescence, it is important not to appear judgmental.]

In spite of Chitan's (and likely Ravi's) distress, they will have greater distress if their parents' authority is questioned or challenged, until they are prepared to do so. Then the physician can help them with this difficulty and how they might cope with it.

There is an issue with respect to what knowledge each has about their own bodies and their sexuality.

Chitan knows nothing about sexuality. She has only heard that there should be a bloody sheet the first night of marriage. She and her fiance need education about her own and her fiance's body and sexuality. She needs to be informed about contraception and spacing of children.

The dialogue may proceed as follows:

P: Chitan, I am so pleased that you have come to our new premarital clinic at the hospital. We want to make you feel more comfortable as you prepare for your wedding and for your new role as wife and eventually as a mother. Tell me about your fiance and your plans.

A: I keep telling my parents that I do not want to get married as I want to go to secretarial school and work in an office. My parents tell me that my place is as a wife and they cannot afford to keep me at home any longer. As it is, they have struggled to provide a decent dowry to give to the family of my future husband. I just met Ravi, my future husband. He is not at all what I pictured my husband would look like. He is too tall, too skinny and seems to be as shy as I am.



P: Have you looked into government funding to send you to school? A: The funding is inadequate.

P: Have you told Ravi your feelings?

A: Yes, and Ravi told me that he is not ready to be married either, but his family needs the dowry.

P: So what do you and Ravi plan to do next go ahead with the marriage or refuse? A: Oh, no we could never refuse.

P: I understand that despite your feelings that the wedding is taking place next month. If both going to school and getting married were possible, would you be interested?

A: Yes, but how?

P: I am going to have you speak with the social worker to see what can be done to help you with schooling. However, I want to talk to you and Ravi together to help you learn more about your bodies. Would you be able to come to the office together?

A: Yes, we would be very glad to make an appointment together.

[NOTE: The next section is difficult to put into dialogue format, but it is important for the physician to know how to proceed. What we want to talk about here is education for Chitan and Ravi. One could start with Chitan but due to time limitations and particularly if the two are virgins, it is important that they both be present at the visit. The education may take several visits.

At these visits with Chitan and Ravi together, the topics need to include questions could include:

1. . What do they know about dating? Do they know what couples might do together like holding hands or kissing, etc.?
2. Have they done any of these things? Have they enjoyed that?
3. Have the two of them talked about this?
4. One very important priority is to ensure that the couple knows about contraception and the different available methods. However, it is important to enquire whether the couple wishes to have children right away or if Chitan is anxious to continue her education and develop a career.
5. Knowledge about STI's is also important but if it is clarified that they both are virgins, the physician needs to be sensitive about how she teaches about this.
6. The physician can then provide education to the couple about the erotic areas of the body and about the range of sexual activities which are very pleasurable and indeed can lead to orgasm (as explained in the narrative).]



Case 12

Rozmin is a 15 year girl who presents to the fistula hospital in Addis Ababa. She became pregnant with her first child soon after her father gave her as a gift to his friend, a man of 50. She was in labour for 4 days before she delivered a dead baby. She never seemed to heal down below after she had the baby and could not control her urine. She smelled so badly that she was thrown out of the village. It is only by luck that she heard of the fistula hospital, which is so kind to girls like herself.

Issues

One issue is that girls in developing countries are merely family property. They have no say in their future and no chance for education and career. They are seen as a burden to the family and in tight financial times, are better married off where the husband's family will be responsible for them.

Another issue is that adolescent pregnancy occurs before the adolescent's body has fully matured and her own nutritional needs are met. She may very well have been anemic at birth and continued to be anemic during childhood, as she would not receive the nutritious food that her brothers received but would only eat after they had finished. With the demands of pregnancy, she would become further nutritionally deprived with complications arising for both her and the fetus. She goes on to have obstructed labour with fistula formation and incontinence, making her repulsive and no longer welcome in the community.

The dialogue may proceed as follows:

P: I am so glad that you have found your way to our clinic. Can you tell me about the problem you are having?

A: I do not have very much schooling so do not know how to explain things well, but I'll try. I was the fifth daughter in the family of nine children. My mother tried to do her best to make the food go around, but by the time my father and four brothers were fed, there was often not enough food for us girls. My mother cried when my father insisted that I be given to his good friend as a wife, as it would be one less mouth to feed. My mother said that I was always smaller than my other sisters and that she was afraid what would happen if I became pregnant. My father said that was nature and what would be would be. My mother tried to tell me what to expect on my wedding night, but nothing she said prepared me for such pain. She told me that I had been circumcised as a baby and that it would be difficult for the man to enter. However, my husband kept trying night after night. When my monthly bleeding did not come, I spoke to my husband's other wives and they told me that I was pregnant. I was so tired during my pregnancy, never getting enough to eat. When I finally started having pains, they went on for days. I was crazy with the pain. Finally, I felt like I was being torn apart and my baby was born, but it was dead. I had so much bleeding and pain down below and I was constantly wet with urine and waste. I knew that I smelled bad and one day my husband told me to go back to my parents. When I reached home, one of my brothers told me that he had heard of this hospital that could help me.



P: Your story is a common one here at the hospital. What we do here is find out where the damage has been done and perform surgery to make sure you can control your body functions once again.

A: I'll be very thankful, but what will happen to me afterwards.

P: We are able to find jobs for many of the girls who have surgery here and to help them recover both physically and socially.



Case 13

Barbara is 16. She started menstruating at age 12. Her periods are regular. Her breasts started developing at age 10 and she wears a 38D bra. She will not wear the latest styles that are clingy as she is self conscious about the large size of her breasts. It becomes even more obvious when she is with her best friend, Sharon, who wears a size 32AA and looks like she has no breasts at all. Both Barbara and Sharon feel that they are freaks and cannot bear to change in the locker room for gym class.

Issues

The issue is one of self-esteem and body image. They need to learn that there are individual differences in body build that do not reflect on the person as a whole. The physician can help her learn how the media makes girls feel unhappy about their bodies by presenting unrealistic images of girls and women. They should be encouraged to be proud of who they are and to identify and celebrate their areas of strength. Both girls should be educated about confidence building and about such practical issues as how to dress to detract from the areas of their concern while highlighting other areas that they consider to be more attractive.

The dialogue may proceed as follows:

P: Hello, Barbara. It is nice to see you. I think it has been a few years since you have been to the office.

A: Yes, it has, because I am rarely sick. I hope you do not think I am wasting your time, but I am so upset that my mother suggested I come and talk to you.

P: I hope you realize that I am always willing to help you with a problem. So, what it is that has got you so upset?

A: You know my mom and my grandma and how big breasted they are? P: Yes, I know the family well.

A: Well, my breasts are just too big and I feel like a freak. All my friends wear these tight tank tops and when I wear mine, I look hideous. I try and walk with my shoulders hunched over a bit so that my breasts are not so obvious. I am embarrassed to change for gym, especially when my best friend, Sharon, has almost no breasts.

P: Everyone is made differently and we have to learn to accentuate our strengths and compensate for our weaknesses. We cannot easily change our physical appearance and it is important to feel good about yourself. Not that this is the only answer, but one thing we can do to change our physical appearance is changing the way we dress. For example, you feel uncomfortable when you try and wear the tight tank top that is in style. I have a friend who works over in the teen ware at the mall. If you would like, I'll ask her to give you some ideas that will make you feel stylish yet not accent your breasts. However, I am concerned about how you feel about yourself and I want to make sure that you feel good about yourself.



[NOTE: At some point, the physician should ask Barbara what she may have had in mind about what the physician could do to help her. Perhaps she has heard about breast reduction surgery. Then the physician would have to ask Barbara what she knows about it and provide information. It is important to emphasize that this is major surgery with potential serious complications and certainly not appropriate for a girl at such a young age.]

A: Thank you very much. I am so glad I came to see you and I'll definitely be back.



Case 14

Maria, who is 14, is brought to emergency beaten and bruised. She is from the Philippines and was told that if she came to Canada she would get a job as a nanny and make good money. When she got here, she found out that she was not going to work as a nanny, but was forced into prostitution. She was one of many girls who found themselves in the same predicament. They tried to protest but were given drugs repeatedly until they became submissive and did what they were told. They had no family or friends in Canada and were at the mercy of the pimp. Maria was working the streets tonight and when she got into a car for a trick, the guy started verbally abusing her. She tried to get out of the car but he sped away and took her to the outskirts of town where he first had sex with her, then beat her and threw her out of the car. If it had not been for some hikers passing by, she would still be lying in the bush unconscious.

Issues

The issue is one of poverty, isolation, lack of self-support and lack of empowerment. In countries where the standard of living is poor, there is a belief that life will be better in distant lands. Adolescents with no recourse are at the mercy of those who exploit them. They are often lured away by sex-traffickers with promises which are never fulfilled. Instead these girls often become enslaved to these criminals.

It is important to determine together with Maria if the police should be notified or if she does not want them involved because of her immigration status.

The dialogue in the emergency department may proceed as follows:

P: Hello, Maria, I am the doctor. Please don't be afraid, as I would like to help you. Do you know what happened tonight?

A: Will you tell anyone else what I am going to tell you?

P: No, only the professionals involved with your care will know what is necessary to help you and this only with your consent.

A: I have been working as a prostitute since I arrived in Canada from Manila a few months ago. My family and I were so excited to hear that I was coming to Canada to be a nanny. When I got here, my employer told me that I would not be a nanny but would work the streets and if I told anyone, he would turn me into the police. Tonight, when I was standing on the corner, this car pulled up and told me he would like my services and that he had a room a few blocks away. I got scared when he kept driving and we ended up in a park at the edge of town. He raped me and beat me and threw me out of the car. I was too beaten up to move. I lay there all night and some hikers found me this morning and the ambulance brought me to hospital. I wish I had died.



P: I am going to try my best to make sure of that. There will be no need to go back to that kind of life. I am going to examine you and treat you for your wounds and for any infections you may have been exposed to last night. I am going to give you some pills to prevent pregnancy in case you are not using contraceptives. I am then going to ask the hospital social worker to access the many resources we have to help you get settled into a better life.

A: Thank you. I am so scared that the john or the pimp will find me.

P: Many of our resources will be able to help protect you from that.

(International Consortium for Emergency Contraception
<http://www.cecinfo.org/files/Guidelines%202nd%20editione.pdf>)



Case 15

Nonhlanhla age 14 was brought to the local health clinic by her mother as she was not well. As the story unfolded, she had been raped by her uncle, who was HIV positive. He was of the belief that if you had sex with a virgin, it would cure you of HIV. Nonhlanhla was tested and found not only to be HIV positive herself, but also to have Chlamydia and Herpes.

Issues

Myths around sexuality are abundant and it will require much education to dispel them. One particularly devastating myth is that HIV can be cured by having sex with a virgin. In developing countries where education is not universal, dissemination of accurate information around sexuality is even more difficult than in a developed country.

The presence of other STI's, namely Chlamydia and Herpes, make the likelihood of contracting HIV higher due to disruption of the vaginal mucosa.

The danger of unplanned pregnancy is real.

Nonhlanhla is not empowered to speak out against her uncle as he has more power in the family than she does, since he is both older and a male. We need to help empower our girls in Africa.

In addition to medical help, education about sexuality, the dispelling of myths, the importance of practising safe sex and the role of gender role socialization in contributing to the spread of HIV all need to be included in the education of the community and the patient.

The dialogue may proceed as follows:

P: Nonhlanhla, I am here to help you. I asked your mother to let us talk alone, so that only you and I shall know what you tell me. I know it is difficult to speak about these things but your mother has told me that you are not well. Your tests show that you have infections and these kinds of infections come from sexual relations.

A: I do not have a boyfriend, so it is not what you think. I was raped but I cannot tell you who did it.

P: Many girls come to me with a similar story and it is often a family member who has raped them. One of the commonest reasons that they are raped is the belief that HIV will be cured if a man has sex with a virgin.

A: My mother said she would not tell you about my uncle. He is the head of our family and would make all our lives difficult if anyone knew what he did to me. He told me he would kill me if anyone found out. My mother knows only because she guessed what had happened and could tell by the look in my eyes.



P: Your mother kept her word. She did not tell me. It is just that your story is so common that it is no secret. I shall not tell anyone. You need to understand about the infections you have and this may be difficult for you. One of the infections is Chlamydia, which I can treat well with some antibiotic medicine. The second infection is Herpes, which is a virus. It is more difficult to treat because it stays in your system and can reappear at various times. Depending on how often it reappears, there is medicine available to suppress it. The third infection is the very one that your uncle hoped to cure by having sex with you and that is HIV.

P: What do you know about HIV?

A: I know that I am going to die, just like so many others in my village have died from HIV.

P: It is true that you have a very serious disease but it does not follow that you will die. Recent developments are making medicine available to the African people for the treatment of HIV/AIDS. We will do everything that we can to help you. We need to help empower our girls in Africa, and providing you with medical help will be one small step in working toward that empowerment.



Case 16

Susan, age 15, found herself pregnant and decided to continue the pregnancy and keep the baby. In grade 10, she realized that she must finish high school if she was to have any future for her and the baby. Her boyfriend dropped her when she would not have an abortion. Her family is supportive, but her mother and father both must work to pay expenses and therefore cannot baby-sit the baby while Susan attends school. Luckily, Susan found a high school that has babysitting arrangements for teen parents and has secured her a spot for the next term. She now comes to the doctor for her postpartum check.

Issues

This case illustrates choices. Susan is fortunate in that there is available help with daycare that will allow her to continue her education. There are issues around acceptance of teen pregnancy, family support, educational opportunities, and future social consequences of being a single parent.

Susan needs education about contraception to prevent future unplanned pregnancies. This case also demonstrates the importance of a physician who is supportive of the patient's decisions.

The dialogue may proceed as follows:

P: Your six-week check-up shows that you have recovered well from your delivery. I would like to talk with you about two things, one of which is birth control and the other is your plans for the future.

A: Thank you, doctor, for looking after me during my pregnancy and delivery. At times, I felt pretty alone. My parents were supportive, but not happy with my decision to continue the pregnancy and keep the baby. My boyfriend has not even asked to see the baby. I love my baby, but I realize that if I am to give her the chance for a good life, I must get my education.

P: How do you plan to manage childcare and school?

A: I have found a school not far from home that provides daycare for students. I am enrolled for next term.

P: Wonderful. How are you going to manage the costs of raising a child?

A: Fortunately, my parents are letting us live with them and I have been accepted to receive welfare payments.

P: How do you feel about your social life, now that you have a baby?



A: My social life has changed. Most of my old friends don't bother with me anymore, but I plan to make new friends with other single mothers when I start school next term.

P: I am pleased that you have your life organized. I wish you every success. Another of my concerns is that you do not have another unplanned pregnancy. What did you have in mind for birth control?

A: I am not going to be sexually active for awhile. If I enter into a new relationship, you can be assured that I shall be in to see you to discuss contraception and get a prescription.



Case 17

Laura is 18 and finished school. She had a learning disability and graduated with a modified high school diploma. She is a very personable girl, but has a pervasive disorder and does not always appreciate the difference between right and wrong. She got a job as a cashier at the donut shop but lost the job as the manager thought it took her too long to make change and she made too many mistakes. She has recently started dating Tom, who is 20 and working at the gas station, pumping gas. He too was slow in school and his last girlfriend left him when she became pregnant and had an abortion. Laura's mother comes into the office asking about birth control.

Issues

One issue is ability to make appropriate decisions. Although not academically inclined, Laura is not mentally delayed but rather impulsive and unable to clearly evaluate the consequences of her behaviour. She is friendly and a people pleaser but often makes wrong choices. She needs to have conversations where she does not feel that she is being spoken down to, yet needs to have things explained in a clear and understandable way.

The mother has come to the physician's office without Laura. It is important that Laura herself be involved in this discussion and the decision. Has the mother talked to Laura about her visit to the physician? It is necessary that Laura has contraception that she will find acceptable, that will be reliable and that she can remember to use. That is why it is critical that Laura be involved in any discussion.

This patient too needs to be empowered but there are other issues at stake. This patient need reliable birth control and if possible it would be advisable to use a method that requires less ongoing motivation and attention like Depo-Provera. Education is important here, because although she is "slow," this is not just an issue

about birth control. It is important to reinforce issues like STD's, the right to say "no," and when and if children should come into their life. These issues should be brought up repeatedly with hypothetical scenarios and discussion of the consequences of actions.

The discussion may proceed as follows, once Laura comes into the office:

P: Laura, nice to see you. What can I do for you today?

A: My mother told me that she had been in to see you and wanted me to be on birth control. She told me that you wanted to talk to me directly.

P: Yes, Laura, it is your body and you must have the information to make the decisions that will work best for you.



A: Thank you. You know that I have been having some trouble keeping a job. People say they like me, but they say that I am too slow in my work and that I do not catch on to new ideas fast enough. I was feeling sad about losing my last job until I met Christopher, who thinks I am great. I like him a lot too. He has been talking about having sex and I think I would like to have sex too.

P: Have you thought about what would happen if you got pregnant or got a sexually transmitted infection?

NOTE: At this point, although it does not need to be spelled out as dialogue, it is important to clarify what Laura knows and means about "having sex" and what does she know about her own body and its sexual responses. It is also important to know what kind of physical intimacy has already taken place and how she felt about that.

A: I have thought about it, but am not sure what I should do.

P: You tend to be very trusting, but I must warn you to look after yourself. There are many different methods of birth control from daily pills to weekly patches to injections to barrier methods. Could I suggest that we give you a method of birth control that will be easy to remember? I would like to suggest an injection that you receive every three months. However, I must remind you that to protect yourself from sexually transmitted infections, you need to have your partner wear a condom. I shall show you how to put on a condom on this model I have.

A: I am a bit confused by all this, but thank you for the handout. I shall buy the shot and be back next week to have the injection. Maybe we can go over things again then.

NOTE: At this point it is important to ask if she would like Christopher to come in with her as it is advisable that he participate in the conversation and that he too understand what you are teaching Laura.

P: Yes, by all means, and please read the book on birth control and STD's I have given you. See you next week



Case 18

Mara is a timid girl of 24 who has never done well in school. She is finally in a training program to learn to be a data entry clerk and has been doing well. She went out with Rob and he talked her into having intercourse, even though she told him she did not want to do so. He did not wear a condom but told her not to worry. She comes to the office feeling awful, unable to concentrate, feeling used and having failed her midterm exam.

Issues

The issue here is her assertiveness in terms of her own decisions about sexual activity and the lack of consideration of her feelings by Rob. She needs to be educated about how to feel empowered to make sexuality decisions that suit her. She is now somewhat depressed and this needs to be addressed. She needs to be educated about contraception and prevention of STI's.

The dialogue may proceed as follows:

A: Doctor, I am so upset. You won't tell my mother anything, will you?

P: Mara, please feel free to tell me anything. Nothing leaves this room without your consent.

A: I have gotten to know Rob at school. He invited me over to his place to watch TV. He got pretty friendly and I told him I did not want to have sex. He kept asking and asking until I gave in. It was all over in a minute and I noticed that he did not wear a condom. When I asked him about it, he said not to worry. But now I am worried about whether I am pregnant and whether he gave me an infection. I feel so cheap, as I planned never to have sex until I was married.

P: I can see how upset you are. I want to make sure that you have the know-how to make sure you do not find yourself in a similar situation again. The decision to have intercourse before marriage is an individual one, but it should be a decision that comes out of a good relationship with good communication and appreciation for each other's feelings. I do have some information for you that discusses how to handle such situations and I would like to talk to you about that. But first, let us check you to deal with your concerns about pregnancy and about STI's.

A: Thank you. I feel a bit better but I can't stop crying.

P: We have discussed quite a bit and you are quite upset. Do you have anyone to be with you tonight?

A: I am living at home right now, so won't be alone. I don't know yet what I am going to say to my mother.

P: I want to see you back again tomorrow or as soon as possible, to discuss your feelings and to have a talk about the prevention of pregnancy and sexually transmitted infections.



Case 19

Martha 16 years old comes to your office very distraught. She was sent by her parents abroad for one year of high school to a school for girls only. She had sex with her roommate and now she is confused, alone and without her parents. She seeks your professional help.

Issues

The issues are about sexual identity, much as in Case 5 with Rob and his fear that he is homosexual. However, her feelings and knowledge about homosexuality need to be explored further.

She should be reassured that one homosexual encounter does not mean she is a lesbian.

The dialogue may proceed as follows:

P: Martha, nice to meet you. I understand you are here from North America to study in Switzerland.

A: Yes, I have really enjoyed being in Switzerland. But, something happened that is making me very worried. Do you mind if I talk to you about it?

P: Not at all. Please go ahead.

A: One night last week, a group of us girls from the dorm went to a party. Someone sneaked in some alcohol and marijuana and I don't know why I did it, but I tried a bit of both. After that, my roommate and I went home and before I knew it, she was touching my private parts. What was worse, was that it felt good and I let her continue. Now, I am so worried. I have dated many boys before and felt attracted to boys, but now I wonder if I am a lesbian.

[NOTE: As in Case 5, it may be harmful to reassure her about her orientation without further exploration. If she is panicky because she now realizes she is gay, reassuring her that she is not could be very harmful. Instead, it is necessary to spend a bit of time exploring her understanding of homosexuality, her fantasies, her dreams and her previous encounters.]

P: Don't be too quick to jump to conclusions. You are still exploring many of your sexual feelings. One homosexual encounter does not make you a lesbian. Many people will have had a similar experience in their adolescent years. Take your time and explore your feelings. If you have anymore questions or concerns, come back and we shall talk some more. Right now, you can rest assured that this has been only an isolated encounter.



Case 20

Patrick, age 17, comes to the office looking quite anxious. With great difficulty, he tells you that he is dating his first girlfriend. They have had intercourse twice now. His worry is that his penis is very small and that he is scared that he can't satisfy her. He is afraid that she doesn't like sex with him. He wants to know if you can help him.

Issues

Patrick should be told that he is insecure because he is sexually inexperienced. He should be advised to talk with his girlfriend and see if she does enjoy having intercourse with him.

He must be told that whether she likes having sex with him has nothing to do with the size of his penis because most of the erogenous parts are outside of the vagina, such as the clitoris. The size of his penis makes no difference to external stimulation.

He should also be told that the size of the flaccid penis is not necessarily proportional to the size of the erect penis.

He should be educated that the vagina adapts to the size of the penis, so it does not matter how long, small, thick or thin it is. He should be told that it is more important to explore with his girlfriend what pleases her. It is important for them to talk to each other about their likes and dislikes.

The dialogue may proceed as follows:

P: Patrick, I see that you are upset about something. May I help you?

A: Yes, I am upset. I have my first serious girlfriend and we have had sexual intercourse twice now. I have rented some of the adult movies and my penis is so small in comparison to the men in the movies. I am afraid that my girlfriend will not be satisfied.

P: The male penis comes in all sizes. The amount of satisfaction during intercourse is influenced by many forms of stimulation, long before the penis enters the vagina.

Such things as stimulation of the woman's clitoris by hand or by mouth are important in ensuring enjoyment. The vagina adapts to the penis, whatever its size.

[NOTE: It is important that he be examined before he is told he is normal, to ensure that he does not have an anatomical abnormality such as hypospadias or chordee.]

A: I really feel that I know almost nothing about having a sexual relationship.



P: I have some very good reference material that I am going to recommend. I want you to make an appointment to see me again in a couple of weeks, once you have read some of this material. At that time, we can discuss what you have read or any other questions or concerns that you might have.

[NOTE: Giving him material and arranging for him to return is a realistic way of dealing with this in a busy office as there is often not time to address the presenting symptom and do education at the same time. However, what is to be avoided is the sense of giving the adolescent the "brush off."]



Case 21

Meghan comes into the office for a routine check-up as she is now 15 and has not been to the office for 3 years. She is a healthy teenager, currently in grade 10 and plans to go to university when she finishes high school. She thinks she would like to train in the health care field either as a nurse or physiotherapist. She is currently involved in sports, playing on the school volleyball team and also plays the saxophone in the school band. She makes friends easily and has a good group of friends, but no steady boyfriend.

On taking the medical history, other than the occasional cold and flu she has no complaints. She started her periods at age 12 and they are no problem. Physical examination shows a healthy teenager.

Issues

Adolescents do not come to the office frequently. This is an excellent opportunity to discuss age-related issues of sexuality and make the adolescent aware that she/he can approach you with concerns regarding sexuality.

Physicians should accept the responsibility for disseminating to their adolescent patients accurate and appropriate information regarding healthy sexuality and its expression.

The dialogue may proceed as follows:

P: It is such a pleasure to see you again, Meghan. Having not seen you for a few years, it is nice for me to see that you have good plans for your future. I find you to be in very good condition. Many girls your age will soon find themselves dating and they often have questions about their bodies and how they are developing, their feelings and their future relationships. Do you have any concerns in that regard?

A: I am so glad that you asked. There is a boy in my class named Jason whom I like. I think he wants to ask me out, but if he does, I am not sure what is expected of me on a date. Some girls in my grade say that all a guy wants from a girl is to have sex with them.

P: The most important thing is that both you and Jason have an equal say in whatever you decide to do. A good relationship has both the boy and the girl respecting one another. Whether the relationship develops into a sexual relationship will be a decision made by both of you and should not be something you feel forced into.

A: Even though I get good marks in school and play sports and play in the band, I really feel that I know nothing about the sexual part of my body.



P: You should find it comforting to know that many people your age are just like you. The schools give you some sexual information in the Career and Personal Planning program, but it often does not answer the nitty gritty questions that you would like to ask, but are afraid to do so. Is there any particular question that you would like to ask me right now? Some young people have concerns about masturbation, about their vaginas becoming wet when they get sexual feelings or about the ways in which they can show they care a lot about someone.

A: May I come and see you when I want to go on birth control or should I go to a youth clinic?

P: I would like you to feel comfortable in coming to me not just to discuss birth control but to discuss other sexual concerns you may have. At that time, if you decide you need it, I can provide the method of birth control you decide would be best for you.

A: Thank you.

P: I would like to give you a website put out by the Society of Obstetricians and Gynecologists of Canada, called sexuality and u. It can be found at www.sexualityandu.ca. I want you to feel comfortable to talk to me about questions you have about your sexuality. Many girls go off to the walk-in clinic to talk about such issues, as they think that the family doctor will discuss the conversation with their parents. I want to reassure you that discussions that go on in this office are confidential. Why don't you have a look at that website, make an appointment to see me again in two weeks and come with a list of questions that you would like answered.

A: Thank you. I feel that I now know that you are more than just a doctor for cough and colds and that I can confidentially discuss much more personal things with you.



Case 22

Michelle and Justin are in grade 12. They have had casual dates with others before but this is the first serious relationship for both of them. They come to the office to talk to you about sex. You delivered Michelle and have looked after her all her life, but do not know Justin.

Issues

The physician must be comfortable talking about adolescent sexuality issues. The information must be accurate, understandable and non-judgmental.

Physicians should accept the responsibility for disseminating to their adolescent patients accurate and appropriate information regarding healthy sexuality and its expression.

The dialogue may proceed as follows:

P: Hello Michelle. It is nice to see you. Whom have you brought with you today? A: Hello, Dr., this is Justin. We are in the same school and have been dating for the last six months.

P: Nice to meet you Justin. Tell me what I can do for you the two of you today.

A: When I was in for a check-up last year, you told me that if I ever had concern about relationships and sex and such things that I should feel free to come and talk to you and that you would not tell my parents.

P: That is true, Michelle, and I am so pleased that you feel confidant that you can confide in me. Were there some specific questions that you wanted to ask me?

A: Michelle wants me to explain our dilemma. I always thought that Michelle was cute, so I asked her out about six months ago and we really hit it off. We are getting to the point where we get pretty aroused when we are together and we think that it won't be long before we can't stop the urge to have sex together. We are not sure that we should go all the way but it is getting difficult to stop. Michelle is worried that some of the things we are doing now are not normal.

P: There are many ways to satisfy one's sexual needs besides actual intercourse.

A: I am glad to hear you say that because Michelle is worried that it is wrong when we touch each other with our hands and mouth.

P: Whatever the two of you decide to do must be comfortable for both of you. What you are describing is certainly okay and commonly practised. Masturbation, mutual masturbation and oral sex are perfectly normal ways to express your Let me give you this handout book called Sex Sense, which answers a lot of questions for adolescents. I am also going to refer you to a couple of good websites, so that the two of you can get a good knowledge base from which to work.



However, if you do think you are going to proceed onto actual intercourse, we need to talk about safe sex, both from the point of view of preventing sexually transmitted diseases and preventing pregnancy. I am going to ask you to read this book, visit those websites and then I want you both to schedule an appointment with me for a week to ten days down the road, so we can talk about what you have read and any questions you may have.

A: Thank you. We feel better already knowing that we can talk to you.

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WEBSITES

Organizations

Adolescent Forum Listserv: www.ippfwhr.org

International Planned Parenthood Federation/Western Hemisphere Region hosts an online newsletter that highlights adolescent sexual and reproductive health programs of IPPF/WHR affiliates and other organizations in the region.

Advocates for Youth: www.advocatesforyouth.org

Advocates for Youth creates programs and promotes policies to help young people make informed and responsible decisions about their sexual and reproductive health.

African Networks for Health Research & Development(AFRO-NETS):
<http://afronets.org/>

The AFRO-NETS website was established in 1997 to facilitate exchange of information among different networks active in health research for development in Anglophone Africa, and to facilitate collaboration in the fields of capacity building, planning, and research.

Volume 1 Growing Up: (<http://afronets.org/files/vol-1.pdf>)

Volume 2: Male- Female Relationships Among Adolescents (<http://afronets.org/files/vol-2.pdf>)

Volume 3: Sexual Relationships: (<http://afronets.org/files/vol-3.pdf>)

Volume 4: Pregnancy (<http://afronets.org/files/vol-4.pdf>)

Volume 5: Healthy Relationships (<http://afronets.org/files/vol-5.pdf>)

Volume 6: HIV/AIDS (<http://afronets.org/files/vol-6.pdf>)

Center for Development and Population Activities (CEDPA): www.cedpa.org

CEDPA is an international women-focused, nonprofit organization that seeks to empower women at all levels of society to become full partners in development. CEDPA's work in youth development aims to expand young people's life choices with regard to fertility, education, health, employment, and civic participation through a comprehensive assets-based approach, infused with a gender and human rights perspective.

Emergency Contraception Website: International Consortium for Emergency Contraception <http://www.cecinfo.org/files/Guidelines%202nd%20editione.pdf>

GenderHealth: www.engenderhealth.org

GenderHealth (formerly AVSC International) works to improve reproductive health services worldwide.

**Family Care International (FCI) <http://www.familycareintl.org/en/home>**

FCI is a nonprofit organization dedicated to improving women's sexual and reproductive health and rights in developing countries. Stepping Out is a video series comprised of six short modules on themes such as human growth and development, self-esteem, decision making, communication skills, relationships, and the consequences of unprotected sex. A second resource, You, Your Life, Your Dreams, is an information handbook designed for youth aged 14 to 19.

Family Health International (FHI) www.fhi.org

FHI works to improve reproductive and family health around the world.

YouthNet (<http://www.pathfind.org/>) is a global, USAID- sponsored program to improve reproductive health and prevent the spread of HIV/AIDS among people 10 -24 years old.

FOCUS on Young Adults. Young Adults was a USAID-funded program that worked from 1995 to 2000 to improve the health and well-being of young adults through effective adolescent initiatives in developing countries. FOCUS developed many publications that may be downloaded or printed directly from the Pathfinder website.

German Foundation for World Population DSW: <http://www.dsw-online.org>

DSW works in developing countries to address the needs of adolescents by building the capacity of NGOs to provide reproductive health information and services.

Global Reproductive Health Forum:

<http://cloud2.gdnet.org/~organizations/Global%20Reproductive%20Health%20Forum%20%28GRHF%29>

Hosted by the Harvard School of Public Health, this site promotes networking and an exchange of perspectives on gender, rights, and reproductive health issues. The Maternal Health section in the Research Library area provides information about adolescent reproductive health. This site is a rich source for links to other organizations. It is available in English and Spanish.

Implementing Adolescent Reproductive Rights Through the Convention on the Rights of the Child: <http://reproductiverights.org/en/resources/publications>

This excellent briefing paper highlights major sexual and reproductive health issues that affect adolescents in the context of their reproductive rights. It focuses on issues that are universal to all girls education, contraception, sexual violence, HIV/AIDS, abortion, and access to reproductive health care in addition to issues of regional significance such as early marriage and female genital mutilation. This paper also presents a comprehensive summary of post-ICPD laws and policies that represent "best practices."

International Planned Parenthood Federation (IPPF) www.ippf.org

IPPF links family planning associations in more than 50 countries worldwide. IPPF has made a strong commitment to meeting adolescent reproductive health needs and has found many innovative ways to involve young people in planning and implementing programs.



Johns Hopkins University Center for Communications Programs (JHU/CCP)

www.jhuccp.org

The JHU/CCP site is a rich source for family planning and reproductive health information. It includes the Media/Materials Clearinghouse (M/MC), an international resource for health professionals who seek samples of media and materials that promote reproductive health; NetLinks, a showcase of online resources useful to those working in population, health, and development; PHOTOSHARE, an online database of international photographs related to reproductive health, public health, and population in developing countries; the full text of

The Joint UN Programme on HIV/AIDS (UNAIDS) <http://www.unaids.org/en/>

This website offers comprehensive global information on HIV/AIDS, including sections on the World AIDS Campaign, best practices in AIDS prevention, and global HIV/AIDS statistics.

DS as it relates to youth worldwide

www.unaids.org/publications/documents/children/index.html#young).

National Campaign to Prevent Teen Pregnancy www.teenpregnancy.org

The National Campaign to Prevent Teen Pregnancy supports values and stimulates actions that are consistent with a pregnancy-free adolescence.

Pacific Institute for Women's Health (PIWH) www.piwh.org

PIWH works to improve women's health and well-being in the United States and around the world.

Pan American Health Organization (PAHO) www.paho.org

PAHO has been a pioneer in addressing the health of adolescents and young people within the context of their social and economic environment, as well as in developing mechanisms to meet their needs, especially their health needs. The adolescent health materials section (www.paho.org/Project.asp?SEL=TP&LNG=ENG&CD=ADOLE) includes an overview of general health and reproductive health issues, program strategies, and links to many organizations working with youth in the Americas. Many of the materials listed are available in Spanish as well as English.

PAHO's plan of Action for Health and Development of Adolescents and Youth in the Americas, 1998-2001 is available online in English <http://www.paho.org/English/HPP/HPF/ADOL/planact.pdf> in Spanish: at www.paho.org/Spanish/HPP/HPF/ADOL/planspa.pdf, and in French: at www.paho.org/French/HPP/HPF/ADOL/adolescentsameriques.pdf.

PATH (Program for Appropriate Technology in Health) www.path.org

PATH has been involved in reproductive health programming worldwide for 25 years.

Pathfinder International www.pathfind.org

Pathfinder International, a U.S.-based nongovernmental organization, supports family planning and reproductive health initiatives in 37 countries in Africa, Latin America and the Caribbean, and Asia and the Near East.



The Population Council www.popcouncil.org

A recent monograph, The Uncharted Passage: Girls' Adolescence in the Developing World, can be ordered from the Population Council.

Save the Children www.savethechildren.org/home.shtml

Save the Children is implementing adolescent reproductive and sexual health activities and programs.

Scientists for Health and Research for Development: www.shared.de

The SHARED project integrates information about health research and development projects in countries in Europe and the developing world.

TeenAIDS: <http://www.teenAIDS.org>

Maintained by PeerCorps with technological support from Harvard and MIT, TeenAIDS is a comprehensive and easy-to-use resource for adolescents and adults affected by AIDS.

UNESCO Bangkok www.unescobkk.org

The Adolescent Reproductive and Sexual Health section of this website includes demographic profiles of adolescents in Asia and the Pacific; advocacy and IEC (information, education, and communication) strategies for adolescent-oriented programs; reproductive and sexual health information; publications and resources; links; and news.

United Nations Population Fund (UNFPA) www.unfpa.org

Adolescent reproductive health is a priority concern of UNFPA. UNFPA's support of activities targeted at adolescents has expanded dramatically in the last decade, as has the scope of UNFPA programs. This site includes sections on youth participation, youth-friendly services, and girls' empowerment.

World Conference on Women: Beijing Declaration and Platform of Action www.un.org/womenwatch/daw/beijing/platform

This report from the World Conference on Women, which was held in Beijing in 1995, includes information about the conference resolutions and specific sections on the reproductive health needs and rights of women and girls.

World Health Organization (WHO) www.who.org

This site offers extensive resources and information, including a list of WHO's publications relating to adolescent sexuality and reproductive health published www.who.int/dsa/cat98/adol8.htm

Youth Coalition on the ICPD+5 www.youthcoalition.org/

This site has been created by a group of more than 50 committed youth from 29 countries working at local, national, and international levels. The site describes their advocacy, program delivery, research, and writing work that promotes the full implementation of the Cairo Programme of Action. It includes information on the ICPD+5 Youth Forum, the Youth Coalition at the PrepComm, and Youth at the UNGASS.



Websites for adolescents and physicians

Act Now! www.entraenaccion.org

Act Now! is the first comprehensive site for Spanish-speaking young people.

Advocates for Youth: www.advocatesforyouth.org/teens/index.htm

This section of Advocates for Youth's website devoted to teens offers information to help young people become more informed about reproductive and sexual health issues, get involved in the issues through advocacy, and connect with others around the world who are interested in the issues.

Canadian government agency produces a website entitled Beyond the Basics for adolescents
<http://www.cfsh.ca/>

Facts of Life Line <https://www.optionsforsexualhealth.org/sex-sense>

The Canadian Planned Parenthood Foundation offers confidential information and referrals about birth control, pregnancy options, emergency contraception, sexually transmitted diseases and HIV.

The Family Planning Council's Teen Talk

www.familyplanning.org/pages/familyteen.htm

This website includes a newsletter, Keepin' It Real, which discusses adolescent self- esteem and how it influences sexual behavior, and a youth-friendly publication on puberty.

Go Ask Alice! www.goaskalice.columbia.edu

This site offers a frank, comprehensive source of general health and sex information maintained by Columbia University health educators.

It's Your (Sex) Life www.itsyoursexlife.com

Sponsored by the Kaiser Family Foundation, this website provides reliable, objective sexual health information to young adults.

Love Life www.lovelife.org.za

Love Life is national collaborative program of leading South African governmental organizations in partnership with the Department of Health, the National Youth Commission, UNICEF, other government agencies and private sector organizations. Its primary goal is to positively influence adolescent sexual behavior to reduce teenage pregnancy, STI's, and HIV/AIDS.

Museum of Menstruation www.mum.org

Developed for the Museum of Menstruation (located in a suburb of Washington, D.C.), this website is devoted to the global rituals and culture of menstruation.



The U.S.-based Network for Family Life Education launched SEX, ETC., a sexuality and health newsletter written by teens for teens www.sxetc.org

SEXUALITY AND U. www.sexualityandu.ca

This Canadian based website of the Society of Obstetricians and Gynaecologists of Canada is a user-friendly site for adolescents and adults alike.

SIECUS for Teens <http://www.siecus.org/index.cfm>

This part of the SIECUS website is a starting place for teens to learn about sexuality issues.

Training and Research Support Centre (TARSC) www.tarsc.org/

Based in Zimbabwe, TARSC provides training, information, research, and capacity support in the areas of public health; social policy; food security; social protection; social and economic rights; reproductive, gender, and child rights; and civic-state relations. TARSC works mainly in southern Africa and networks with nongovernmental, governmental, and academic organizations.

Auntie Stella: Teenagers Talk About Sex, Life and Relationships was originally produced by TARSC as an activity pack for young Zimbabweans aged 13 to 17 years, and later developed as a website (www.tarsc.org/auntstella/index.html) to encourage young people to discuss key teenage issues and to give information that teenagers find hard to get elsewhere.

UNICEF's Voices of Youth www.unicef.org/voy

This website is designed for youth worldwide as a venue for them to share ideas on important world issues and to get involved in activities and problem solving.



APPENDIX 1: Methods of Contraception

Birth control pill ("the pill")

What it is: The birth control pill (BCP) is a mixture of estrogen and progesterone in a small tablet that you take 2 days and stay off 7 days.

How it works: The pill works by a variety of methods, the most important being that it stops a female from ovulating. It also increases the thickness of the mucus from the cervix, making it harder for the sperm to penetrate. If you miss one pill take it as soon as you remember. If you miss two pills take two the day you remember and two the next day and use backup contraception. If you miss more than two pills throw away the package, use backup contraception and start a new package that day.

Effectiveness: 99.9%

Side effects: If you are prone to blood clots in your legs and lungs, you should not take the pill. If you have liver disease or migraines, you should ask your doctor if you are able to take the pill. The commonest side effects are the ones that usually wear off after taking a few packages of the pill. When you first begin the pill, you may have spotting throughout your menstrual cycle, sore breasts or feel a bit nauseated.

Correcting false beliefs:

The pill does NOT cause cancer. In fact, taking the pill makes it less likely to develop ovarian cancer later in life.

The pill does not stop a woman from becoming pregnant later in life.
There is NO time limit to how many years you can take the pill. Providing you have no health problems, you can take the pill until menopause.

Depending on when you start taking the pill, you need some time before it starts working. It is best to take one full package before you feel you are protected.

The pill does NOT cause you to gain any significant amount of weight beyond one or two pounds.

The pill does not protect you against sexually transmitted infections. You must use a condom with the pill for dual protection.



Hormone patch

What it is: The patch contains estrogen and progesterone like the birth control pill does, but it enters your body through your skin.

How it works: The patch works by stopping ovulation. The only advantage over the birth control pill is the ease of administration.

Effectiveness: 99.9%

Side effects: Irritation from the glue of the patch. If you are prone to blood clots in your legs and lungs, you should not take the patch. If you have liver disease, you should ask your doctor if you are able to take the patch.

Correcting False Beliefs:

The patch does NOT cause cancer. In fact, taking the patch makes it less likely to develop ovarian cancer later in life.

The patch does not stop a woman from becoming pregnant later in life.

The patch does not protect you against sexually transmitted infections. You must use a condom with the patch for dual protection.

Depo-Provera

What it is: Depo-Provera is a hormone known as progestin which is like the progesterone portion of the birth control pill without the estrogen given by a needle every three months.

How it works: It works by having the body slowly release the hormone into your system to prevent ovulation and changes the lining of the uterus.

Effectiveness: 99.7%

Side effects: Some people will have irregular spotting. This is not serious and disappears the longer you use this method. Some people find that their appetite increases. There is nothing in the medicine to put on weight, but excessive eating will make you gain weight. Over long periods of time, there is some thought that the medicine can make your bones weak, so make sure you take enough calcium and vitamin D in your diet.

Correcting False beliefs:

It is NOT harmful not to have periods. The menstrual blood is not backing up in your body. As the hormone affects the lining of the uterus, there is little to no blood to be shed at period time. The shot does NOT protect against sexually transmitted infections. You must use a condom for dual protection.



Male condom

What it is: The condom is a latex cover that is rolled over the penis. Some Brands are made of polyurethane.

How it works: The condom collects so that it does not enter the partner's body. It is used for the dual purpose of preventing pregnancy and sexually transmitted infections.

Effectiveness: 97% if applied correctly. The breakage rate for latex condoms is 1.2 % and for polyurethane condoms is 3.8%.

Side effects: Allergic reactions if either partner is allergic to latex.

Correcting False Beliefs:

Vaseline (Petroleum jelly) should NOT be used as a lubricant. If a lubricant is necessary, it should be water based like KY Jelly.





Female condom

What it is: The female condom is made of polyurethane and is a bag that fits into the vagina and over the pubic area.

How it works: The female condom mechanically prevents sperm from entering the vagina. It is used for the dual purpose of preventing both pregnancy and sexually transmitted infections.

Effectiveness: 95%

Side effects: The female condom may squeak during use. This squeaking is decreased by using lubricant in the vagina.

Correcting False Beliefs:

You do NOT need a prescription as it can be purchased from the drugstore.

Contraceptive sponge

What it is: It is a disposable sponge containing spermicide.

How it works: It works as both a barrier and as a spermicide to kill sperm.

Effectiveness: Poor by itself. 98% if used in combination with a condom.

Side effects: Some people find it irritates the vagina and gives them a discharge. Some people find it difficult to remove as it fits snugly against the cervix. You may find it helpful to bear down as if you are moving your bowels.

Correcting False Beliefs:

The sponge does NOT protect against sexually transmitted disease. A condom must be used in combination.



Diaphragm

What it is: The diaphragm is a covered ring made of latex.

How it works: The diaphragm covers the cervix and does not allow the sperm to enter into the uterus. One to two teaspoons (5 to 0 mls.) of spermicide must be placed into the cup of the diaphragm where it will touch against the cervix to kill sperm.

Effectiveness: 92 to 96% if used with spermicide

Side effects: Local irritation in the vagina, particularly if using the wrong size.
Sensitivity to the spermicide.

Correcting False Beliefs:

You can NOT pick up a diaphragm without being fitted for the correct size. You are NOT protected for sexually transmitted diseases unless you use a condom with the diaphragm.

Cervical cap

What it is: The cervical cap is a small version of a diaphragm made of latex that fits over the cervix.

How it works: The cervical cap works by mechanically covering the cervix. One to two teaspoons (5 to 0 mls.) of spermicide must be placed into the cup of the cervical cap where it will touch against the cervix to kill sperm.

Effectiveness: 87-90% if used with spermicide

Side effects: Local sensitivity to latex or spermicide. Mechanical irritation from the cap on the cervix. The number of different sizes of cervical cap available is inadequate to fit many females. It can easily become dislodged during sexual intercourse.

Correcting False Beliefs:

You can NOT purchase a cervical cap without first being fitted for the proper size.

You are NOT protected for sexually transmitted diseases unless you use a condom with the diaphragm.



Lea Contraceptive

What it is: It is a variation on the diaphragm but made of silicone.

How it works: The Lea Contraceptive sits in front of the cervix to mechanically prevents sperm from entering the cervix. It must be used with spermicide.

Effectiveness: 87% if used alone 9 % if used with spermicide

Side effects: Mechanical irritation. It is difficult to insert. Sensitivity to the spermicide.

Correcting False Beliefs:

The Lea Contraceptive does NOT protect against pregnancy unless used with spermicide.

You are NOT protected for sexually transmitted diseases unless you use a condom with the diaphragm.

Intrauterine Contraceptive Device (IUD)

What it is: The IUD is a small T-shaped device that fits inside the uterus. There are two types, one that has a copper wire wrapped around the long arm of the T and the second that has progesterone inside the long arm of the T.

How it works: The IUD works both by killing sperm and changing the lining of the uterus. Both the copper wire and the progesterone affect the lining of the uterus.

Effectiveness: Good for 5 years.

Side effects: Your period may be heavier and crampy but the newer Mirena IUD containing progesterone actually decreases the menstrual flow and the cramping pain

There is a higher risk of pelvic inflammatory disease if you contract a sexually transmitted disease.

If you have not had a baby, it may be difficult and painful to insert.

Correcting False Beliefs:

The IUD does not protect you against sexually transmitted diseases. In fact, the presence of the string protruding into the vagina may make it easier for viruses and bacteria to travel into the uterus and Fallopian tubes and cause pelvic inflammatory disease. .



Tubal Ligation

What it is: Tubal ligation is an operation to permanently close the Fallopian tube. This requires the female to be anesthetized. A laproscope is inserted through the abdomen and the tubes are either burned or a Filsche clip is placed on the tube which cuts it in half and closes the tube.

How it works: When the passageway through the Fallopian tube is destroyed, sperm cannot pass through the tube to meet up with the egg. Fertilization occurs in the outer third of the Fallopian tube.

Effectiveness: 97.5 to 99%

Side effects: Complications of surgery include bleeding, infection and damage to surrounding tissues like bladder and bowel.

If you do become pregnant following tubal ligation, the pregnancy will be in the tube (ectopic) 50% of the time, which can be life threatening if not recognized and surgery performed.

Correcting False Beliefs:

Tubal ligation is permanent. People who have it reversed can expect the reversal procedure to be expensive and with no guarantee of success.

You are NOT protected from sexually transmitted diseases unless you use a condom.

Vasectomy

What it is: Vasectomy is the permanent closure of the sperm ducts (vas deferens).

How it works: Vasectomy stops sperm from entering the ejaculate. Without a microscope you could not tell that the ejaculate is devoid of sperm.

Effectiveness: 98-99.9%

Side effects: Swelling, infection and bleeding after surgery.

Correcting False Beliefs:

Vasectomy does NOT cause an increased chance of heart attack.

Vasectomy does not cause cancer of the prostate.

Vasectomy does not protect you against sexually transmitted diseases.

You are NOT protected from sexually transmitted diseases unless you use a condom.

It can take up to three months before there are no sperm in the ejaculate.

A semenanalysis is required to make sure that the ejaculate

Contains no sperm. .



Withdrawal

What it is: Withdrawal means pulling the penis out of the vagina before ejaculation.

How it works: It works very poorly, but the concept is that the sperm will not enter the vagina.

Effectiveness: 8 %

Side effects: Failure of mutual pleasure by both partners as sexual intercourse stops just prior to the male ejaculating and the female partner may not have reached orgasm.

Correcting False Beliefs:

There ARE sperm in the secretion that comes from the penis prior to ejaculation. These sperm can cause pregnancy.

You are NOT protected from sexually transmitted diseases unless you use a condom.

Billings Method

What it is: The Billings method is a complex system of looking at the mucus in the vaginal discharge to see if your body has reached ovulation time and having sexual intercourse only when it is not ovulation time.

How it works: If ovulation does not occur around the time of sexual intercourse, the sperm and egg cannot make contact and pregnancy cannot occur.

Effectiveness: depends on the skill of the person

Side effects: nil

Correcting False Beliefs:

A female's cycle is not always constant. Ovulation may occur earlier or later than normal and the change in vaginal discharge may be missed.

Sperm CAN survive for several days in a female's body and wait around until ovulation occurs.

You are NOT protected from sexually transmitted diseases unless you use a condom.



Emergency Contraception

What it is: It is the taking of hormones in specific doses after unprotected intercourse to prevent pregnancy.

How it works: It works by changing the mucus from the cervix so it does not let the sperm enter as easily and changes the lining of the uterus so that it is not ready for pregnancy.

Effectiveness: 99%

Side effects: Nausea and vomiting

Correcting False Beliefs:

Should the emergency contraception fail, the baby will NOT be harmed by having taken the medicine.

(International Consortium for Emergency Contraception
<http://www.cecinfo.org/files/Guidelines%202nd%20editione>) .



APPENDIX 2 Sexually Transmitted Infections (STI's)

Chlamydia

Cause: This is a genital infection caused by a bacteria. Unprotected sex including oral sex causes it to spread.

Symptoms: Vaginal discharge, abnormal vaginal bleeding and painful urination can be symptoms but just as often there are no symptoms. Make sure you get screened for sexually transmitted infections when you have your Pap smear. For males, a urine sample can be used for screening.

Treatment: Various antibiotics can be used including Zithromax, Doxycycline. Both partners need to be treated at the same time. Follow-up cultures for infection need to be done.

Complications: The presence of any other sexually transmitted infection increases the risk of HIV. Untreated infection in women may cause pelvic infection which may result in the inability to get pregnant. If pregnancy does occurs there is an increased chance of the pregnancy being in the tube (ectopic pregnancy) due to scarring in the pelvis.

Gonorrhea

Cause: This is a genital infection caused by a bacteria. It is spread by unprotected sex including oral sex.

Symptoms: There may be no symptoms. Some females have vaginal discharge or abnormal vaginal bleeding. Some males have discharge from the penis or burning when passing the urine.

Treatment: Both partners need to be treated with antibiotics. Follow-up cultures should be done to make sure the infection is cleared.

Complications: In females, the infection can cause pelvic inflammatory disease with the result that the woman will not be able to get pregnant. If she does, due to scarring in the pelvis, she may have a tubal (ectopic) pregnancy. Some people can develop arthritis from gonorrhea infection. Having gonorrhea at the same time you are exposed to HIV, makes it more likely that you will become infected with the Human Immunodeficiency Virus.



Genital Herpes (Cold Sores)

Cause: Cold sores are caused by a virus. Touching the infected area either with your hands or genitals through unprotected intercourse. Like warts, using a condom only protects the area covered by the condom. If your partner has a cold sore on his/her mouth or genitals, do not kiss or have contact with the genitals.

Symptoms: Cold sores look like blisters on a red background and are usually very painful. They can be spread by touching the infected area either with your genitals or your mouth or your hands. They can appear around your mouth, on your penis, anus, labia, vagina or cervix. With your first Herpes infection you may feel like you have a terrible "flu" with fever, headache, body aches and swollen glands.

Treatment: There is no cure. Medicines by mouth can reduce the symptoms and decrease how often the cold sores appear, but are very expensive and often must be taken for a long period of time.

Complications: Having genital herpes increases your risk for HIV. If you have an active cold sore at the time you are delivering a baby, the infection can be spread to the baby.

HIV/AIDS

Cause: The Human Immunodeficiency Virus is the cause of the infection. It is spread through body fluids including semen, vaginal secretions, breast milk and blood. These fluids can be passed during sexual activity, through blood transfusions or by sharing needles. This virus destroys the body's ability to fight infection and causes the body to develop AIDS which is Autoimmune Deficiency Syndrome. Having any other sexually transmitted disease at the time you are exposed to the HIV virus weakens your tissues and makes it more likely that the virus will enter your system. Your body is also more susceptible if intercourse is anal or if you are having your menstrual period. Even if you are on other forms of birth control, you must always use a condom if you are a male or make sure that your partner wears a condom if you are a female, as a condom is the best protection against HIV (and other sexually transmitted diseases). You should seek out voluntary counselling and testing for HIV.

Symptoms: Many people do not know they are infected with HIV as they have no symptoms. Other people when they acquire the HIV virus have symptoms of the "flu" with fever, headache, general body aches and swollen glands. Those infected seem to catch more infections than normal including unusual infections like meningitis and severe pneumonias. They can become tired, lose weight, have constant headaches and generally feel unwell. Some people lose weight which is why it was called the "thin disease" early on in the HIV/AIDS epidemic.



Treatment: At present, there is no cure. Using drugs to suppress the virus early on in the disease before you actually progress to AIDS is important. AIDS itself is a fatal disease. There is an ethical dilemma as to why these drugs are available in the developed nations and not in the developing nations. Most of the world's HIV/AIDS is found in sub-Saharan Africa where the drugs have not been available.

Complications: The ultimate complication is death. The earliest complications are numerous infections of any kind. Some infections can be life-threatening such as meningitis and pneumonia. If you have Human Papilloma Virus (HPV) and HIV/AIDS, you may develop a cancer of the cervix which will quickly cause death. The explanation is that HPV is believed to cause cancer of the cervix and with the body's ability to fight the infection hampered by HIV, the HPV can go on to cause the cancer unchecked.

If you are pregnant with HIV, you can transmit this infection to your unborn baby, during pregnancy, during delivery and during breastfeeding

Syphilis

Cause: Syphilis is a sexually transmitted infection caused by a bacteria. It is spread by kissing someone who has an open syphilis sore or through unprotected intercourse.

Symptoms: The initial sore is called a chancre and may be on the genitals or the mouth. It is an open sore that looks like it should be painful yet is painless. Syphilis stays in your system and progresses through many stages. One stage includes a rash on your palms, soles and genitals. It can go on to affect even your brain.

Treatment: Intramuscular antibiotics are used early on. Once syphilis has reached its later stages, there is no cure for the damage done.

Complications: If untreated, syphilis can damage your brain, heart, nervous system and lead to death

Genital Warts (Condyloma accuminata)

Cause These warts are caused by a virus called Human Papilloma Virus or HPV. Direct contact with hands or genitals through unprotected intercourse causes the warts to spread.

Symptoms: Growths around the genitals can be felt. They are soft but rough and can be itchy.

Treatment: Prevention is the best treatment. For a male, wearing a condom only protects the area covered by a condom

Warts can be removed by a liquid called Podophyllin or by liquid nitrogen or by electric cautery. The virus stays in your body.



Complications: Cancer of the cervix has been linked to infection with HPV.

Regular Pap smears are doubly important if you have ever been diagnosed with genital warts.

APPENDIX 3

CHARACTERISTICS OF ADOLESCENT FRIENDLY HEALTH SERVICES

Adolescent friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO expert advisory group in Geneva in 2002. They require:

1 Adolescent friendly policies that:

- fulfill the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations,
- take into account the special needs of different sectors of the population, including vulnerable and under-served groups,
- do not restrict the provision of health services on grounds of sex, disability, ethnic origin, religion, sexual orientation or age (unless strictly appropriate),
- pay special attention to gender factors,
- guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care, ensure that services are either free or affordable by adolescents.

2 Adolescent friendly procedures to facilitate:

- easy and confidential registration of patients, retrieval and storage of records,
- if possible, short waiting times and (where necessary) swift referral,
- if possible, consultation with or without an appointment.

3 Adolescent friendly health care providers who:

- are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances,
- have interpersonal and communication skills, c) are motivated and supported,
- are non-judgmental and considerate, easy to relate to and trustworthy, e) devote adequate time to clients or patients,
- act in the best interests of their clients,
- treat all clients with equal care and respect,
- provide information and support to enable each adolescent to make the right free choices for his or her unique needs.

**4 Adolescent friendly support staff** who are:

- understanding and considerate, treating each adolescent client with equal care and respect,
- competent, motivated and well supported.

5 Adolescent friendly health facilities that:

- provide a safe environment at a convenient location with an appealing ambience, b) have convenient working hours,
- offer privacy and avoid stigma,
- provide information and education material.

6 Adolescent involvement, so that they are:

- well informed about services and their rights, b) encouraged to respect the rights of others,
- involved in service assessment and provision.

7 Community involvement and dialogue to:

- promote the value of health services, and
- encourage parental and community support.

8 Community based, outreach and peer-to-peer services

- to increase coverage and accessibility.

9 Appropriate and comprehensive services that:

- address each adolescent's physical, social and psychological health and development needs,
- provide a comprehensive package of health care and referral to other relevant services,
- do not carry out unnecessary procedures.

10 Effective health services for adolescents

- that are guided by evidence-based protocols and guidelines,
- having equipment, supplies and basic services necessary to deliver the essential care package,
- having a process of quality improvement to create and maintain a culture of staff support.



- a management information system including information on the cost of resources,
- a system to make use of this information.

11 Efficient services which have:

Source: World Health Organization. Adolescent Friendly Health Service-An Agenda for Change. Written for the WHO by Peter McIntyre, Oxford, UK. 2003

