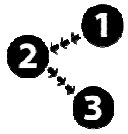
Module 2 The Nature of Adolescence and the Provision of Youth-Friendly Services

Total Module Time: 200 minutes (3 hours, 20 minutes)

Learning Objectives

After completing this module, participants will be able to:

- Define adolescence
- Identify some of the physical changes that occur during adolescence
- Define the stages of adolescent development
- Describe how ALHIV are different from children and adults living with HIV
- Discuss the ways in which adolescents are a heterogeneous group
- Discuss risk-taking as a normal part of adolescence as well as the consequence of negative risk-taking
- Discuss some of the vulnerabilities faced by adolescents
- Describe the characteristics of youth-friendly HIV care and treatment services

Methodologies	
	• Interactive trainer presentation • Large group discussion • Brainstorming • Small group work

Materials Needed	
	• Slide set for Module 2 • Flip chart and markers • Tape or Bostik (adhesive putty) • Participants should have a copy of their Participant Manuals. The Participant Manual contains background content and information for the exercises.

Resources	
	• UNICEF. (2011). *Opportunity in crisis: Preventing HIV from early adolescence to young adulthood.* New York, NY: United Nations Children's Fund. • WHO. (2010 revision). *Antiretroviral therapy for HIV in infants and children: Towards universal access. Recommendations for a Public Health Approach.*

	• WHO. (2010 revision). *Antiretroviral therapy for HIV infection in adults and adolescents. Recommendations for a public health approach.* • WHO. (2010). *IMAI One-day orientation on adolescents living with HIV*. Geneva, Switzerland: WHO Press.

Advance Preparation	
	• Read through the entire module and ensure that all trainers are prepared and comfortable with the content and methodologies. • Exercise 2 requires advance preparation. • Review the appendices so that you can refer to them and integrate them into your presentation.

Session 2.1: Stages and Changes of Adolescence

Activity/Method	Time
Interactive trainer presentation and large group discussion	40 minutes
Exercise 1: Adolescents: Not Big Children, Not Little Adults: Small group work and large group discussion	35 minutes
Questions and answers	5 minutes
Total Session Time	80 minutes

Session 2.2: Adolescent Vulnerabilities, Risk-Taking Behaviors, and Their Consequences

Activity/Method	Time
Interactive trainer presentation and large group discussion	30 minutes
Questions and answers	5 minutes
Total Session Time	35 minutes

Session 2.3: Providing Youth-Friendly Services to Adolescents

Activity/Method	Time
Interactive trainer presentation and large group discussion	30 minutes
Exercise 2: Making Services Youth-Friendly: Small group work and large group discussion	45 minutes
Questions and answers	5 minutes
Review of key points	5 minutes
Total Session Time	85 minutes

Session 2.1 Stages and Changes of Adolescence

Total Session Time: 80 minutes (1 hour, 20 minutes)

Trainer Instructions
Slides 1-5

Step 1: Review the Module 2 learning objectives and the session objectives, listed below.

Step 2: Ask participants if they have any questions before moving on.

Session Objectives

After completing this session, participants will be able to:

- Define adolescence
- Identify some of the physical changes that occur during adolescence
- Define the stages of adolescent development
- Describe how ALHIV are different from children and adults living with HIV
- Discuss the ways in which adolescents are a heterogeneous group

Trainer Instructions
Slides 6-7

Step 3: Ask participants to brainstorm what we mean by the terms "adolescents," "youth," and "young people." Record their responses on flip chart and refer back to these notes as you present the content on the next four pages.

Continue by explaining the definition of each of these three terms.

Make These Points

- According to the World Health Organization (WHO), adolescents are individuals in the 10–19 years age group. Youth are individuals in the 15–24 years age group.
- "Young people" refers to both adolescents and youth and includes the 10–24 years age group.
- In this training, we will primarily focus on adolescents — those between the ages of 10–19 years.

Who Are We Talking About?

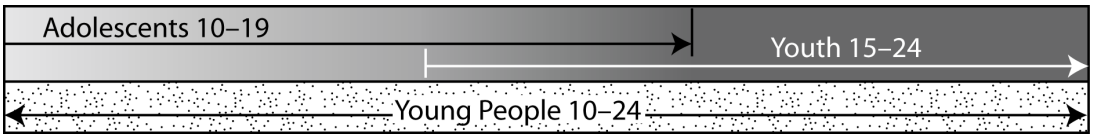
Who are we referring to when we talk about "adolescents?" In general, the term "adolescent" refers to people in their second decade of life, meaning those between the ages of 10 and 19 years. Other commonly used terms are "youth" and "young people." These terms have slightly different definitions (see Table 2.1) but are sometimes used interchangeably with the term "adolescent."

Table 2.1: Key definitions

Group	Age range (according to WHO)
Adolescents	10–19 years
Youth	15–24 years
Young people	10–24 years

Focus of this training

Figure 2.1: Young people (age 10–24 years) includes the overlapping categories of "Youth" and "Adolescents"



Adolescence has many dimensions: physical, psychological, emotional, and sociological. Adolescence is a **phase** of an individual's life that is defined differently across cultures and communities.

Trainer Instructions
Slides 8–12

Step 4: Ask participants to think back to what they were like as adolescents and to also think about the adolescents they know in their lives (their own children, the children of family members, adolescent clients, etc.).

Post 2 sheets of flip chart paper where participants can see them. Label one: **"PHYSICAL AND SEXUAL CHANGES"** and label the other: **"SOCIAL AND EMOTIONAL CHANGES."** Ask participants to brainstorm what they think the key physical/sexual and social/emotional changes are that occur during adolescence. Record their responses in the appropriate column. Fill in as needed using the content below and in the slides.

(optional) Ask the adolescent co-trainer to comment on the key changes that were recorded and/or discussed (above).

Make These Points

- Adolescents undergo rapid growth and development, resulting in both physical changes and changes in thinking, social skills, problem solving, and relationships. These changes influence how adolescents interact, behave, and process information.

Key Changes During Adolescence

There are a number of physical and sexual changes that occur during adolescence.

In females:

- Development of breasts
- Appearance of pubic and underarm hair
- Widening of the hips
- Menarche
- Development of the vulva and pelvis

In males:

- Growth of the penis, scrotum, and testicles
- Appearance of pubic, underarm, chest, and leg hair
- Night-time ejaculation
- Morning erection
- Development of back muscles

In both females and males:

- Accelerated growth
- Increased perspiration
- The presence of acne
- Face has characteristics of young adult
- Change in tone of voice
- Sexual desire activated
- Initiation of sexual activities

The system used most frequently to categorize these physical and sexual changes in girls and boys is referred to as the "Tanner staging system" (see *Appendix 2A: Tanner Staging System)*. The first stage represents the pre-pubertal child and the final stage represents the "mature" or adult stage. The Tanner staging system can be used to determine maturity when deciding whether an adolescent should receive an adult or pediatric ARV dosing, as discussed in the next module.

There are also a number of psychological and emotional changes that occur during adolescence:[1]

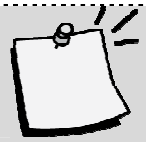
- Mood swings
- Insecurities, fears, and doubts
- Behavioral expressions of emotion, which may include withdrawal, hostility, impulsiveness, and non-cooperation
- Self-centeredness
- Feelings of being misunderstood and/or rejected
- Fluctuating self-esteem
- Interest in physical changes, sex, and sexuality
- Concern about body image
- Concern about sexual identity, decision-making, and reputation
- A need to feel autonomous and independent

Trainer Instructions
Slide 13

Step 5: Lead participants in a discussion of the 3 stages of adolescent development, referring to Table 2.2 in the Participant Manual. Ask one participant to read the first "Category of Change" row in the Table, which is entitled "Growth of Body." The participant should read the "Growth of Body" descriptions for each of the age groups: early, middle, and late adolescence. Next, ask another participant to read the second row, entitled "Cognition," and then ask further volunteers to read the 4 remaining rows.

After each row is read, ask participants:

- *Do these changes and characteristics sound familiar based on your experiences?*
- *Which of the characteristics are most noticeable in the adolescents of this age group that you work with?*



Make These Points

- Adolescence can be divided into 3 overlapping developmental stages: early adolescence (10–15 years), middle adolescence (14–17 years), and late adolescence (16–19 years). Although specific ages have been attached to each of these stages, it is important to understand that there is much individual variation and that changes during this period do not necessarily correspond with precise ages.
- The 3 stages of adolescent development correspond with the stages in physical, psychological, social, emotional, and sexual development that occur during the transition from childhood to adulthood. These stages can provide a basic framework for understanding adolescent development.

The Stages of Adolescent Development

Adolescence can be categorized into 3 overlapping developmental stages:

- The ages listed are approximate — maturation is more important than specific ages when discussing adolescent development.
- Maturation occurs in fits and starts and is not always coordinated.
- Growth in each of the categories listed in Table 2.2 can occur at different rates. For example, an adolescent girl may look like an adult physically (a characteristic of late adolescence), but may not yet be capable of abstract thinking (a characteristic of early adolescence). Another adolescent may appear small and stunted, but may demonstrate advanced intellectual or psychological maturity.
- HIV disease impacts maturation in a number of ways (as discussed in the next section).

Table 2.2: Stages of adolescence

CATEGORY OF CHANGE	EARLY (10–15 years)	MIDDLE (14–17 years)	LATE (16–19 years)
GROWTH OF BODY	• Secondary sexual characteristics appear • Rapid growth reaches a peak	• Has advanced secondary sexual characteristics • Growth slows down; reaches approximately 95% of adult size	• Physically mature
COGNITION (ability to get knowledge through different ways of thinking)	• Thinks in concrete terms (i.e. the "here and now") • Does not understand how actions affect future	• Thinking can be more abstract (theoretical) but goes back to concrete thinking when under stress • Better understands long-term results of own actions	• Abstract thinking now established • Plans for the future • Understands how current choices and decisions have an effect on the future
PSYCHO-LOGICAL AND SOCIAL	• Worries about rapid physical growth and body image • Has frequent mood changes	• Has established body image • Thinks about fantasies or impossible dreams • Feels very powerful • May experiment with sex, drugs, friends, risks	• Plans and follows long-term goals • Has established sense of identity (who he or she is)
FAMILY	• Still defining comfort with independence/ dependence	• Has conflicts with authority figures	• Is moving from a child-parent/ guardian relationship to more adult-adult relationships
PEERS	• Peers very important for development • Has intense friendships with same sex • Has contact with opposite sex in groups	• Has strong peer friendships that help affirm self-image • Peer groups define right and wrong	• Decisions/values less influenced by peers and more influenced by individual friendships • Selection of partner based on individual choice rather than on what others think
SEXUALITY	• Focus is on self-exploration and evaluation	• Has preoccupation with romantic fantasy • Tests how he or she can attract others • Sexual drives emerging	• Forms stable relationships • Has mutual and balanced sexual relations • Is more able to manage close and long-term sexual relationships • Plans for the future

Sources:
WHO. (2003). *Orientation programme on adolescent health for health-care providers*. Geneva, Switzerland: WHO Press.
WHO. (2010). *IMAI one-day orientation on adolescents living with HIV*. Geneva, Switzerland: WHO Press.

Trainer Instructions
Slides 14–19

Step 6: Ask participants to give examples of how perinatally-acquired HIV can affect normal growth and development during adolescence. Record key points on flip chart and fill in using the content in the next section.

Step 7: Next, ask participants if they think their adolescent clients with HIV have been affected either psychologically or socially. If so, can they give examples? Again, record key points on flip chart and fill in using the content below.

Make These Points

- HIV infection can influence how an adolescent experiences and advances through adolescence.

Effects of HIV Infection on the Changes of Adolescence[2]

Growth:
HIV affects growth in adolescents who are perinatally infected with HIV. The following section is not meant to pertain to ALHIV who were infected as adolescents, as they have typically already reached their adult height by the time they are diagnosed with HIV. Even in perinatally infected children, the physical effects of HIV may be minimized through the use of effective ART.

- If HIV disease is fairly advanced, an adolescent may experience delays in physical development, including delays in the physical changes of puberty (for example, delayed or irregular menstrual cycles in girls). As a result, ALHIV may appear younger and smaller than other adolescents because they have not yet begun the physical process of becoming adults.
- ALHIV may be shorter than their peers, either because of stunting early in life or slowed growth throughout childhood and adolescence. This may lead to a negative self-image and may also affect how other people view the adolescent (e.g. as sick and younger than his or her actual age).
- ALHIV may experience drug-related side effects, including those that change physical appearance, like lipodystrophy (changes in fat distribution on the body).

Cognition:

- Adolescents perinatally infected with HIV may experience neurological consequences of longstanding HIV infection. The result may be developmental delays and learning problems.

Psychological and social effects:

- ALHIV are very likely to experience emotional difficulties. These difficulties may not necessarily be due to health status, but rather to the pressures of life and a history of loss (including the loss of parents and home).
- Illness may prevent ALHIV from going to school regularly, from making friends, and from learning sports and hobbies. Due to illness, ALHIV may miss out on activities that help define adolescents' identities.[3]
- HIV can bring with it concerns about prognosis; body image; stigma and isolation; fear of disclosure; and having to take multiple medications. These concerns may affect ALHIV's mental health and their sense of fitting in with peers.
- Many ALHIV live with either one or neither birth parent. Although they may be living with extended family, in some cases these adolescents may not feel "attached" or like they are a part of their adopted home. This can lead to a sense of isolation or a sense that "nobody loves them."

Peers:

- ALHIV may experience peer problems, which can be exacerbated by the stigma associated with HIV.
- ALHIV may have to regularly miss school to attend clinic appointments. This may impact their educational attainment and their sense of fitting in with peers.
- In some places, few ALHIV attend school. This suggests that the school environment is not supportive of ALHIV's needs, which further alienates them from their school-attending peers.[4]
- If adolescents feel different from their peers, they have a harder time bonding with them. This can have an adverse effect on the attachments of ALHIV, making it difficult for them to separate from their parents or caregivers.

Trainer Instructions
Slides 20–21

Step 8: Ask participants to share ideas on what is meant by the phrase, *"not big children, not little adults."*

Then ask participants to brainstorm some of the key characteristics that distinguish adolescents from children and adults. Record responses on flip chart and fill in as needed using the content below.

For each of the key characteristics listed, ask participants what implications this characteristic might have for ALHIV services. For example, if the characteristic is "influenced by peers," one of the implications might be "peer group can be an important source of support." If the characteristic is "inquisitive," then the implications might be "open to new information," "takes risks," etc.

(optional) Ask the adolescent co-trainer to comment on the discussion about adolescents being caught between childhood and adulthood.

Make These Points

- There are a number of characteristics that distinguish adolescents from children and adults. These characteristics influence HIV prevention, care, treatment, and support needs.

No Longer Children, Not Yet Adults[5]

There are a number of characteristics that distinguish adolescents from both children and adults. As these are generalizations or even stereotypes, however, they are not applicable to every adolescent client. Distinguishing characteristics of adolescents may include:

- Energetic, open, spontaneous, inquisitive
- Unreliable and/or irresponsible
- Moody
- Desire independence
- Influenced by friends
- Less influenced by family
- Looking for role models (often outside the family)
- Embarrassed to talk to adults about personal issues
- Desire to be different from parents and previous generation in general

HIV prevention, care, treatment, and support services need to be tailored to meet the needs and characteristics of adolescent clients. Services that are tailored in this way are referred to as "youth-friendly services" and are discussed further in Session 2.3.

Trainer Instructions
Slides 22–30

Step 9: Lead participants through Exercise 1, which provides them with an opportunity to discuss the special needs of adolescent clients, as well as how adolescents differ from pediatric and adult clients, the ways in which adolescents are a heterogeneous group, and the implications of these factors on their care.

When you debrief, draw on the section below on special considerations for adolescent clients. Once you have completed the exercise, fill in any content from the section that has not already been covered.

Exercise 1: Adolescents: Not Big Children, Not Little Adults: Small group work and large group discussion	
Purpose	• To understand some of the important things health workers should consider about the special needs of adolescent clients • To understand how and why adolescents are a heterogeneous (diverse) group and what implications this has for their care
Duration	35 minutes
Advance Preparation	None
Introduction	It is often said that adolescents are "neither big children nor little adults." It is important that health workers recognize the special needs of adolescents as a group and that they also understand how these needs affect the care that ALHIV require. Remember that adolescents are a heterogeneous group with much variation from one individual to another. This exercise will help

	you learn more about the special needs of ALHIV and the implications these needs have for their care.
Activities	**Small Group Work** 1. Break participants into 3 small groups and ask each to assign a facilitator and note-taker. Give each group flip chart paper and markers. 2. Ask each small group to discuss 1 of the following questions: • *What are some of the special characteristics of adolescents that health workers need to consider when providing them with HIV care and treatment?* • *How do the needs of adolescent clients differ from those of pediatric and adult clients?* • *Adolescents are a heterogeneous/diverse group. What are some of the differences health workers may see among different adolescent clients? What are the implications of these differences for their HIV care?* 3. Give the small groups 15 minutes to discuss their question and to record key points on flip chart. **Large Group Discussion** 4. Ask each small group to briefly report back to the large group, summarizing the key points of their discussion (5 minutes or less). Record key points on flip chart. Fill in any key information as needed, using the content from the sections below.
Debriefing	• The care, treatment, and support provided to an individual adolescent client needs to be tailored to that adolescent's maturity level, social situation, and level of understanding. • ALHIV differ from both children and adults living with HIV because of the rapid changes that occur during adolescence. • Adolescents are a heterogeneous group — not only do they differ from each other, but each individual adolescent also changes as he or she matures and develops over time. • Health workers need to understand these differences and consider them when providing care to ALHIV.

Special Considerations for Adolescent Clients[2]

Adherence to medicines:

- Although younger adolescents may still rely on a parent or caregiver to remember to take their medicines, older adolescents need to take some or all of the responsibility for taking their medicines every day and as directed by the health worker.
- Often, adolescents struggle with adherence at various points in their development, as they strive to form their own identity and to fit in with peers.

(Adherence to medications is discussed further in Module 8.)

Adherence to care:

- Adolescent clients often have less disciplined or structured lives than adults. They may also have less stable relationships outside of the family. These factors make adherence to care and treatment more difficult.
- Adolescent clients are more likely than adults to lack the skills to negotiate health services and to understand side effects, treatment options, and regimen requirements.
- Outreach is more difficult with adolescents because they are scattered and it is harder to bring them into care (while children are accessible through their parents and caregivers).
- Adolescents can become lost in the system when in transition from pediatric to adult HIV services. (Transition is discussed further in Module 13.)

(Adherence to care is discussed further in Module 8.)

Stigma and discrimination:

- Blame is often placed on adolescents living with HIV (especially those who acquire HIV behaviorally) because of an assumption that they were infected after voluntarily engaging in "risky behavior." This blame — often misplaced and always oversimplified — results in stigma and discrimination.
- The stigma and discrimination associated with HIV prevents many adolescents from disclosing their HIV-status. This may be a particular issue when adolescents decide to become involved in a sexual relationship.

(Stigma and discrimination is discussed further in Module 5.)

Counseling adolescents:

- Adolescents' cognitive abilities and skills are different from adults. They require both different counseling approaches and, in many cases, more extensive and intensive counseling sessions.
- Conflicts between cultural or parental expectations and adolescents' emerging values can present serious challenges for adolescents.
- Adolescent clients often depend on their parents or caregivers (for example, for money and housing) and can therefore not always make independent decisions.
- Adolescent clients have a range of future decisions to make, like whether to have children, whether to get married, etc.
- Adolescents face strong peer pressure and tend to be dependent on peers for lifestyle guidance.

(Counseling is discussed further in Module 4.)

Safer sex:

- Adolescents may not understand risk-taking behavior or the importance of risk reduction. This makes them vulnerable to unintended pregnancy and sexually transmitted infections (STIs).
- There is a widespread belief that adolescents living with HIV are "not supposed" to be having sex. As a result, they often hide their sexuality.
- Adolescents may have limited access to condoms and other contraceptives. Even when they do have access to contraceptives, they may lack the skills to use them correctly and/or negotiate their use.
    - For young women living with HIV, gender inequality may further reduce their ability to negotiate condom use.

(Safer sex is discussed further in Module 10.)

How Adolescents Differ from One Another

Adolescents are a heterogeneous group. By definition, they range in age from 10 to 19 years. The personality and expectations of a person who is 10 years old is very different from that of a 19-year-old, even though both are adolescents.

Adolescents differ according to their stage of development; gender; sexual orientation; home and family situation; and educational level. Some come from well-off families, others come from poor families; some are from urban areas while others are from rural areas. Some adolescents are in a relationship, some are married, and others have yet to have a romantic relationship. Some adolescents know their HIV-status while others do not; some have never experienced stigma or discrimination while others may face it every day.

Health workers need to assess each adolescent client's care, treatment, and support needs. They must also ensure that the adolescent's care and treatment plan is tailored to meet these unique needs. In particular, counseling and education need to "meet the adolescent where he or she is."

(Sexual orientation is discussed further in Module 10.)

Trainer Instructions
Slide 31

Step 10: Allow 5 minutes for questions and answers on this session.

Session 2.2 Adolescent Vulnerabilities, Risk-Taking Behaviors, and Their Consequences

Total Session Time: 35 minutes

Trainer Instructions
Slides 32-33

Step 1: Review the session objectives listed below.

Session Objectives

After completing this session, participants will be able to:

- Discuss risk-taking as a normal part of adolescence as well as the consequences of negative risk-taking
- Discuss some of the vulnerabilities faced by adolescents

Trainer Instructions
Slides 34-38

Step 2: Discuss risk-taking as a normal part of adolescence. Start the discussion by asking participants:

- *What risks did you take when you were an adolescent?*
- *Thinking back, why do you think you took these risks?*

Fill in the discussion using the content below and re-frame risk-taking as either healthy or unhealthy. Next, discuss some of the consequences of unhealthy risk-taking behavior, with a focus on consequences for ALHIV.

(optional) Ask the adolescent co-trainer to give insights into the healthy and unhealthy risk-taking that he or she has seen among peers. The adolescent co-trainer should also discuss some of the consequences he or she has seen first-hand (in his or her own case or in the case of peers).

Make These Points

- Adolescents take risks as a normal part of growing up. Risk-taking is the tool adolescents use to define and develop their identity. Healthy risk-taking is a valuable experience.
- Risk-taking among adolescents varies with cultural factors; individual personality and needs; social influences and pressures; and available opportunities. Sometimes, unhealthy risk-taking can have lifelong consequences.
  - For ALHIV, such consequences can include poor adherence to medications or the discontinuation of care, which can lead to drug-resistance, OIs, and other negative health outcomes.
  - ALHIV may also take sexual risks, which can lead to re-infection and/or the further spread of HIV to sexual partners.
- When faced with adolescents who are testing their limits, health workers must help them avoid taking risks with serious or dangerous consequences (instead of blaming them). With support, adolescents can be encouraged to experiment in ways that are healthy and that provide them with valuable life experiences.

Risk-Taking As a Normal Part of Growing up

Risk-taking is simply part of an adolescent's struggle to test out an identity that provides self-definition and separation from others, including the adolescent's caregivers. Adolescents must attain social autonomy during their second decade of life and this often involves moving away from dependence on their family. As the influence of their family decreases, new social relationships — especially with peers — begin to gain greater importance. Adolescents' peers often influence their risk-taking.

Risk-taking can be healthy or unhealthy. Healthy-risk taking provides important opportunities for growth, whereas unhealthy risk-taking involves activities that are dangerous.

- Healthy risk-taking includes participating in sports, developing artistic and creative abilities, traveling, making new friends, and contributing constructively to one's family or community.
- Curiosity, sexual maturity, a natural inclination toward experimentation, and peer pressure can lead to unhealthy or negative risk-taking (risk-taking that can be dangerous). This includes drinking, smoking, using drugs, driving recklessly, unsafe sexual activity, self-mutilation, running away, and stealing.
- A sense of powerfulness, feelings of invulnerability, and impulsiveness can lead to a lack of future planning and can compromise protective behavior.
- Sometimes, unhealthy risk-taking is caused by a lack of knowledge about life's risks. For example, adolescents may know little about STIs, may find it difficult to use condoms consistently and correctly, or may lack communication and negotiation skills. As a result, they may not use condoms during sex.
- In some cultures, young men are encouraged to take risks as a way of proving their masculinity.

Health workers should:

- Encourage and help adolescents to find healthy risks, which may prevent unhealthy risk-taking.
- Help adolescents evaluate risks, anticipate the consequences of their choices, and develop strategies for diverting their energy into healthier activities when necessary.
- Share lessons learned from their own histories of risk-taking and experimenting.
- Advise adolescents to seek additional help if they are:
  - Experiencing psychological problems (such as persistent depression or anxiety that goes beyond more typical adolescent "moodiness")
  - Having problems at school
  - Engaging in illegal activities

(Psychosocial support and mental health issues are discussed further in Modules 5 and 6.)

Types and Consequences of Unhealthy Risk-Taking Behavior[1,2,6]

Unhealthy risk-taking can result in:

- Poor adherence to ART or HIV care and treatment, resulting in a drop in CD4 count, disease progression, opportunistic infections (OIs), a greater chance of passing HIV to sexual partners, and drug-resistance
- Unprotected sex, resulting in putting partners at risk of HIV infection and resulting in a risk of unwanted pregnancy, unsafe abortion, and contracting STIs (including re-infection with different strains of HIV)
- Experimentation with substances, such as alcohol and marijuana, resulting in short- and long-term consequences:
  - Substance use and abuse can interfere with judgment and adherence; poor medication adherence will cause a decline in immune-system function.
  - Alcohol use can suppress the immune system, can lead to increased susceptibility to opportunistic infections, and can compromise the body's response to AZT.[2]
  - Many illicit drugs, including nicotine, can reduce the functioning of the immune system, which may strengthen the virus.[2]
  - For adolescents on ART, substance use and abuse can adversely interact with HIV medications, causing illness.[2]
  - Like many ARVs, illegal substances are often processed through the liver. Combining illegal substances with ARVs can lengthen the time that illegal substances stay in the bloodstream, thus increasing toxicity and the chance of overdose.[2]
  - Alcohol reduces inhibitions and affects decision-making. Alcohol can also cloud people's judgment and give them the "courage" to do things they would not normally do. A study from Botswana (the study focused on people age 15–49, but findings are most likely applicable to adolescents) found that people who drink heavily were more likely to have unprotected sex, to have multiple partners, and to pay for sex with money or other resources. [6] Intergenerational sex was also strongly associated with heavy drinking.

  (Substance abuse is discussed further in Module 9).

Trainer Instructions
Slides 39-42

Step 3: Ask participants to brainstorm responses to the following questions:

- *What do we mean when we say adolescents are vulnerable? Vulnerable to what?*
- *What makes adolescents, and in particular ALHIV, vulnerable to poor health? What makes them emotionally vulnerable? What makes them economically vulnerable?*
- *What specifically makes adolescent girls vulnerable? Adolescent boys?*

Encourage participants to think beyond vulnerability to HIV and poor health outcomes. Fill in using the content below, explaining the many levels/types of vulnerabilities that adolescents face. Note that there is more about at-risk adolescents in Module 5.

(optional) Ask the adolescent co-trainer to comment on the specific things that can make adolescents vulnerable.

Make These Points

- Many adolescents are vulnerable physically, emotionally, and socioeconomically. This vulnerability can be amplified for ALHIV due to their health status and their ongoing need for care and treatment.
- Gender issues have a great impact on these vulnerabilities as well, particularly in traditional cultures and families.
- Health workers should remember the reasons that clients may be vulnerable as well as the ways these vulnerabilities relate to risk-taking behavior and their participation in and adherence to HIV care and treatment. An understanding of their adolescent clients' lives can help health workers work with ALHIV to transition safely into adulthood.

Physical Vulnerabilities[1,7]

- Young people are more vulnerable to STIs than adults for many reasons (see next section).
  - Young women are particularly susceptible to STIs because the cells that line the inside of the normal adolescent cervical canal are more vulnerable to infections than the cells that line the mature cervical canal of an adult.
  - The prevention and early treatment of STIs in people living with HIV is important to reduce the risk of both STI and HIV transmission to sexual partners (and babies), as well as to prevent the long-term health consequences of STIs.
- Adolescence is a time of rapid growth and development, creating the need for a nutritious and adequate diet. ALHIV, like all people living with HIV, are particularly vulnerable to nutritional and caloric deficiencies, due to the increased energy demands that HIV imposes on the body.

- HIV can contribute to compromised physical and psychological development, including stunting and slower than normal growth.

Social, Psychological, and Emotional Vulnerabilities[1]

- Psychological factors that put many adolescents at increased risk of physical harm (e.g. of having an automobile accident or getting an STI) include a general sense of invulnerability, the desire to try new things (including drugs and alcohol), and a willingness to take risks (e.g. having unsafe sex, changing sexual partners often, or having a partner who has multiple partners).
- Adolescents may be living in family situations where there is little social and material/ financial support.
- Mental health problems can increase during adolescence, due to the hormonal and other physical changes of puberty and changes in adolescents' social environment. (Mental health issues of ALHIV are discussed further in Module 6.)
- Adolescents often lack assertiveness and good communication skills, which can make them unable to articulate their needs and withstand pressure or coercion from peers or adults.
- Adolescents may feel pressure to conform to stereotypical gender roles.
- Often, there are unequal power dynamics between adolescents and adults (adults may still view adolescents as children).
    - Adolescents are more vulnerable than adults to sexual, physical, and verbal abuse because they are less able to prevent these shows of power.
- Adolescents may lack the maturity to make good, rational decisions.

Socioeconomic Vulnerabilities[1]

- During adolescence, young people's need for money often increases, yet they typically have little access to money or gainful employment. This may lead adolescents to steal or take work in hazardous situations. Girls, in particular, may be lured into transactional sex.
- Poverty and economic hardship can increase health risks, particularly if accompanied by poor sanitation, lack of clean water, or an inability to afford/access health care and medications.
- Adolescents are more likely to experiment with drugs and alcohol, and disadvantaged adolescents are at greater risk of substance abuse.
- Young women often face gender discrimination that affects food allocation, access to health care, adherence to care, the ability to negotiate safer sex, and opportunities for social and economic well being.
- In many societies, a girl's status is only recognized when she marries and has a child. Some young women marry very young to escape poverty and, as a result, may find themselves in yet another challenging situation.
- Many young people are at risk due to other socioeconomic and political reasons. These especially vulnerable youth include street children, sex workers, child laborers, refugees, young criminals, those orphaned because of AIDS or other circumstances, and other neglected and/or abandoned youth. (Most-at-risk adolescents are discussed further in Module 5.)

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Step 4: Allow 5 minutes for questions and answers on this session.

Session 2.3 Providing Youth-Friendly Services to Adolescents

Total Session Time: 85 minutes (1 hour, 25 minutes)

Trainer Instructions
Slides 44–45

Step 1: Review the session objective listed below.

Session Objective

After completing this session, participants will be able to:

- Describe the characteristics of youth-friendly HIV care and treatment services

Trainer Instructions
Slides 46–50

Step 2: Ask participants to brainstorm what we mean by "youth-friendly services." Record responses on flip chart.

Step 3: Next, present to participants the characteristics of youth-friendly services, which are listed in Table 2.3. Ask participants to react and reflect on these characteristics.

(optional) Ask the adolescent co-trainer to share some of his or her experiences as a client, highlighting what he or she thinks are the most important characteristics of a clinical setting, in terms of making adolescents feel welcome and comfortable.

Make These Points

- In order to serve adolescent clients with HIV prevention, care, treatment, support, and related health services, clinics and programs must be able to attract, meet the needs of, and retain these clients.
- Youth-friendly services, whether they are related to HIV, reproductive health, or other types of care, have a number of key characteristics.

Characteristics of Youth-Friendly Services

Table 2.3: Characteristics of youth-friendly services

Health worker characteristics	Health facility characteristics	Program design characteristics
• Specially trained/oriented staff* • All staff display respect for youth • All staff maintain privacy and confidentiality • Enough time for health worker-client interaction	• Separate space for young people • Special times when young people can receive services • Convenient hours • Convenient location • Adequate space and privacy • Comfortable, youth-friendly surroundings • Peer Educators available	• Youth involvement in program design and monitoring • Drop-in clients welcomed • Short waiting times • Set up to provide chronic disease management, including multiple appointments and medications • Appointment systems in place as well as tracking systems for clients who miss appointments • Affordable rates or no fees for services • Publicity, marketing, or recruitment materials that inform and reassure youth • Friendly to both male and female clients • Wide range of services available —"1-stop shopping" • Referrals available to clinical and community-based services • Youth-friendly educational materials available to take away • Youth support groups • Peer Educators available

* Including training in the following areas:

- Clinical HIV care for adolescents
- How to build trust with and counsel adolescents
- Providing psychosocial support to adolescents
- Mental health assessment, counseling, and referrals
- Disclosure counseling
- Adherence counseling
- Positive living counseling
- Sexual and reproductive health counseling and services
- Preparing adolescents for the transition to adult care

Adapted from: Senderowitz, J., Solter, C., & Hainsworth, G. (2004). *Comprehensive reproductive health and family planning training curriculum. 16: Reproductive health services for adolescents.* Watertown, MA: Pathfinder International.

Trainer Instructions
Slides 51–54

Step 4: Tell participants that now that they know the characteristics of youth-friendly services, the next step is to improve the youth-friendliness of their own HIV clinical programs and services. Ask them to brainstorm what steps they might take to make existing clinical services in their own settings friendlier to ALHIV.

Make These Points

- There are many ways to improve the youth-friendliness of HIV care and treatment services. Additional resources and staff are often not required — and sometimes even small changes can have a big impact.
- It is important that we first assess where we are with adolescent services. One way to do this is by conducting a needs assessment of adolescent services currently being provided at the health facility.
- Based on the findings of the needs assessment, multidisciplinary teams and managers can prioritize key problems and areas for improvement, identify existing human and financial resources, and make a measurable action plan.
- We will talk more about how to improve the youth-friendliness of the services we provide at the end of the training, when participants will create an action plan for their health facility.

Organizing Youth-Friendly Services

There are many things health workers, health facility managers, and youth can do to improve the youth-friendliness of comprehensive HIV care and treatment services. Sometimes even the smallest adjustments or changes can help — without necessarily creating additional workload or incurring any additional costs. A step-by-step guide for making services more youth-friendly is provided in Table 2.4. In addition, a sample of a client satisfaction survey for youth is provided in *Appendix 2C*. Please note that the topics of program modification and quality improvement will be discussed further in Module 14.

Table 2.4: Making services more youth-friendly

Step	How
Assess clinic needs: figure out what needs to be done to make services more youth-friendly.	• Conduct an assessment using a tool such as the one included in *Appendix 2B: Checklist and Assessment Tool for Youth-Friendly HIV Care and Treatment Services*. • **Ask clients** what they like about the clinic and what needs improvement. ◦ Interview clients who have dropped out of care — ask them why they decided not to come back and what could be done to make the clinic more youth-friendly. • **Ask parents** what could make services more welcoming for their children. • **Ask colleagues** what needs to change in order to ensure that services are accessible and meet the needs of young people. • Review national or local reports on the topic or review manuals from other clinics or programs to find out what others have done to attract and retain young people. • Visit a neighboring clinic that has been very successful in welcoming youth.

Step	How
Design an action plan that will respond to the needs identified in the assessment. This plan should list the most important activities first. For each activity, it should include a timeline and list the person responsible for that activity.	• Based on interviews and research done during the assessment phase, list the areas that need improvement and how they can be improved. ◦ For example, if several clients mentioned that they are scared of the receptionist because she is rude, one of the areas for improvement might be: "Ensure that receptionist makes clients feel welcome." Then suggest ways to address this need; for example, by providing one-to-one training and support for the current receptionist, by relieving the receptionist of other duties so that he or she can focus solely on welcoming clients, by recruiting a new receptionist, etc. Be sure to include the date by which this activity should be completed and the person who is going to make it happen. (See Module 16 for a template.)
Identify the needed human and material resources.	• If an activity requires funds, identify the budget where these funds could come from. **Remember that making services youth-friendly does not need to be expensive.**
Present the action plan to stakeholders.	• To gain general agreement and support for the action plan, first present it to the manager/supervisor. • Work with others in management to ensure that the needed support exists to implement the recommended changes. • The action plan may need to be revised several times to incorporate the suggestions of those in management and ensure their support. • Once management has approved the plan, present it to the health workers and youth that will be involved in the program.
Implement, monitor, and evaluate the planned activities.	• Start implementing the activities in the action plan. • Provide support to the people responsible for each activity. • Revisit the action plan monthly at first to see what progress has been made and where adjustments are needed. • Six months to a year after implementation, evaluate: find out if the action plan has had an effect on the number of clients retained in care by comparing the present year's figures with those of the previous year.

Remember that setting up youth-friendly HIV care and treatment services is a start, but in order to really meet the needs of adolescent clients, **quality, evidence-based HIV care** must be provided within the context of youth-friendly services.

Trainer Instructions
Slides 55–56

Step 5: Lead participants through Exercise 2, which will give them the chance to learn more about the characteristics of youth-friendly services and how to assess and improve the youth-friendliness of services at their facility.

Exercise 2: Making Services Youth-Friendly: Small group work and large group discussion	
Purpose	• To learn more about the characteristics of youth-friendly HIV care and treatment services • To begin to assess gaps and challenges, and to start planning next steps for providing youth-friendly HIV care and treatment services at participants' health facilities
Duration	45 minutes
Advance Preparation	Review *Appendix 2B: Checklist and Assessment Tool for Youth-Friendly HIV Care and Treatment Services* and make additional copies for participants to write on during the training.
Introduction	Now that we know the key first steps to making services more youth-friendly, we are going to talk about HOW to actually do this in our own clinical settings. We are discussing this now because we would like you to keep the issue of making services youth-friendly in mind throughout the training. We will also return to this issue at the end of the training (during Module 16), when participants will work on an adolescent HIV care and treatment action plan. **Suggest to participants that they keep their notes from this exercise in order to review them during Module 16 (Session 16.1).**
Activities 	**Small Group Work** 1. Break participants into 3 (or more) small groups so that health workers from the same facilities are grouped together. 2. Ask each small group to assign a facilitator and a note-taker. Give each group flip chart and markers. 3. Refer participants to *Appendix 2B: Checklist and Assessment Tool for Youth-Friendly HIV Care and Treatment Services*. 4. Ask that the small groups take 10–15 minutes to read through *Appendix 2B: Checklist and Assessment Tool for Youth-Friendly HIV Care and Treatment Services* and to then discuss how this tool might be useful in their clinic setting. Ask that each group record key points on flip chart. 5. Next, ask each small group to select 2-3 sections of the tool, going through each question in that section and reflecting on their own clinic. Ask them to record their answers and recommendations on flip chart. **Report Back and Large Group Discussion** 6. Bring the large group back together and ask each small group to give a brief, 5-minute presentation on their small group discussion, including how the Assessment Tool might be useful in their facility and their experience going through specific sections of the tool. 7. Note that we will re-visit this discussion and their partly completed Assessment Tools in Module 16. Recommend that participants keep their notes from this exercise until then. 8. (optional) Ask the adolescent co-trainer to share any thoughts or experiences related to the discussion points or to how adolescents and adults can work together to make services more youth-friendly. 9. Summarize the discussion before moving on.

Debriefing	When working to make services friendlier to ALHIV, we must first assess where we currently are so we can then decide the improvements that need to be made. One way of doing this is by using an assessment tool that includes questions on all of the key characteristics of youth-friendly services. We will discuss this more at the end of the training, when we develop an action plan for our facilities.

Trainer Instructions
Slide 57

Step 6: Allow 5 minutes for questions and answers on this session.

Trainer Instructions
Slides 58-60

Step 7: Ask participants what they think the key points of the module are. What information will they take away from this module?

Step 8: Summarize the key points of the module using participant feedback and the content below.

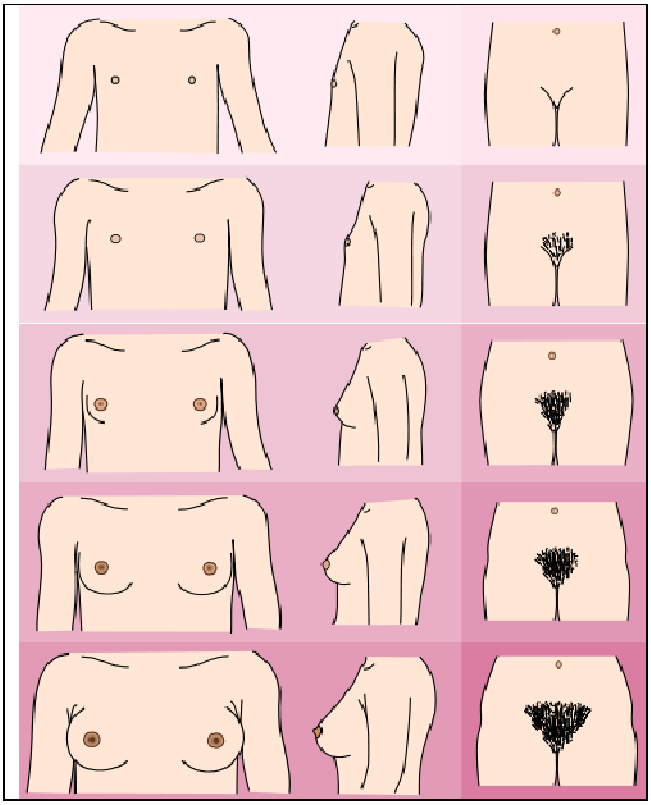
Step 9: Ask if there are any questions or clarifications.

Module 2: Key Points

- Adolescence, the years between the ages of 10 and 19, is characterized by rapid growth and development as well as significant psychological and emotional changes.
- During adolescence, social relationships move from being family-centered to being more peer- and community-centered. It is also a time when new skills and knowledge are acquired and new attitudes are formed.
- ALHIV may experience adolescence differently. Most notably, long-standing HIV infection and/or advanced HIV disease may affect ALHIV's expected physical and emotional development. Social development may be atypical as well, particularly if the adolescent has been ill for significant periods of time or if he or she has felt alienated from peers because of HIV-related discrimination or because he or she feels different from peers.
- As part of growing up, adolescents take risks. Risk-taking is the tool adolescents use to define and develop their identities. Healthy risk-taking is a valuable experience.
- Unhealthy risk-taking, however, can sometimes have lifelong consequences. For ALHIV, such consequences can include poor adherence to medications or the discontinuation of care. ALHIV may also take sexual risks, which can lead to the further spread of HIV.
- Health workers should remember the reasons that clients may be vulnerable as well as the ways these vulnerabilities relate to risk-taking behavior and their participation in and adherence to HIV care and treatment. An understanding of their adolescent clients' lives can help health workers work with ALHIV to transition safely into adulthood.
- In order to serve adolescent clients with HIV-related health services, clinics and programs must be able to attract, meet the needs of, and retain these clients.

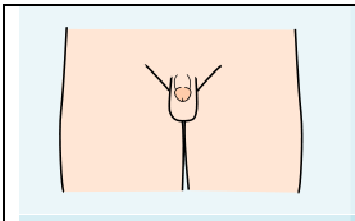
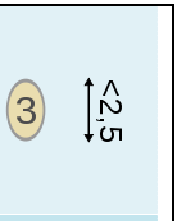
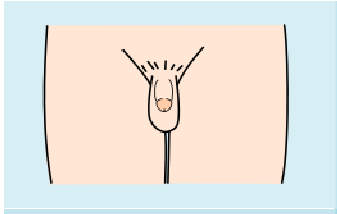
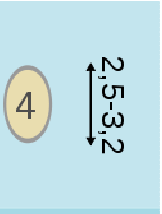
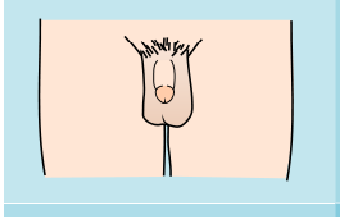
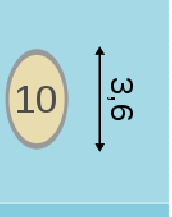
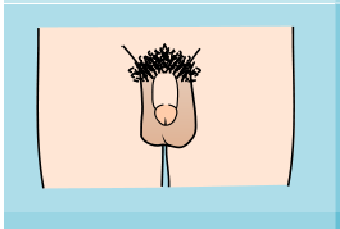
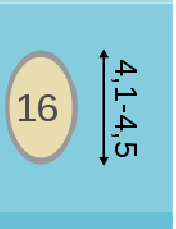
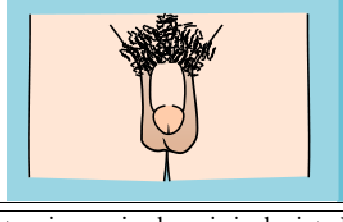
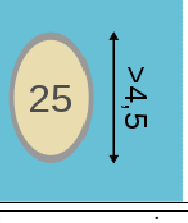
Appendix 2A: Tanner Staging System

Girls — breast and pubic hair development

Stage	Breast development	Pubic hair development	Description
1			Breasts: pre-pubertal, no breast tissue with flat areola. No pubic hair.
2			Breast budding with widening of the areola. Small amount of long hair at base of female labia majora.
3			Larger and more elevated breast extending beyond the areola. Pubic hair: moderate amount of curly and courser hair extending outwards.
4			Larger and more elevated breast; areola and nipple projecting from the breast contours. Pubic hair resembles adult hair but does not extend to inner surface of thigh.
5			Mature stage: breast is adult size with nipple projecting above areola. Pubic hair: adult type and quantity extending to the thigh surface.

Female Tanner staging image by Michal Komorniczak, medical illustrations. Poland.

Boys — development of external genitalia and pubic hair

Stage	Development of external genitalia and pubic hair*	Testicular volume in ml, length in cm	Description
1			Genitals: pre-pubertal, testes small in size with childlike penis. No hair.
2			Testes reddened, thinner, and larger (1.6–6cc) with childlike penis. Small amount of long hair at base of male scrotum.
3			Testes larger (6cc–12cc) and scrotum enlarging; increase in penile length. Moderate amount of curly and courser hair extending outwards.
4			Testes larger (12cc–20cc) with greater enlargement and darkening of the scrotum; increase in length and circumference of penis. Pubic hair resembles adult hair but does not extend to inner surface of thigh.
5			Testes over 20cc with adult scrotum and penis. Pubic hair: adult type and quantity extending to the thigh surface.

* Note that a circumcised penis is depicted here — an uncircumcised penis would look slightly different.

Male Tanner staging image by Michal Komorniczak, medical illustrations. Poland.

Appendix 2B: Checklist and Assessment Tool for Youth-Friendly HIV Care and Treatment Services

Facility name: _____ **Type of facility/clinic:** _____

Questions to Assess Youth-Friendliness	Answer	Comments/Recommendations
Location		
How far is the facility from public transportation?		
How far is the facility from places where adolescents spend their time?		
How far is the facility from local schools?		
Facility hours		
During what hours is the clinic open?		
Does the clinic have separate hours/days for youth?		
Is there a sign listing services and clinic working hours?		
What times are convenient for adolescents to seek services?		
Facility environment		
Does the facility provide a comfortable setting for young clients?		
Does the facility have a separate space to provide services to adolescent clients?		
Does the facility have a separate waiting area for adolescent clients?		
Is there a counseling area that offers both visual and auditory privacy?		
Is there an examination room that provides both visual and auditory privacy?		
Are both young men and women welcomed and served at the clinic?		

Questions to Assess Youth-Friendliness	Answer	Comments/Recommendations
Staffing		
Are all health workers trained in pediatric HIV care and treatment?		
Are all health workers trained in adolescent HIV care and treatment?		
Have all staff members (including data clerks, pharmacists, receptionists, etc.) received orientation about adolescent services?		
Do health workers show respect for adolescent clients during counseling sessions and group sessions?		
Are there job aides available to help health workers in their daily work with adolescents?		
Services provided		
Is 1-stop shopping provided to adolescent clients? Describe.		
Are the following services provided to adolescent clients directly (note if through referral):		
• HIV testing and counseling		
• Comprehensive care, including the prevention and treatment of OIs		
• Malaria prophylaxis and treatment		
• ARVs/ART		
• Adherence preparation		
• Ongoing adherence assessment & counseling (at each visit)		
• Pregnancy testing, antenatal care, and PMTCT		
• Sexual and reproductive health counseling		
• Condoms and water-based lubricant		
• Contraception (which methods?)		
• STI screening and treatment		
• Positive prevention counseling		
• Psychosocial counseling and support		

Questions to Assess Youth-Friendliness	Answer	Comments/Recommendations
• Nutrition counseling		
• Laboratory tests (CD4, other HIV tests)		
• PEP, as per national guidelines		
Are there outreach services, especially targeting most-at-risk adolescents? Explain.		
Do adolescent request services other than the ones offered? Which ones?		
Is there a formal referral system for services not provided at the clinic?		
Is there a formal referral system for services required by most-at-risk adolescents (sexual abuse counseling and treatment, drug/alcohol rehabilitation, support for youth-heads of household, etc.)? Which ones?		
Is there a tracking and follow-up plan in place for clients who do not return?		
Peer education and counseling		
Is a peer education program available?		
How many Peer Educators are working at the facility?		
How many hours/days per week do Peer Educators work at the facility?		
What are the roles and responsibilities of Peer Educators?		
How are the Peer Educators trained?		
Is there a system for supervising and monitoring Peer Educators?		
Educational activities		
Are educational/information materials available? Which ones?		
Are there educational posters displayed?		
Are there posters or brochures that describe clients' rights?		
Are there materials for adolescent clients to take home?		
In what languages are the materials?		

Questions to Assess Youth-Friendliness	Answer	Comments/Recommendations
Are group education sessions held with younger adolescents? Describe.		
Are group education sessions held with older adolescents? Describe.		
Are group education sessions held with parents/caregivers? Describe.		
Are adolescent support groups held (with younger adolescents)? Describe.		
Are adolescent support groups held (with older adolescents)? Describe.		
Are there ways for adolescent clients to access information or counseling off-site (via a hotline, etc.)?		
Youth involvement		
Are adolescents involved in decision-making about how programs and services are delivered?		
What ways are there for adolescents to give feedback to clinic staff?		
How could adolescents be more involved in decision-making at the facility?		
What other roles could adolescents play in clinic planning, operations, and evaluation?		
Supportive policies		
Do clear, written guidelines or standard operating procedures (SOPs) exist for adolescent services?		
Do written procedures exist for protecting client confidentiality?		
Are records stored so that confidentiality is ensured?		
Is parental/guardian/spousal consent ever required? In what cases?		
Is there a minimum age required for adolescents to receive HIV testing?		
Is there a minimum age required for adolescents to receive contraceptives?		

Questions to Assess Youth-Friendliness	Answer	Comments/Recommendations
Are there policies or procedures that pose barriers to youth-friendly services?		
Administrative procedures		
Is the registration process private so that others cannot see or hear?		
Can adolescent clients be seen without an appointment?		
How long do adolescent clients normally have to wait?		
What is the average time allotted for client/health worker interaction?		
Publicity/recruitment		
Does the clinic publicize the services available to adolescents, stressing confidentiality?		
Are there staff or volunteers who do outreach activities? Describe.		
Fees		
Are adolescents charged for any services? If so, which ones and how much?		
If there are fees, are they affordable to adolescent clients?		
OTHER?		

Adapted from: Senderowitz, J., Solter, C., & Hainsworth, G. (2002). *Clinic assessment of youth friendly services: A tool for assessing and improving reproductive health services for youth*. Watertown, MA: Pathfinder International.

Appendix 2C: Sample Client Satisfaction Survey for Youth

Clinic/Facility: _____
Lead physician or nurse *(if applicable):* _____
Your name *(optional):* _____ Date: _____

Please help us improve our services by answering some questions about the services you received.

We are interested in your honest opinion — whether positive or negative. Your answers will be kept confidential.

1. The staff at the clinic communicated clear information to me.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

2. People at the clinic included my opinions when making decisions.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

3. The staff at the clinic listened to me.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

4. The staff at the clinic involved my family/caregivers in my care.

1	2	3	4
More than I wanted	About the right amount	Less than I wanted	No involvement, which is what I wanted

5. I am satisfied with the progress I have made toward my treatment goals (taking medication/adherence, participating in psychosocial support activities, etc.)

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

6. The staff at the clinic worked well together.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

7. The staff at the clinic spent enough time with me.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

8. The staff at the clinic treated me with respect.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

9. The staff at the clinic gave me support.

1	2	3	4	5
Strongly Disagree	Disagree	Somewhat Agree	Agree	Strongly Agree

10. I would recommend this clinic/program to a friend who needed similar help.

1	2	3	4	5
Strongly Disagree	Disagree	Don't Know	Agree	Strongly Agree

11. On a scale from 1-10, how would you rate the care you received?

1	2	3	4	5	6	7	8	9	10
WORST									BEST

12. Is there a staff member who worked especially well with you? If yes, can you explain why?

_____
_____
_____
_____

13. Comments? *(Please use the back of this page if necessary)*

_____
_____
_____
_____

Thank you for helping us improve the quality of our services. Your opinion is important to us!

Adapted from: Foster Family-based Treatment Association. *Sample TFC youth satisfaction survey* (2008) and *Customer satisfaction survey, Child version* (2007).

References

[1] Senderowitz, J., Solter, C., & Hainsworth, G. (2004). *Comprehensive reproductive health and family planning training curriculum. 16: reproductive health services for adolescents.* Watertown, MA: Pathfinder International.

[2] Baylor International Pediatric AIDS Initiative. (2010). *HIV curriculum for the health professional.* Houston, TX: Baylor College of Medicine.

[3] Usitalo, A. *Psychiatric issues in adolescents with HIV/AIDS*. PowerPoint presentation for the Florida/Caribbean AIDS Education and training Center, May 13-14, 2011 in Orlando, Florida.

[4] Obare, F., van der Kwaak, A., et al. (2010). *HIV-positive adolescents in Kenya: access to sexual and reproductive health services.* KIT Development Policy and Practice, Bulletin 393. Amsterdam: KIT Publishers.

[5] WHO. (2010). *IMAI one-day orientation on adolescents living with HIV*.

[6] Weiser SD., Leiter K., Heisler M., McFarland W., Percy-de Korte F., et al. (2006). *A population-based study on alcohol and high-risk sexual behaviors in Botswana.* PLoS Med, 3(10): e392. Available at: http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030392

[7] Hsu, JW., et al. (2005). *Macronutrients and HIV/AIDS: a review of current evidence: consultation on nutrition and HIV/AIDS in Africa: evidence, lessons and recommendations for action.* Durban, South Africa: WHO, Department of Nutrition for Health and Development.