CSE Harmful Elements Analysis Tool

The CSE Harmful Elements Analysis Tool[1] was created to help parents, school administrators, educators, and other concerned citizens assess, evaluate, and expose harmful elements within comprehensive sexuality education (CSE)[2] curricula and materials. For more information, visit www.stopcse.org.

Analysis of

Malawi Youth-Friendly Health Services Training Manual Second Edition

Based on 15 Harmful Elements Commonly Included in CSE Materials

CSE HARMFUL ELEMENTS SCORE = 15 OUT OF 15

Malawi Youth-Friendly Health Services Training Manual **contains: 15 out of 15** of the harmful elements typically found in CSE curricula or materials. The presence of **even one of these elements indicates that the analyzed materials are inappropriate for children**. Having several of these elements should disqualify such materials for use with children.

Program Description: This program is not directly administered to youth. Facilitators teach participants (healthcare providers) how to administer youth-friendly health services, particularly related to HIV prevention and so-called "safer sex." Medical providers are encouraged to provide condoms and contraception and educate young people on all aspects of sexuality, including masturbation, anal and oral sex, consent, sexual pleasure, and deciding when to be sexually active.

Target Age Group: Teaches healthcare providers to administer YFHS to youth ages 10-24

International Connections: World Health Organization, Christian Health Association of Malawi, USAID-funded Health Policy Project (HPP), Health Policy Plus (HP+), Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), the National Youth Council of Malawi (NYCOM), Banja La Mtsogolo (BLM), Farm Radio, Baylor Children's Hospital, Youth Net and Counselling (YONECO), Lilongwe and Kasungu District Health Office

HARMFUL CSE ELEMENTS	EXCERPTED QUOTES FROM CSE MATERIAL
1. SEXUALIZES CHILDREN *Normalizes child sex or desensitizes children to sexual things. May give examples of children having sex or imply many of their peers are sexually active. May glamorize sex, use graphic materials, teach explicit*	"Looking at the picture below, we see that the rational portion of a young person's brain only fully develops at age 24 (the small portion at the back of the brain labelled 'homework'). They are more concerned with forming relationships with peers, romantic relationships, and their image. Therefore, by association, **logical aspects such as** nutrition, **safer sex practices**, and other positive health-related behaviours are mostly reinforced by what the other people in their age group (television idols included) are proposing and consider 'cool.'" (Facilitator's Guide, p. 76)

[1] The CSE Harmful Elements Analysis Tool was created by Family Watch International. Family Watch is not responsible for the way in which the tool is used by individuals who do independent analyses of CSE materials. Visit www.stopcse.org for a blank template or to see analyses of various CSE materials.

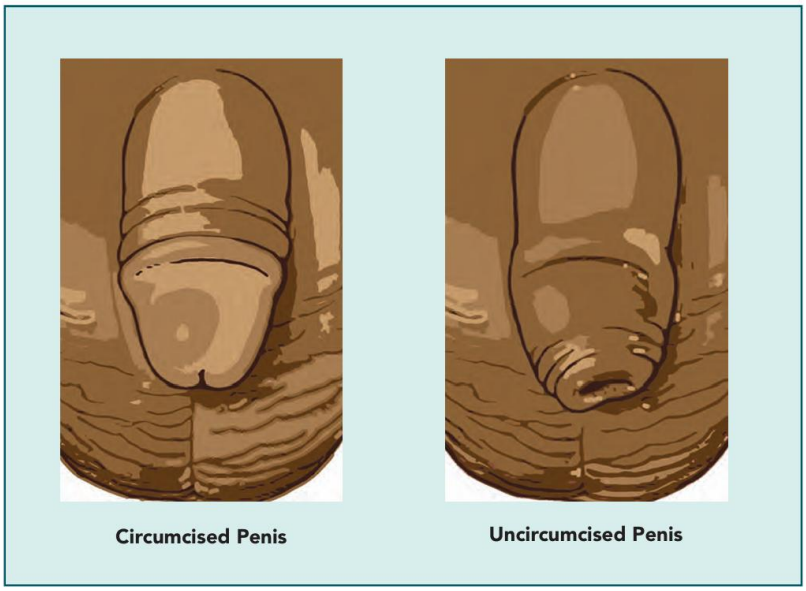
[2] CSE programs are often labeled as comprehensive sex education, sexual education, sexuality education, anti-bullying programs, sexual and reproductive health education, Welcoming Schools programs, and even family life, life skills or abstinence plus education programs, etc. Regardless of the label, if program materials contain one or more of the 15 harmful elements identified in this analysis tools, such materials should be categorized as CSE and should be removed from use in schools.

sexual vocabulary, or encourage discussion of sexual experiences, attractions, fantasies or desires.	"Explain that this way of looking at human sexuality breaks it down into five components: ***sensuality, intimacy, identity, behaviour and reproduction,*** **and** ***sexualisation****.* Everything related to human sexuality will fit in one of these circles." (Facilitator's Guide, p. 90) "In many places, information and education programmes to **help adolescents learn about sexuality** and sexual health are generally lacking." (Facilitator's Guide, p. 126) "**Sexuality is much more than sexual feelings or sexual intercourse**. It is an important part of who a person is and what he or she will become. It includes all the feelings, thoughts and behaviors of being a female or male, being attractive and being in love, as well as being in relationships that include sexual intimacy and physical sexual activity." (Facilitator's Guide, p. 309) "REPRODUCTION and SEXUAL HEALTH are the capacity to reproduce and the behaviors and attitudes that make sexual relationships healthy, physically and emotionally. **Specific aspects of sexual behavior and reproduction** that belong in this circle include: • *Factual information about reproduction* is necessary to understand how male and female reproductive systems work and how conception occurs. Adolescents typically have inadequate information about their own or their partners' bodies. They need the information that is essential for making informed decisions about sexual behavior and health. • *Feelings and attitudes* are wide-ranging when it comes to sexual behavior and reproduction, especially health-related topics such as sexually transmitted diseases (including HIV infection) and the use of contraception, abortion and so on. Talking about these issues can increase adolescents' self-awareness and **empower them to make healthy decisions about their sexual behavio**r. • *Sexual intercourse* is one of the most common human behaviors, capable of producing **sexual pleasure** and/or pregnancy. In programs for young adolescents, discussion of sexual intercourse is often limited to male-female vaginal intercourse, but **all young people need information about the three types of intercourse people commonly engage in – oral, anal and vaginal**. • *Contraceptive information* describes all available contraceptive methods, how they work, where to obtain them, their effectiveness and their side effects. **The use of latex condoms for disease prevention must be stressed.** Even if young people are not currently engaging in sexual intercourse, they will in the future. They must know how to prevent pregnancy and/or disease." (Facilitator's Guide, p. 310) "SEXUALIZATION is using sex or sexuality to influence, manipulate or control other people. Often called the 'shadow' side of our sexuality, **sexualization spans behaviors that range from harmlessly manipulative to sadistically violent and illegal**. Behaviors include flirting, seduction, withholding sex from a partner to 'punish' the partner or to get something you want, sexual harassment (a

supervisor demands sex for promotions or raises), sexual abuse and rape. Teens need to know that no one should exploit them sexually. They need to practice skills to avoid or fight against unhealthy sexualization should it occur in their lives." (Facilitator's Guide, p. 311)

SOURCE: Life Planning Education, Advocates for Youth, Washington, DC.

"The term 'sexual health' describes the absence of illness and injury associated with sexual behaviour and a **sense of sexual well-being**. It has been defined as '...the positive integration of physical, emotional, intellectual and social aspects of sexuality. **Sexuality influences thoughts, feelings, interactions and actions** among individuals, and motivates people to find love, contact, warmth and intimacy. It can be expressed in many different ways and is closely linked to the environment in which people live (WHO, n.d.).'" (Participants Handbook, p. 41)

	FIGURE 4. Circumcised and uncircumcised penis  (Participants Handbook, p. 121)
2. TEACHES CHILDREN TO CONSENT TO SEX *May teach children how to negotiate sexual encounters or how to ask for or get "consent" from other children to engage in sexual acts with them. While this may be appropriate for adults, children of minor age should never be encouraged to "consent" to sex.* *Note: "Consent" is often taught under the banner of sexual abuse prevention.*	"Adolescents need social skills that will enable them to say 'no' to sex with confidence and **negotiate safer sex** if they wish to. If they are sexually active, they also need physical skills, such as knowing how to use condoms." (Facilitator's Guide, p. 99) "Adolescents need social skills that will enable them to say no to sex with confidence **and negotiate safer sex**, if they wish to do so. If they are sexually active, they also need physical skills, such as the ability to use condoms correctly." (Participants Handbook, p. 51)
3. PROMOTES ANAL AND ORAL SEX *Normalizes these high-risk sexual behaviors and may omit vital medical facts, such as the extremely high STI infection rates (i.e., HIV and HPV) and the oral and anal cancer rates of these high-risk sex acts.*	"Sexual intercourse is one of the most common human behaviors, capable of producing sexual pleasure and/or pregnancy. In programs for young adolescents, discussion of sexual intercourse is often limited to male-female vaginal intercourse, but **all young people need information about the three types of intercourse people commonly engage in – oral, anal and vaginal**. (Facilitator's Guide, p. 310) "Risk factors for HIV: Unprotected sex (**anal and vaginal**)" (Participants Handbook, p. 111)
4. PROMOTES HOMOSEXUAL/	"'**LGBT**' refers to persons who are **lesbian, gay, bisexual, or transgender**. LGBT persons have much higher rates of depression and suicide because of the

BISEXUAL BEHAVIOR *Normalizes or promotes acceptance or exploration of diverse sexual orientations, sometimes in violation of state education laws. May omit vital health information and/or may provide medically inaccurate information about homosexuality or homosexual sex.*	increased violence they have suffered and rejection they feel by society. In our respective roles in health, social welfare, and law enforcement, it is our duty to protect all individuals from violence and provide them services when needed." (Facilitator's Guide, p. 155) Participants indicate whether they agree or disagree with the following statements: "Read the **value statements** aloud one by one. After each one, ask for a volunteer or choose someone to explain their choice. Allow participants to pass if they feel uncomfortable but encourage them to speak as much as possible. You should try to hear from at least one learner who agrees and one who disagrees. Every now and again, also ask a third learner who is unsure. The statements are the following: • The **LGBT community exists in Malawi**. • LGBT youth are copying Western cultures. • LGBT youth deserve equal access to YFHS. • LGBT youth should feel free to disclose their sexual orientation to YFHS providers. • LGBT youth who have been sexually or physically abused deserved it. • Providers must maintain the privacy of LGBT youth." (Facilitator's Guide, p. 156) "**Heterosexual, gay, lesbian and bisexual youth** can all experience same-gender sexual activity around puberty. Such behavior, including sex-play with same-gender peers, crushes on same-gender adults or **sexual fantasies about people of the same gender are normal for pre-teens and young teens** and are not necessarily related to sexual orientation. Because of negative social messages, young adolescents who are experiencing sexual attraction to, and romantic feelings for, someone of their own gender may need support from adults who can help teens **clarify their feelings and accept their sexuality**." (Facilitator's Guide, p. 310)
5. PROMOTES SEXUAL PLEASURE *May teach children they are entitled to or have a "right" to sexual pleasure or encourages children to seek out sexual pleasure. Fails to present data on the multiple negative potential outcomes for sexually active children.*	"Reproductive health implies that people are able to **have a satisfying and safe sex life**, and that they have the capability to reproduce and the freedom to decide when and how often to do so." (Facilitator's Guide, p. 84 and Participants Handbook, p. 41) "SENSUALITY is awareness and feeling about your own body and other people's bodies, especially in the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. **Sensuality also allows us to enjoy the pleasure our bodies can give us and others**. This part of our sexuality affects our behavior in several ways: • *Need to understand anatomy and physiology* – with knowledge and understanding, adolescents can appreciate the physiology of their bodies. • *Body image* – whether we feel attractive and proud of our own bodies and the way they function influences many aspects of our lives. Adolescents often choose media personalities as the standard for how they should look, so they are likely to be disappointed by what they see

	in the mirror. They may be especially dissatisfied when the mainstream media does not portray positively, or at all, their types of skin, hair, eyes, body sizes and other physical characteristics. • ***Experiencing pleasure and release from sexual tension*** – sensuality allows us to experience pleasure when we or others touch certain parts of our bodies. As the culmination of the sexual response cycle, males and females can **experience orgasm when they masturbate or have a sexual experience with a partner**. • *Satisfying skin hunger* – our need to be touched and held by others in loving caring ways is often referred to as skin hunger. Adolescents typically receive less touch from family members than do young children. Therefore many teens satisfy their skin hunger through close physical contact with a peer. Sexual intercourse may result from a teen's need to be held, rather from sexual desire. • *Feeling physical attraction for another person* – the center of sexuality and attraction to others is not in the genitals, but in **the brain, the most important 'sex organ.'** The unexplained mechanism responsible for sexual attraction rests here. • *Fantasy* – the brain also give [sic] us the capacity to have fantasies about sexual behaviors and experiences. **Adolescents often need help understanding that the sexual fantasies they experience are normal**, but do not have to be acted upon." (Facilitator's Guide, p. 309)
6. PROMOTES SOLO AND/OR MUTUAL MASTURBATION *While masturbation can be part of normal child development, encourages masturbation at young ages, which may make children more vulnerable to pornography use, sexual addictions or sexual exploitation. May instruct children on how to masturbate. May also encourage children to engage in mutual masturbation.*	"Ask different participants to read about each psychosocial issue below in their manuals, one at a time. This should be followed by a short discussion by all members: …**Is there anything wrong with masturbation**?" (Facilitator's Guide, p. 100) "Growth and developmental stages, ages 10–13: Begins to feel attraction to others; **may masturbate/ experiment with sex**; females may have started menstruation" (Participants Handbook, p. 46) **"**There are many **other ways of expressing sexual feelings** that do not involve penetration (vaginal, anal, and oral sex) and are safe regarding preventing pregnancy and infection from HIV and other STIs. Examples of these behaviours are the following: • Holding hands • Hugging • Kissing • Rubbing bodies • **Masturbation** • **Mutual masturbation**" (Participants Handbook, p. 47) "Is there anything wrong with masturbation? No**. Many young people may engage in masturbation** and wonder about it. Does it have any effect on the body, mind, or social relationships? Masturbation is when a girl rubs her clitoris with her own hand until she has an orgasm, or when a boy rubs his penis with his own hand until he ejaculates. **Masturbation is perfectly normal and has no**

	negative consequences. It is safe sex." (Participants Handbook, p. 53) "As a young person, what should I do when I feel sexual desires? As adolescents transition to adulthood, they often do feel sexual desires. Some distract themselves through physical exercise, studying, helping at home, or participating in youth groups. Others take a cold shower to cool down. **Masturbation is also an option; it has no consequences and it is safe**." (Participants Handbook, p. 53) "Examples of sexual activity: hand holding, hugging, massaging, kissing, **mutual masturbation**" (Participants Handbook, p. 60)
7. PROMOTES CONDOM USE IN INAPPROPRIATE WAYS *May inappropriately eroticize condom use (e.g., emphasizing sexual pleasure or "fun" with condoms) or use sexually explicit methods (i.e., penis and vagina models, seductive role plays, etc.) to promote condom use to children. May provide medically inaccurate information on condom effectiveness and omit or deemphasize failure rates. May imply that condoms will provide complete protection against pregnancy or STIs.*	"The use of latex condoms to prevent the exchange of body fluids during sex is an essential element of all HIV prevention. **Safer sex depends on the correct and consistent use of condoms**. Female condoms offer women an option that may give them more control. Female condoms require more counselling and assistance with respect to their proper use. They are also more expensive." (Facilitator's Guide, p. 204) "An adolescent male who comes in for treatment of an STI has obviously had unsafe sex with an infected person. He needs help to avoid these infections in the future. In this role play, the healthcare provider has an opportunity to give the patient information that builds on his knowledge and experience and is relevant to his stage of development and circumstances, and to teach him skills enabling him to cope with the realities of his everyday life. In addition, the healthcare worker has the opportunity to provide the young man with condoms. **If the healthcare worker cannot provide these, he or she should at least direct the client to an individual or organisation that can do so**. A young woman, like the young man in the previous role play, needs to be given information tailored to her special needs. She must also have the skills to put this information to use. In addition, **if she is sexually active, she will require condoms** and contraceptives to avoid STIs and an unwanted pregnancy. The additional challenge facing the doctor in this role play is that of introducing the sensitive subject of sexuality into the discussion." (Participants Handbook, p. 107) "They need access to a range of information, life skills, and HIV prevention methods (including information on the advantages of delaying sexual activity, practicing safer sex, **negotiating condom use and correct use of condoms**, and the importance of sterile needles and syringes) to be able to opt for healthful choices in risky situations. Comprehensive prevention means encouraging young people and supporting them to **be aware of their options for a safe life**, and assisting them to make the right choices for their individual circumstances. The most significant services for the prevention and care of HIV among young people have the following characteristics: • Strengthen the ability of young people to avoid infection, including information and counselling interventions. • Reduce risks by **providing condoms to those who are sexually active**." (Participants Handbook, p. 115)

	"The use of condoms to prevent the exchange of body fluids during sex is an essential element of HIV prevention and also offers protection from pregnancy. **Safer sex depends on the correct and consistent use of condoms**, so condom provision must be **accompanied by clear instructions on their use for every act of penetrative sex**. Female condoms offer women an option that may give them more control but, in comparison with male condoms, they require more counselling and assistance to be used correctly and are more expensive and less available." (Participants Handbook, p. 116)
8. PROMOTES PREMATURE SEXUAL AUTONOMY *Teaches children they can choose to have sex when they feel they are ready or when they find a trusted partner. Fails to provide data about the well-documented negative consequences of early sexual debut. Fails to encourage sexually active children to return to abstinence.*	"Access to SRHR means that individuals are **able to choose whether, when, and with whom to engage in sexual activity**; to choose whether and when to have children; and to access the information and means to make these choices." (Facilitator's Guide, p. 84 and Participants Handbook, p. 41) "To discuss how to **promote young people's sexual and reproductive health**" (Facilitator's Guide, p. 99) "Discuss the **initiation of sexual activity** in young people." (Facilitator's Guide, p. 103) "**Age does not constitute a medical reason** for withholding the provision of any method [of contraception]." (Facilitator's Guide, p. 112)
9. FAILS TO ESTABLISH ABSTINENCE AS THE EXPECTED STANDARD *Fails to establish abstinence (or a return to abstinence) as the expected standard for all school age children. May mention abstinence only in passing.* *May teach children that all sexual activity—other than "unprotected" vaginal and oral sex—is acceptable, and even healthy. May present abstinence and "protected" sex as equally good options for children.*	"Factors contributing to STIs in young people: • **Unprotected sexual intercourse** • **Sex with multiple partners** • **Lack of sexual experience** and skills in self-protection (i.e., correct and consistent use of condoms) • Lack of accurate information about STIs and how to avoid contracting them (correcting misinformation) • Lack of access to preventive services and protective supplies (such as condoms) • Pride: adolescent boys in many cultures feel they have to prove themselves sexually; in some cultures, they may even regard STIs as 'warrior marks' to indicate the transition to adulthood • Exposure during sexual assault" (Facilitator's Guide, p. 178) "Adolescents who engage in premarital sexual activities or **have several partners** are at greater risk of exposure to STIs than those in stable relationships. However, current research in Malawi shows that **marriage is no longer protective against HIV or STIs**. Thus, married young people are still at risk." (Facilitator's Guide, p. 178) ***Note:*** *Abstinence before marriage and complete fidelity to your spouse after marriage is the only guaranteed protection against HIV and STIs.* "Will anyone want to have sex with me if they know I am HIV positive? Yes, but

	condom use is very important." (Facilitator's Guide, p. 211) "The objective of **promoting safer sex** is to help young patients to avoid STIs. This will involve providing them with the information they need on how they can protect themselves (abstinence, **having sex only with a mutually faithful partner**, and **using condoms**); the skills they need (e.g., how to refuse unwanted sex and how to negotiate safer sex); and the supplies they need (condoms)." (Facilitator's Guide, p. 186) "HIV prevention strategies: • Information and **education on HIV and safer sex** • Abstinence/delaying the first sexual encounter • **Being faithful** to one mutually faithful partner • Correct and consistent **condom use** • HIV testing and counselling • VMMC • Behaviour change to **safer sexual practices** • Prompt and effective management of STIs • Early initiation of ART and adherence to treatment by those who are HIV positive" (Facilitator's Guide, p. 203) "Young people need more information and education on sexuality and HIV prevention to help them **practice responsible sexual behaviour**." (Facilitator's Guide, p. 204) "PRIMARY PREVENTION [for cervical cancer], Girls 9-13 years: • HPV vaccination • Girls and boys, as appropriate • Health information and warnings about tobacco use • **Sexuality education** tailored to age and culture • Condom promotion/ provision **for those engaged in sexual activity** • Male circumcision" (Participants Handbook, p. 50) "Young people receive information from different sources and may be confused about how safe 'safe sex' really is. Safe sex generally refers to engaging in sexual activity with significant reduced risk of acquiring STIs, including HIV, and becoming pregnant. The safest way to prevent STIs and unwanted pregnancy is to abstain from sex. **Malawi's policy on SRHR promotes young people's access to condoms and other modern contraceptive methods**. Appropriate information should be given to them on the effectiveness of these methods so they can make informed decisions." (Participants Handbook, p. 52) "Many young people say they need more education on sexuality and HIV prevention **to help them practise responsible sexual behaviour**. It has been shown that young people can responsibly protect themselves and others if they receive support." (Participants Handbook, p. 116)
10. PROMOTES TRANSGENDER	"Gender. **Socially constructed roles**, behaviours, activities, and attributes that a

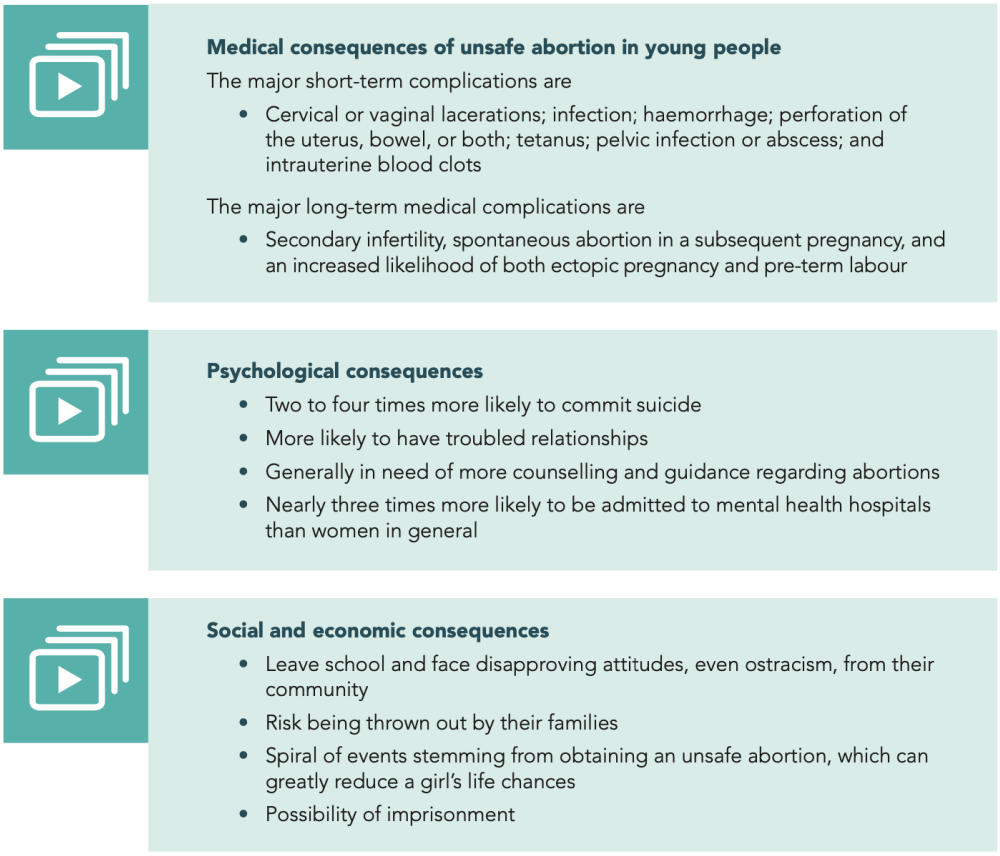
IDEOLOGY *Promotes affirmation of and/or exploration of diverse gender identities. May teach children they can change their gender or identify as multiple genders, or may present other unscientific and medically inaccurate theories. Fails to teach that most gender-confused children resolve their confusion by adulthood and that extreme gender confusion is a mental health disorder (gender dysphoria) that can be helped with mental health intervention.*	given society considers appropriate for men and women." (Facilitator's Guide, p. 17) "LBGT refers to persons who are lesbian, bisexual, gay, or **transgender**. On June 17, 2011, the UN passed a resolution (Resolution of Sexual Orientation and Gender Identity, A/HRC/17/L.9/Rev.1) expressing concern about prejudice and violence against LGBT persons." (Participants Handbook, p. 88)
11. PROMOTES CONTRACEPTION/ABORTION TO CHILDREN *Presents abortion as a safe or positive option while omitting data on the many potential negative physical and mental health consequences. May teach children they have a right to abortion and refer them to abortion providers.* *May encourage the use of contraceptives, while failing to present failure rates or side effects.*	"**Contraceptive use.** The percentage of all women and men **ages 15–19** who are using any form of contraception. 'Modern' methods are **pills, intrauterine contraceptive devices, injectables, implants**, female and male **condoms**, **emergency contraception**, and female and male **sterilisation**. 'Any' methods include not only modern but also traditional methods, such as rhythm/periodic abstinence and withdrawal (Ministry of Finance, Economic Planning and Development, 2013, Malawi Youth Data Sheet)." (Facilitator's Guide, p. 17) "Unit objectives: 1. Define contraception. 2. **Describe contraceptive use** among adolescents and young people. 3. List at least five common barriers to contraceptive use among adolescents. 4. Discuss ways to provide adolescents with contraceptive information and services. 5. In a classroom exercise, **demonstrate effective counselling for a contraceptive method** through informed choice." (Facilitator's Guide, p. 107 and p. 119) "Condoms are the **most commonly used contraceptive method among young people**, followed by the injectable contraceptive depot medroxyprogesterone (sold as Depo Provera). The choice of method mostly has been due to availability, accessibility, and knowledge about contraceptives, but also due to fertility preferences." (Facilitator's Guide, p. 108) "What are common **barriers to contraceptive use** among adolescents? Allow 20 minutes for participants to brainstorm on this topic. Wrap up the session by highlighting some of the following barriers: • Providers' display of unfavourable attitudes • Providers' poor communication skills and an inability to understand

	young people's needs • Providers' offers of unsolicited advice • Providers' **refusal to provide long-acting reversible contraceptives** • Adolescents' fear of being labelled promiscuous • HIV testing requirements before accessing other services • Adolescents' **lack of knowledge about sources of family planning services** • Adolescents' misinformation regarding how to prevent pregnancies • Community leaders' discouragement • Adolescents' shyness and embarrassment • Adolescents' fear about getting contraception • Cost of accessing the services (transportation to a facility; also, some facilities charge for contraceptive services) • **Restrictive policies**: adolescents and young people under age 18 are often asked to seek **parental consent**, especially for long-acting methods • Stockouts of family planning commodities in most institutions" (Facilitator's Guide, p. 109 and Participants Handbook, p. 58) "Divide the participants into six small groups and **assign each group one of the main contraceptive methods used** in Malawi (see Table 6). Ask each group to **create a funny television advertisement for their assigned contraceptive** and act it out for the group as a whole. Inform the group that in their advertisement, they should explain the following: • Name of method, how it works, its effectiveness, whether it protects from HIV and other STIs, side effects, and also some myths and misconceptions about the method. • Then review the contraceptive list in Table 6 with everyone. (This list is also in the *Participants Handbook in Table 5*.)" (Facilitator's Guide, p. 110) "In Malawi, SRHR calls for 'all sexually active people to be able to access contraception.' Therefore, **young people can access all forms of contraception**. However service provision guidelines only allow young people age 16 and above to be able to access contraception **without the consent of a parent/guardian**." (Facilitator's Guide, p. 111) "Aim of the session: To identify the **contraceptive methods most appropriate** to the social circumstances and behaviour/lifestyle of different groups of young people" (Facilitator's Guide, p. 113) "Explain that this session will build on the previous one by looking at **which contraceptive methods are most appropriate** to the special needs of different groups of young people… • Does the method **meet the needs of young people** for pregnancy prevention/fertility regulation? • Does the method meet the needs of young people for prevention of HIV and other STIs? • Are special considerations regarding its provision likely to **make it**

	difficult for a young person to use the method? • Are special considerations regarding its utilisation likely to make it difficult for a young person to use the method? • Are the side effects of the method likely to hinder its use by a young person?" (Facilitator's Guide, p. 113) "Some **adolescents may find it easier to use an injectable method** (which requires a brief visit to a clinic every two to three months) than oral contraceptives (which require a packet of tablets to be kept with the person, who must remember to take one every day)." (Facilitator's Guide, p. 113) "Briefly inform the adolescent about the available contraceptive methods. Provide information on the characteristics of the method(s) that the provider believes is (are) most appropriate to the situation. **Work with the adolescent to help him/her choose a method**. Provide further information on the correct use of the method and where supplies can be obtained for future use." (Facilitator's Guide, p. 115) "In many places, adolescents with an unwanted pregnancy resort to termination (whether this service is available legally or not). **Making safe pregnancy termination services available and accessible to this age group** will reduce the proportion that will carry on with the pregnancy. It also will reduce maternal mortality resulting from unsafe abortions." (Facilitator's Guide, p. 126) "Unit objectives: • **Define unsafe abortion**. • Discuss the scope of unsafe abortion in Malawi, including the legal status of abortion. • Mention at least four reasons why adolescents and youths seek unsafe abortion. • State the single largest factor in determining the risk of complications and death **due to unsafe abortion among young women**. • Discuss the medical, psychological, and social consequences of unsafe abortion in young women. • Describe ways to detect unsafe abortion and how to refer for treatment. • Discuss what needs to be done to **prevent unsafe abortion**." (Facilitator's Guide, p. 135) ***Note:*** *No mention is made of the medical, psychological, and social consequences of so-called "safe abortion" done by a medical provider.* "The six women described below have come to you requesting a referral for abortion. Due to circumstances beyond your control, **only one more abortion can be done, so you must choose which one of your six patients is to receive the last abortion**. Rank the cases from 1 (most want to refer for an abortion) to 6 (least want to refer). • Phales is 14 years old and unsure about what to do. She has supportive parents.

	• Taona is 19 years old, has two children, and has had two previous abortions. • Khumbo is 24 years old, a student in medical school, and engaged to be married. She wants to begin her career before starting her family. • Pacharo is 29 years old, single, and pregnant with an IUD in place. • Maggie is 35 years old, divorced, and pregnant from a one-night encounter – her first sexual experience following her divorce. • Mtisunge is 45 years old and married with three grown children. Neither she nor her husband wants any more children." (Facilitator's Guide, p. 136) "This exercise helps to **identify the areas where participants are most challenged on the issue of abortion**. In this exercise, do the following: …Inform participants that you will draw an imaginary line (or create a physical line) dividing the space into two areas: agree and disagree. Read out the statements and ask participants to cross the line into the 'agree' half circle if they agree with it and into the 'disagree' half circle if they don't agree. Those with neutral opinions should remain where they are. Read the statements below: • I would feel very uncomfortable in referring a young woman for abortion services. • My religion considers abortion a sin even if the life of the mother is in danger. • Abortion should not be legalised in Malawi. • Young people who obtain abortion services are promiscuous. • Abortion should be offered to older people only, not young people. Use the questions below to guide the discussions in plenary: • What factors influenced your choice? • How did it feel to make this choice?" (Facilitator's Guide, p. 137) "A study on **unsafe abortion in Malawi** found that the most important factors contributing to unintended pregnancy and induced abortion included inaccessibility of safe abortion services, particularly for poor and young women; and lack of adequate family planning, youth-friendly healthcare, and post-abortion care services. By now, **most participants should agree that unsafe abortion is a serious health problem**, and that a significant proportion of those having abortions are adolescents." (Facilitator's Guide, p. 140) "Role Play 1: A **14-year-old girl**, dressed in her school uniform, comes during school hours to see the duty medical officer in the casualty department of a district hospital. She explains to the doctor that she thinks she is pregnant and **wants a termination**. She does not want to talk about who the father might be, even on probing. She tells him that she is the first-born in a family with six children. She attends a local Catholic secondary school and lives with an uncle who is her local guardian and is paying for her upkeep. Her parents are poor farmers living in a rural area. The girl believes that her future education and her relationship with her family will be irrevocably damaged by carrying through with this pregnancy. She says that she is depending on the support of the duty medical officer to find a solution. The doctor seems willing to consider assisting

her, but the nurse on duty **is a staunch Christian who believes that abortion is murder**.
ROLES: The doctor, the girl, and the nurse" (Facilitator's Guide, p. 147)



(Facilitator's Guide, p. 142)

"Service guidelines allow for youths age 16 and up to access contraception without parental consent. However, the SRHR policy stipulates that **ALL sexually active persons, including youths, can access any method of their choice**." (Participants Handbook, p. 58)

"Some adolescents **may have temporary sexual relationships and multiple partners**, which puts them at a high risk of acquiring HIV and other STIs. Sexually active adolescents need to be aware of the importance of protection against both pregnancy and STIs, including HIV. In Malawi, there is no law or policy that bars adolescents and young people from **accessing any type of contraceptive of their choice**. Thus, it is wrong for providers to refuse to provide any contraceptive method based on their personal values or beliefs." (Participants Handbook, p. 58)

"In helping adolescents and young people **choose which contraceptive to use,** healthcare providers must provide them with information about the methods available and help them consider their merits and downsides of each. In this way, they will **guide their adolescent clients to make well-informed and voluntary choices of the method most suitable to their needs** and circumstances (taking eligibility, practicality, and legality into consideration)." (Participants Handbook, p. 62)

	"Summary:
	• Adolescents are entering their reproductive years **ill-prepared to protect** and safeguard their sexual and reproductive health.
	• For all adolescents, and especially those sexually active outside the context of marriage, access to appropriate information and services – and the assurance of confidentiality – are particularly important.
	• **To help ensure that sexually active adolescents use contraceptives**, contraception information and services must be made readily available through a variety of delivery points, including community-based points and outreach services.
	• By providing quality services that respect adolescents' rights and respond to their needs, **reproductive health programmes** will contribute to the overall health and well-being of adolescent clients and their communities." (Participants Handbook, p. 63)
	
	"**Definition of unsafe abortion**:
	• WHO defines unsafe abortion as, 'a procedure for terminating an unintended pregnancy carried out either by persons lacking the necessary skills or in an environment that does not conform to minimal medical standards, or both' (WHO, 2007).
	• Skilled professionals in a suitable environment to terminate pregnancy **perform safe abortion**. Safe abortion prevents the deaths and complications that can result from unsafe abortion." (Participants Handbook, p. 77)
	
	"**The consequences of unsafe abortion**
	• **Medical consequences** – The major short-term complications are as follows: Cervical or vaginal lacerations, infection, haemorrhage; perforation of the uterus, bowel, or both; tetanus; pelvic infection or abscess; and intrauterine blood clots
	• The major long-term medical complications are as follows: Secondary infertility, spontaneous abortion in a subsequent pregnancy, and an increased likelihood of both ectopic pregnancy and pre-term labour
	• **Psychological consequences** – Those who have unsafe abortions
	  ○ Are two to four times more likely to commit suicide
	  ○ Are more likely to have troubled relationships
	  ○ Are generally in need of more counselling and guidance regarding abortion
	  ○ Are nearly three times more likely to be admitted to mental health hospitals than women in general
	• **Social and economic consequences** – Those who have unsafe abortions
	  ○ Often leave school and face disapproving attitudes, even ostracism, from their community
	  ○ Risk being thrown out by their families
	  ○ Have greatly reduced life chances owing to the spiral of events stemming from having obtained an unsafe abortion
	  ○ Face imprisonment" (Participants Handbook, p. 81)

TABLE 5. Available contraceptive methods for young people

METHOD	EFFECTIVENESS AGAINST PREGNANCY		PROTECTION AGAINST STIS/HIV	COMMENTS AND CONSIDERATIONS
	As Commonly Used	Used Correctly and Consistently		
Abstinence and non-penetrative sex	Not effective	Very effective	Protective against HIV and other STIs	Most effective method for dual protection; only provides dual protection when used correctly and consistently
Male condom	Somewhat effective	Effective	Protective against HIV and other STIs	Only provides dual protection when used correctly and consistently
Female condom	Somewhat effective	Effective	Protective against HIV and other STIs	Only provides dual protection when used correctly and consistently
Combined oral contraceptives (COCs)	Effective	Very effective	Not protective	Only protective against pregnancy when used correctly and consistently; if at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method
Progestin-only pills (POPs)	Very effective (during breastfeeding)	Very effective (during breastfeeding)	Not protective	Only protective against pregnancy when used correctly and consistently; if at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method
Long-acting hormonals: injectables or implants	Very effective		Not protective	If at risk of STIs/HIV, recommend switching to condoms or using condoms along with this method
Copper intrauterine device (IUD)	Very effective		Not protective; insertion of an IUD in a woman with an STI increases the risk of pelvic inflammatory disease	Use of IUDs among women at risk of STIs/HIV is generally not recommended (unless other, more appropriate methods are not available) If an IUD user becomes at risk of STI, treatment of STI is possible without removing it; however, in some cases, recommend switching to condoms or using condoms along with this method
Fertility awareness-based methods	Somewhat effective	Effective	Not protective	Only protective against pregnancy when used correctly and consistently; if at risk of STI/HIV, recommend switching to condoms or using condoms along with this method
Lactational amenorrhoea (LAM) during first 6 months postpartum	Effective	Very effective	Not protective	
Withdrawal	Not effective	Low effectiveness	Not protective	Not ideal method but can be used with fertility awareness-based methods for pregnancy prevention if other methods are not feasible

(Participants Handbook, p. 59)

12. Promotes Peer-to-Peer Sex Ed or Sexual Rights Advocacy

May train children to teach other children about sex or sexual pleasure, through peer-to-peer initiatives. May recruit children as spokespeople to advocate for highly controversial sexual rights (including a right to CSE itself) or to promote abortion.

"**Sexual and reproductive health rights**:

- Right to seek, receive, and impart information related to sexuality
- Right to **receive sexuality education**
- Right to have respect for bodily integrity
- Right to choose one's partner
- Right to **decide to be sexually active or not**
- Right to have consensual sexual relations
- Right to have consensual marriage
- Right to decide whether or not and when to have children
- Right to **pursue a satisfying, safe, and pleasurable sexual life**" (Participants Handbook, p. 41)

"Young people need to be **trained to spread messages and promote responsible behaviour** among their peers." (Participants Handbook, p. 117)

	"Involving young people: Services that achieve high quality are those that closely involve youth in their planning and monitoring. **Through the involvement of young people**, service providers can be confident that they are providing services in the right place, at the right time, and in the right style." (Participants Handbook, p. 166)

13. UNDERMINES TRADITIONAL VALUES AND BELIEFS
 	
May encourage children to question their parents' beliefs or their cultural or religious values regarding sex, sexual orientation or gender identity.
	"Begin by informing participants that you want them to do a **values clarification exercise** and that you hope they will be as honest as possible about their feelings and the reasons for them. Choose statements of issues that affect adolescents and young people, and ask each group member to state her/his opinion of the following statements, using the barometer of values below:
	-3 Strongly disagree, -2 Moderately disagree, -1 Slightly disagree, 0 Neutral, 1 Slightly agree, 2 Moderately agree, 3 Strongly agree
	• Adolescents should **first seek parental consent** before accessing a long-acting family planning method.
	• I can **give condoms to my neighbour's 17-year-old** son or daughter.
	• I will tell my neighbour if I know her daughter came in for a family planning method.
	• There is no need to offer privacy when dealing with young people." (Facilitator's Guide, p. 54)
	
	"**Group work on traditional cultural practices**
	• Ask each group to make a list of cultural practices from where they live or work that affect young people.
	• List which ones are beneficial (promoting good health or protection) for young people, and why. Can these be promoted in their communities?
	• **List which ones are harmful** and answer the following questions about them.
	  ○ Are they common in your area?
	  ○ How can young people be protected from these harmful practices?
	  ○ How can harmful practices be managed?" (Facilitator's Guide, p. 70)
	
	"**A harmful practice is defined as a social, cultural, or religious practice** that, because of sex, gender, or marital status, does or is likely to undermine the dignity, health, or liberty of any person or result in physical, sexual, emotional, or psychological harm to any person (Gender Equality Act, 2013)." (Facilitator's Guide, p. 70 and Participants Handbook, p. 5)
	
	"As health service providers working with young people, it is our duty to **be on the lookout for harmful cultural practices** and then report them. These practices are highly linked to gender, so girls are more affected than boys in most communities. Because of these cultural practices, more girls will drop out of school, get married when they are still children, have unwanted pregnancies, and have a higher risk of acquiring an STI, including HIV." (Facilitator's Guide, p. 70)

	"**Pregnancy and the responsibility of childbearing can reduce a girl's ability to continue with her education and explore employment opportunities**. Although it is government policy to allow readmission of girls who have withdrawn from school because of pregnancy and childbirth, the situation on the ground poses problems. Stigma from peers as well as reluctance by some school administrators can make return to school difficult." (Facilitator's Guide, p. 127) "Factors that could help reduce unsafe abortion in young people. • Availability and accessibility of contraceptive information and services • Availability and **accessibility of safe abortion services** • Healthcare providers who are helpful and nonjudgmental • **Community norms** that permit open and frank discussion about sexuality in young people • **National laws and policies** that facilitate the provision of reproductive health information and services that young people need." (Facilitator's Guide, p. 141) "The purpose of this unit is to help you to **examine what makes it difficult for young people to get the health services they need**, and then to consider what actions you could take to make the health facilities in your community more youth friendly than they currently are. Obviously, some people are in greater positions of authority than others, but every one of us can do something meaningful." (Facilitator's Guide, p. 259) "The legitimacy of religious institutions is indisputable. **Linking SRHR to religious institutions** can strengthen access to services by young people." (Facilitator's Guide, p. 273) "The Special Law Commission **resolved and agreed that abortion law in Malawi should be liberalised** (i.e., institute a conditional relaxation of the restrictions) as opposed to being decriminalised, to accommodate certain justifiable instances in which termination of a pregnancy should permissible [sic]. Therefore, grounds for a woman to terminate a pregnancy, in addition to saving the life of a pregnant woman, would be when termination is necessary to **prevent injury to the** physical or **mental health of a pregnant woman**; when a severe malformation of the foetus would affect its viability or compatibility with life; and when the pregnancy is the result of rape, incest, or defilement." (Participants Handbook, p. 79) "In both urban and rural areas, there is a need to provide services away from hospitals and health centres to reach out to young people who are unlikely to attend otherwise. Increasingly in towns and cities, **services are being provided in shopping malls and community or youth centres**. Some countries have **promoted services on the internet** to catch the attention of young people who have access to computers." (Participants Handbook, p. 177) "Schools provide a natural entry point for reaching young people with health education and services… Inclusion of life skills education and **SRHR topics in the**

	primary curriculum has provided an opportunity to impart essential knowledge to inform young people's health decisions… However, in practice, schools' potential is seldom realised. Schools are short of resources and teachers have neither the training nor the equipment to deliver health education in addition to their existing workload. To turn this situation around requires effective training to build the motivation and skills of staff, and **may require outside support for sex education lessons**. Some successful schemes train young people as peer educators in schools." (Participants Handbook, p. 177)
14. UNDERMINES PARENTS OR PARENTAL RIGHTS *May instruct children they have rights to confidentiality and privacy from their parents. May teach children about accessing sexual commodities or services, including abortion, without parental consent. May instruct children not to tell their parents what they are being taught about sex in school*.	"Ensure and respect **confidentiality** so that facilitators and participants are able to discuss sensitive issues (such as those relating to SRH, mental health, and substance use) without concern about possible repercussions." (Facilitator's Guide, p. 40) "As seen in the unit, our customers are key and are kings/queens! Adolescents and young people, like any other client accessing services, should receive respect, **privacy, and confidentiality**." (Facilitator's Guide, p. 57) "Some of the issues that health service providers face when dealing with adolescents are simple and clear-cut (such as providing dietary advice and medication to treat anaemia). Other issues (such as dealing with the request of a 15-year-old unmarried, sexually active adolescent for a contraceptive method without the knowledge of her parents) raise a **conflict between the rights and responsibilities of adolescents and those of their parents, or between the best interests of adolescents and the prevailing laws**." (Facilitator's Guide, p. 79) "Healthcare providers may find themselves in the difficult situation of trying to find a **balance between the rights of parents** (or guardians) to be told about the health problems of their children (especially when the children are still minors), and the **rights of their adolescent clients to privacy and confidentiality**. This is particularly so when laws and policies specify that the consent of parents (or guardians) is mandatory for the provision of certain health services to minors. It is important that healthcare providers deal with such situations in a responsible manner, **doing everything in their power to safeguard the health and well-being of their adolescent clients**." (Facilitator's Guide, p. 184) "Characteristics of YFHS: …Privacy and confidentiality, **without the requirement of parental permission to attend.**" (Facilitator's Guide, p. 263) "Does the **tension between the rights of parents** to know about the health problems of their adolescents and the **rights of adolescents to privacy** hinder the ability of adolescents to use health services? Are the barriers that have been identified the same for all adolescents, or are they different for some categories of adolescents (based, for instance, on gender or socioeconomic status)?" (Facilitator's Guide, p. 267) "**Any person age 13 and above should be considered mature enough to give full and informed consent** for HIV testing and counselling (HTC)… There is no minimum age for accessing contraceptives. Adolescents and youth can access

	any contraceptive of their choice at any time." (Participants Handbook, p. 27) "In many societies, parents and other community members believe that the provision of information on sexuality to adolescents does more harm than good. As a healthcare provider, **you know this is not true**." (Participants Handbook, p. 52) "Providing access to life skills education, individualised counselling, and **group education for young girls on sex and sexuality** are critical components of psychosocial support." (Participants Handbook, p. 52) "Unmarried adolescents may be less likely to seek contraceptive services at health facilities because of embarrassment and fears that staff may be hostile or judgmental, or that their parents might learn of their visit. Adolescents need to feel that they are respected, that their needs are taken seriously, and that **they have the right to use contraception if they desire**." (Participants Handbook, p. 63) "When making referrals, do the following: Assure the clients of **confidentiality**." (Participants Handbook, p. 102) "Privacy and confidentiality, **without the requirement of parental permission to attend**" (Participants Handbook, p. 167)
15. REFERS CHILDREN TO HARMFUL RESOURCES *Refers children to harmful websites, materials or outside entities. May also specifically refer children to Planned Parenthood or their affiliates or partners for their lucrative services or commodities (i.e., sexual counseling, condoms, contraceptives, gender hormones, STI testing and treatment, abortions, etc.)* *Please Note: A conflict of interest exists whenever an entity that profits from sexualizing children is involved in creating or implementing sex education programs.* *(For more information on how Planned Parenthood sexualizes*	"Provide additional information on some of the referral points where young people could access assistance pertaining to their needs: • **Youth clubs/NGOs** • Community home-based care groups • Community-based organisations • **NGOs dealing with youth issues:** for example, World Vision International (WVI), Plan Malawi, Care Malawi, Action Aid, Save the Children (U.S.), Inter-aide, Malawi Girl Guides Association (MAGGA), Family Planning Association of Malawi (FPAM), Banja La Mtsogolo (BLM), post-test clubs, schools, etc. • Family, religious institutions, District Youth Officers, and Social Welfare Department • The Victim Support Unit Conclude the activity by saying that **young people need empowerment** and that this can be achieved by ensuring that their needs are met." (Facilitator's Guide, p. 74) "Inform participants that this is a 15-minute video by the **Population Reference Bureau** that advocates giving priority to young people in health and development: https://www.youtube.com/watch?feature=player_embedded&v=xWMVpjXQWw0" (Facilitator's Guide, p. 75) ***Note:*** *This video promotes making youth SRHR a priority on Malawi's policy*

children for profit see www.WaronChildren.org and www.InvestigateIPPF.org)	*agenda.*
	
	"**Plan to visit a nearby facility providing YFHS** (preferably one that is YFHS accredited)… On the day of visit:
	• Divide the participants into three or four groups and assign each an assessment task to conduct at the facility.
	• Use the YFHS accreditation tool and divide responsibilities among the groups (this is a more comprehensive assessment tool)…
	• Come up with two or three difficult scenarios involving young people and ask the staff how they have dealt with them either in the past or now.
	• Basic things you may need to observe are the following:
	  ○ YFHS poster; availability of policies and guidelines for delivery of YFHS; how many staff are trained in YFHS; the environment of the facility (privacy, cleanliness); **availability of IEC [information, education, and communication] specifically for young people**; any sporting activities; whether they have periodic meetings with young people; and how they collect data on services for young people and use the data.
	  ○ Also ask about any involvement by the community, including **involvement of young people**, in planning and monitoring services." (Facilitator's Guide, p. 245)
	
	"For existing services to reach more young people, more active means of informing youth about them should be prioritised. Staff with a special interest in working with young people should be identified and encouraged to network with outside agencies to establish referral mechanisms and communication channels that will **raise awareness of the availability of services**. The following steps can be used to create a referral system:
	• Have a referral book or cards in which you can document those referred.
	• List the names of organisations and institutions **supporting young people with different services**.
	• List these sites' addresses and telephone numbers, and the names of contact persons (**ensure that these staff are trained in YFHS**).
	• Make this list available to all service providers.
	• Ensure that all referrals made for adolescents and young people are confidential." (Participants Handbook, p. 104)

For the complete text of *Malawi Youth-Friendly Health Services Training Manual, Facilitator's Guide* see: https://drive.google.com/file/d/1y0THzp6I77s9coDqypSFtai8rg4Z2Ct6/view?usp=drive_link For the complete text of *Malawi Youth-Friendly Health Services Training Manual, Participants Handbook* see: https://drive.google.com/file/d/19HJq7JznbEUOtRhqGTS4tP7rqu6v97tx/view?usp=drive_link	