Republic of Malawi
Ministry of Health

YOUTH-FRIENDLY HEALTH SERVICES TRAINING MANUAL

FACILITATORS GUIDE

Second Edition
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ABBREVIATIONS

AIDS	acquired immune deficiency syndrome
ART	antiretroviral therapy
BLM	Banja La Mtsogolo
HIV	human immunodeficiency virus
HPV	human papilloma virus
IEC	information, education, and communication
IUCD	intrauterine contraceptive device
MDHS	Malawi Demographic and Health Survey
MOH	Ministry of Health
PEP	post-exposure prophylaxis
PLHIV	people living with HIV
PMTCT	prevention of mother-to-child transmission of HIV
RHD	Reproductive Health Directorate
SRH	sexual and reproductive health
STI	sexually transmitted infection
TOT	training of trainers
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
VIPP	visualisation in participatory programmes
VMMC	voluntary medical male circumcision
WHO	World Health Organization
WVI	World Vision International
YFHS	youth-friendly health services

GLOSSARY

Categories of youth. Early adolescents: ages 10–14; late adolescents: ages 15–19; young people: ages 10–24 (United Nations).

Cephalo-pelvic disproportion (CPD). Occurs when a baby's head or body is too large to fit through the mother's pelvis. It is believed that true CPD is rare, but many cases of "failure to progress" during labour are given a diagnosis of CPD.

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).

Depression. A mental disorder characterised by low moods and a decrease in functional activity.

Demographic dividend. The accelerated economic growth that may result from a decline in a country's mortality and fertility, a change in the age structure of the population (increased number of working-age adults), and the increased ratio between a productive labour force and nonproductive dependents.

Embolus. A blood clot, air bubble, piece of fatty deposit, or other object that has been carried in the bloodstream to lodge in a vessel and cause an embolism.

Ectopic pregnancy. A pregnancy in which the foetus develops outside of the uterus, typically in a fallopian tube.

Gender. Socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

Gender-based violence. Violence targeted at girls, boys, women, and men based on the gender roles assigned to them. This violence often arises from unequal power relationships between men and women, and women are the victims (United Nations International Research and Training Institute for the Advancement of Women, United Nations Population Fund, 2010).

Haemorrhage. An escape of blood from a ruptured blood vessel, especially when profuse.

Harmful cultural practices. A social, cultural, or religious practice that, on account of sex, gender, or marital status, does or is likely to undermine the dignity, health, or liberty of any person or to result in physical, sexual, emotional, or psychological harm to any person (Malawi Gender Equality Act, 2013).

Obesity. Weight that is 20 percent above the standard weight for a person's height.

Obstetric fistula. Commonly referred to as fistula, this is a hole between the vagina and rectum or bladder caused by prolonged obstructed labour, often leaving the woman incontinent, with involuntary release of urine, faeces, or both.

Premature labour. Regular contractions of the uterus resulting in changes in the cervix that start before 37 weeks of pregnancy. Changes in the cervix include effacement (the cervix thins out) and dilation (the cervix opens so that the foetus can enter the birth canal).

Primi gravida. A woman who is pregnant for the first time.

Psychoactive substance. A substance that, when taken into the system, affects mental processes, consequently affecting other social and biological dimensions of human life.

Psychosis. An abnormal mental condition in which one loses contact with reality and exhibits personality changes and thought disorders.

Schizophrenia. A mental disorder characterised by abnormal psychosocial behaviour and inability to recognize what is real in one's environment.

Septicaemia. Blood poisoning, especially that caused by bacteria or their toxins.

Sexual abuse. Any sort of nonconsensual sexual contact.

Stunting. When one is too short for one's age, as measured by medical standards for height.

Stress. A state of mental or emotional tension resulting from adverse or very demanding circumstances. It may lead to feeling sad and low; loss of appetite; difficulty in sleeping; and being fearful, tense, or panicky.

FOREWORD

Youth are the window of hope for the development of this country. As such, they need proper care and guidance to ensure that they remain healthy and productive. Young people have needs and challenges that affect their growth and development. However, many young people and the adults around them either are unaware of these needs or what to do about them. Those who are aware often have problems accessing services that address their needs.

The Malawi Youth-friendly Health Services (YFHS) Training Manual aims to improve the way service providers respond to the needs of young people and improve providers' ability to communicate with other stakeholders to improve young people's health.

This training manual is not a clinical manual. It is intended for trained registered health service providers offering preventive, curative, and promotive health services to youth. The manual will be useful to doctors, clinical officers, nurses, and other professionals, such as psychologists, social workers, teachers, youth development workers, community-based distribution agents, and youth peer educators, as well as young people themselves. To be eligible for training, service providers will need to have at least a Junior Certificate (JCE) and experience in community work. Ability to communicate in English (both spoken and written) will also be a key selection criterion. Anyone lacking the above minimal criteria will be oriented only on selected topics: effective communication with young people, issues affecting young people, laws and policies affecting young people in health service delivery, and the YFHS standards (Unit 7 of this training manual).

The training is expected to be implemented as a stand-alone five-day workshop. Participants will

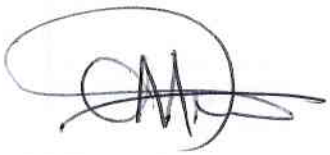
- Become more knowledgeable about young people, their needs, and aspects of youth health and development
- Gain skills in effective communication with young people; challenge their own attitudes affecting their capacity to deliver services to young people; and acquire an understanding of laws, policies, and standards for YFHS delivery
- Be better equipped with facts and figures to advocate for increased investment in young people's health and development
- Be better able to provide health services that respond to young people's needs and be sensitive to their preferences
- Prepare a personal action plan to carry out the changes they will make in their work with and for young people

Other capacity-building programmes organised by the Ministry of Health (MOH) and its partners are in place to equip participants with specific clinical skills in youth healthcare. The training package does not intend to duplicate these, but where relevant, facilitators should refer to the materials from these programmes during the training workshop and make them available to participants. Facilitators should be flexible enough to gauge the level of capacity of their participants and tailor the materials in this training package to complement these capacity-building materials.

In practical terms, the training will provide participants with ideas and practical tips to answer two fundamental questions:

- What do I, as a health-service provider, need to know and do differently if the person who walks into my clinic is 16 years old, rather than 6 or 36?
- How can I help other influential people in my community understand and respond better to the needs and problems of young people?

This training operationalises the *National Youth Friendly Health Services Strategy 2015–2020*. It was developed in line with the World Health Organization (WHO) recommendations of YFHS competency for providers in three domains: (1) basic concepts in adolescent health and development, and effective communication; (2) law, policies, and quality standards; and (3) critical care of adolescents with specific conditions. Through this manual, the MOH expects that service providers will be able to re-examine and re-orient their work to address the needs and problems of youth, as clearly reported in the 2014 YFHS evaluation study for Malawi. This manual is intended to help service providers from the government, the Christian Health Association of Malawi (CHAM), nongovernmental organisations, and all other stakeholders review, redesign, and develop programmes and policies focusing on the promotion of health services that are friendly to young people in Malawi.



Dr Charles Mwansambo
Chief of Health Services

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The *Malawi Youth-friendly Health Services (YFHS) Training Manual* culminates the concerted efforts of many people who developed the Malawi Youth-Friendly Health Service Standards and adapted WHO's 2006 Orientation Programme on Adolescent Health for Health-care Providers. This work significantly informed the content of the training package. WHO supported the first edition of the YFHS training package in 2011. The Reproductive Health Directorate (RHD) is indebted to the USAID-funded Health Policy Project (HPP) and Health Policy Plus (HP+) project for financing the development of the second edition. This new edition has given us the opportunity to update material and include emerging issues, aligning with several policy documents released after 2011.

The RHD would therefore like to sincerely express its gratitude and appreciation to all individuals, partner agencies, and collaborating institutions for their support and valuable contributions during the process of developing this manual.

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PREFACE

Youth-friendly health services (YFHS) have been implemented through the oversight of the Reproductive Health Directorate (RHD) in Malawi since 2007 in accordance with the *Youth-Friendly Health Services National Standards* (2007). YFHS are high-quality services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to young people. The first edition of the *YFHS Training Manual (Facilitators Guide and Participants Handbook)* was developed in 2011 to ensure that service providers fully comply with the minimum health package of the national standards and increase young people's acceptability and use of these services.

A recent evaluation of the YFHS programme revealed that only 31.7 percent of young people have heard of YFHS and 13 percent have ever used these services. Poor provider attitude was cited as one of the main barriers to the programme's use.[1] In response, and in recognition of emerging trends in youth and adolescent sexual and reproductive health (SRH), the RHD, with support from the USAID-funded Health Policy Project (HPP) and Health Policy Plus (HP+) project, has revised the training package. This second edition of the *Facilitators Guide* includes all resources necessary to train service providers on YFHS. For each topic, the guide offers an introduction, suggested activities, video clips, and handouts. The manual also seeks to respond to service providers' needs as defined in the *National Youth Friendly Health Services Strategy 2015–2020* and is itself one of that strategy's implementation approaches.

The *National Youth Friendly Health Services Strategy* has employed an approach that will involve service providers from multiple sectors and at varied levels to effectively and efficiently deliver YFHS in Malawi to young people ages 10–24 years. Few standardised training resources are available for professionals and volunteers concerning youth sexual and reproductive health rights (SRHR). This resource aims to help fill this gap in two ways:

1. Provide a workshop curriculum that can easily be adapted to specific situations, including those in resource-poor areas
2. Support a YFHS skills-building approach that focuses on enhancing providers' capacity to consistently and ably deliver high-quality services that are relevant, accessible, attractive, affordable, appropriate, and acceptable to young people

The second edition was developed in line with the World Health Organization definition of YFHS competency as having three domains: (1) basic concepts in adolescent health and development, and effective communication; (2) law, policies, and quality standards; and (3) critical care of adolescents with specific conditions.

[1] Evidence to Action (E2A) Project and University of Malawi. 2014. *Evaluation of Youth-Friendly Health Services in Malawi.* Washington, DC, USA: E2A Project, United States Agency for International Development. Available at: http://www.e2aproject.org/publications-tools/evaluation-of-yfhs-malawi.html.

THE SCOPE AND LIMITS OF THE MALAWI YFHS TRAINING PACKAGE

The scope and limits of the training package are informed by the YFHS standards. The standards have identified three areas of focus in the minimum package of services to address the health needs of young people:

- Health promotion
- Delivery of health services
- Referral and follow-up

The interventions in these areas are to be provided within the framework of the national healthcare delivery system. Furthermore, the standards have identified the services to be provided within the normal clinical standards and procedures as approved by the Ministry of Health (MOH). The services to be provided must also be in line with Malawi's Essential Health Package (EHP).

The services are listed below.

At the community level

- Contraceptive services, including condoms
- HIV testing and counselling
- Referral to health facilities or other service delivery points

At the health centre level

- Contraceptive services, including condoms
- Prevention, diagnosis, and management of sexually transmitted infections (STIs)
- Antenatal, delivery, and postnatal care services
- Post-abortion care
- Prevention of mother-to-child transmission of HIV (PMTCT)
- HIV testing and counselling
- Treatment of sexual abuse victims
- Referral to hospitals or other service delivery points
- Counselling and referral for nutrition, substance abuse, and mental health
- Voluntary medical male circumcision (VMMC)

At the hospital level

All of the services above, plus the following:

- Post-abortion care
- Treatment of sexual abuse victims, including post-exposure prophylaxis (PEP)
- Reproductive health cancer screening
- Provision of antiretroviral drugs

Health promotion and counselling during service delivery at all levels

- STIs
- Family planning
- Reproductive health cancers, including human papilloma virus (HPV) vaccine
- Psychosocial support
- Substance abuse
- Nutrition
- HIV and AIDS
- Sexual abuse
- Maternal healthcare
- Adolescent growth and development
- VMMC

AIMS AND COMPONENTS OF THE *FACILITATORS GUIDE*

The training package is designed to be implemented through a workshop. It is intended to be a dynamic and interactive programme, in which facilitators actively engage the participants in the teaching and learning process. A range of teaching or learning methods have been carefully selected to enable this to happen in an effective manner. *This Facilitators Guide* provides information to the organisers and facilitators for planning the workshop. The workshop may be in the form of a training-of-trainers (TOT) workshop, an orientation workshop, or refresher training.

The aims of the *Facilitators Guide*

- To provide information on planning and preparing for the specified training programme
- To provide an overview of the teaching and learning methods used in the selected training programme
- To give detailed instructions for conducting individual units
- To build the capacity of existing trainers, new trainers, or service providers for facilitating the YFHS training

The guide includes the unit schedule and step-by-step instructions to run each of the sessions. It also includes all of the support materials needed to run a given unit: slides with accompanying talking points; flip charts and their contents; and case study material, with notes on issues that arise. Finally, it includes *Tips for you*, to help you respond to questions that participants might ask, identifying matters that may be sensitive and how to deal with them.

Components of the *Facilitators Guide*

Unit 1 Getting started and basics

Unit 2 Adolescence and public health

Unit 3A Introduction to sexual and reproductive health and young people

Unit 3B Pregnancy prevention and fertility regulation in young people

Unit 3C Care of adolescents during pregnancy and childbirth

Unit 3D Unsafe abortion and young people

Unit 3E Sexual and physical abuse and young people

Unit 3F Sexually transmitted infections and young people

Unit 3G HIV and AIDS and young people

Unit 4 Nutrition and young people

Unit 5 Substance abuse and young people

Unit 6 Mental health and young people

Unit 7 Providing young people with the health services they need

INTRODUCTION TO THE TRAINING PACKAGE

Who is the YFHS training for?

This training package is intended to support two groups of service providers:

- Health service providers at all levels who interact with young people
- Professionals and volunteers from other sectors who work with adolescents on SRH issues, such as the staff of nongovernmental organisations (NGOs), youth outreach workers, youth club leaders, and teachers, among others

PLEASE NOTE: In this training manual, sometimes the terms adolescents, young people, and youths are used interchangeably. The package defines young people as those ages from about 10 to 24 years.

Facilitators are expected to adapt the training to suit the audience. For example, training youth club leaders, teachers, volunteers, and others outside the health sector may require more explanation of technical terms than necessary for professional service providers.

Content of the training package

This *Facilitators Guide* has been prepared to help plan, implement, and evaluate the training package. Table 1 shows the agenda. Table 2 shows the content of the training package. Running each unit takes about three hours (or half a day), except for the unit on SRH, which has been split into several units—3A to 3G—and takes about three days.

TABLE 1. Training package agenda

DAY	TIME	TOPIC
1	AM	Formal opening **Unit 1:** Getting started and basics
	PM	Lunch **Unit 1:** Getting started and basics **Unit 2:** Adolescence and public health
2	AM	**Unit 3A:** Introduction to sexual and reproductive health and young people
	PM	**Unit 3B:** Pregnancy prevention and fertility in young people **Unit 3C:** Care of adolescents during pregnancy and childbirth
3	AM	**Unit 3D:** Unsafe abortion and young people **Unit 3E:** Sexual and physical abuse and young people
	PM	**Unit 3E:** Sexual and physical abuse and young people **Unit 3F:** Sexually transmitted infections and young people
4	AM	**Unit 3G:** HIV and AIDS and young people **Unit 4:** Nutrition and young people **Unit 5:** Substance abuse and young people
	PM	Field visit to a YFHS facility
5	AM	**Unit 6:** Mental health and young people **Unit 7:** Providing young people with the health services they need
	PM	**Unit 7:** Providing young people with the health services they need Closing

Training of trainers. The TOT workshop will cover all topics in their entirety, with participants having to practice delivering the session. The training package is envisaged to be covered in five days. Facilitators must be able to assess participants during practice sessions to ensure that "graduates" of the training are competent to conduct further trainings in their respective sectors.

TABLE 2. Content of the TOT programme

UNIT	TITLE
1	Introduction
2	Adolescence and public health
3A	Introduction to sexual and reproductive health and young people
3B	Pregnancy prevention and fertility regulation in young people
3C	Care of adolescents during pregnancy and childbirth
3D	Unsafe abortion and young people
3E	Sexual and physical abuse and young people
3F	Sexually transmitted infections and young people
3G	HIV and AIDS and young people
4	Nutrition and young people
5	Substance abuse and young people
6	Mental health and young people
7	Providing young people with the health services they need

Orientation training. The orientation training will entail going through all of the above topics, with emphasis on the policies and service provider guidelines for topics **3B to 6**. Topics 1, 2, 3A, and 7 must be done in full. This training requires **three days**.

Refresher training. This will entail selecting topics for which new policies and guidelines have been instituted, and/or emerging issues within the topical areas. Facilitators will select topics amongst the seven units. This training will last for only **two days**.

Support materials used to run the training package

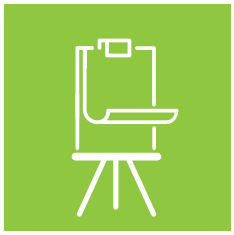
Each unit consists of support materials. You will need to read them carefully and understand them to run the unit effectively. Table 3 provides a list of the support materials with a brief description of each.

TABLE 3. Support materials for the training package units

SUPPORT MATERIAL	BRIEF DESCRIPTION AND PURPOSE
Participants Handbook	The *Participants Handbook* provides participants with technical information on the specific areas covered in each unit.
Learning objectives	These standards cover content related to knowledge, skills, and attitude learning. They appear in the beginning of each unit in the *Participants Handbook* under the heading, "This unit provides information on the following."
Spot checks	These comprise a set of five to six questions in each unit. The purpose of the spot checks is to help participants assess their increased knowledge as a result of participating in the unit.
Training programme personal diary	Each participant should have a notebook in which they will record the key messages they will take with them at the end of each unit. Participants will be asked to put down three key lessons they learned from their participation in the unit, and three actions they plan to take in their work for and with young people. The purpose of this exercise is to provide information for participants to develop their personal plans during the concluding unit.
Session support materials: Role plays Case studies Activity sheet Video clips	Role plays and case studies are materials developed for use in different units. The activity sheet for the concluding unit provides a framework for each participant to develop a personal plan to improve his/her work with young people. Video clips will be used for some sections (this is not mandatory but advisable) with self and trainer analysis.
PowerPoint presentation	This manual includes information for slides that can be used to create a PowerPoint presentation for each of the units.

Navigation aids

The Facilitators Guide uses codes, symbols, and colours to help you navigate the document.



FLIP CHARTS

ROLE PLAYS

SLIDES

KEY AREAS
for emphasis, summaries of important concepts, and information facilitators need to reinforce

TIPS

LET'S GET THE

WORKSHOP STARTED!

SESSION 1.
INTRODUCE YOURSELF AND ASK PARTICIPANTS TO INTRODUCE THEMSELVES 1 HOUR

Aims of the session

- To get to know everyone and their specific areas of work concerning youth
- To introduce and orient service providers to the special characteristics of young people, and the appropriate approaches to address selected priority health needs and challenges of young people

Instructions

- Welcome the participants to the training programme on YFHS.
- Introduce yourself and your co-facilitator(s).
- Explain that before the programme starts, a few minutes will be spent on general introductions to introduce the facilitators and participants to each other.
- Pin up a flip chart with the information below and ask participants to pair up (opposite-sex pairs would be ideal). Ask the pairs to introduce themselves to each other by answering the questions in the box. Then bring the group back together and ask each participant to report the answers of his or her partner.

Please tell the group about yourself.

- Your name and preferred name (if they're different)
- The town or city in which you currently work
- A few words about the organisation you work for
- The nature of your work and whether you are currently working with young people

- After these introductions, stress that there is a wealth of experience among the participants present in the room. Clearly, there will be much that every individual can share and learn from the others in the group.
- Next, distribute name cards and ask the participants to write clearly the name they would like to be called during the programme (some people prefer their first name and others their surname). The name cards should be placed in front of each participant so that everyone can see them.

The overall aim of the training programme

- To introduce and orient service providers to the special characteristics of young people, and the appropriate approaches to address selected priority health needs and challenges of young people

TIP FOR YOU

In the facilitator guidelines of each unit of the training package, you will find a section entitled "Talking Points," which accompanies the slides. These talking points have been created to give you more information to help you to explain further the content of the slides.

Instructions

- Inform the participants that the specific characteristics of young people, their needs and problems, and approaches to meet these needs and problems will be discussed in subsequent units.
- Explain that by participating in the training, they will be able to answer the questions shown in the box below. (This box is a slide in the PowerPoint deck for Day 1.)
- Stress that the package does not provide training in clinical skills for youth health service provision but rather focuses on the interpersonal skills providers must have when dealing with young people in the context of SRHR.

The training will help you answer questions.

- What do I, as a health-service provider, need to know and do differently if the person who walks into my clinic is 16 years old, rather than 6 or 36? (Remember that YFHS is meant for 10- to 24-year-olds.)
- How could I help? Are there other influential people in my community who understand and respond better to the needs and problems of adolescents?

- Next, show the slide below and go through the objectives for this introductory unit.

Unit objectives

1. Introduction
2. Expected outcomes
3. Agenda for the workshop
4. Group work process
5. Hopes, expectations, and concerns the participants might have

- Give the participants copies of the training package agenda and refer them to the *Participants Handbook.*

SESSION 2.
PROGRAMME OBJECTIVES AND AGENDA 15 MINUTES

Aims of the session

- To establish the training outcomes for the TOT

Activity 2.1. Plenary presentation of the training package

Instructions

- Briefly show the slide below on expected training outcomes and take the participants through it, asking for questions and comments, and responding to them as you proceed.
- Explain the overall expected outcomes of the training.

Expected outcomes of the training

- Be more knowledgeable about the characteristics of young people's development
- Be more sensitive to the needs of young people
- Be better equipped with SRHR information and resources
- Be more knowledgeable about the policies and guidelines regarding young people
- Be better able to provide youth-friendly health services
- Prepare a personal plan outlining the changes participants will make in their work

- The personal plan should accomplish the following:
  - List the changes the participant proposes to make in the way he/she works with and for young people
  - Identify how the participants will assess whether or not he/she is being successful in making the proposed changes
  - List the personal and professional challenges and problems they may face
  - Identify alternative approaches to address the expected challenges and problems
  - Highlight key guidelines for delivering services to young people

Activity 2.2. Mini lecture

Instructions

- Having covered the expected outcomes of the training package, ask the participants to look at the schedule and briefly take them through each day's work.
- Show the slide below that lists all of the currently available units of the training package.

Units of the training package

Unit 1	Getting started and basics
Unit 2	Adolescence and public health
Unit 3A	Introduction to sexual and reproductive health and young people
Unit 3B	Pregnancy prevention and fertility regulation in young people
Unit 3C	Care of adolescents during pregnancy and childbirth
Unit 3D	Unsafe abortion and young people
Unit 3E	Sexual and physical abuse and young people
Unit 3F	Sexually transmitted infections and young people
Unit 3G	HIV and AIDS and young people
Unit 4	Nutrition and young people
Unit 5	Substance abuse and young people
Unit 6	Mental health and young people
Unit 7	Providing young people with the health services they need

Instructions

- Please explain the following points to the participants:
  - The subject units of the training programme have been selected on the basis of regional and national data, which reflect the priority health problems and health risk behaviours of young people.
  - Ask the participants to look again at the agenda as you briefly take them through each day of the workshop, highlighting the units to be covered and the rationale for selecting the specific units.
  - To round off your introduction to the agenda, ask for and respond to any questions and concerns the participants may have. Then you will ask them to state their own expectations of the training programme.

SESSION 3.
THE WORKSHOP PROCESS 45 MINUTES

Aims of the session

- To help participants gain a general understanding of the methodology and tools of the workshop
- To establish ground rules for the duration of the workshop

Activity 3.1. Mini lecture: visualisation in participatory programmes (VIPP)

Instructions

- Display your prepared "VIPP definition" and put it where the participants can see it throughout the programme.

VIPP definition

A participant-centred approach to group learning

- Trusting people and what they can do
- Interactive learning + visualisation techniques
- Democratic participation + consensus
- Lots of multi-coloured cards to express ideas
- Drawing on people's experience

- Talk through each point and encourage the participants to compare this participatory approach with their ideas about other learning events. Be sure to ask participants to discuss the question below, which you can post on a flip chart.

Why should we use a participatory approach?

Talking points

Sometimes people are resistant to visuals because it is "a waste of time when you (the facilitator or instructor) could simply tell us." The ancient quotation below stresses an essential element of learning that is still true today.

What I hear, I forget. What I see, I remember. What I do, I understand.

— Confucius (551–479 BCE)

Inform the participants that during the training, everyone will be asked to share their views and perspectives with the others. In this way, everyone (including the facilitators) will be equal participants.

Instructions

- Explain that there are some ground rules for participatory learning.
- Post a blank flip chart page and ask participants to brainstorm ground rules and agree on them. Write the rules on the page.
- Leave the flip chart page posted until the end of the workshop for all to see.

Examples of ground rules for participatory learning

- Treat everyone with respect at all times, regardless of sex or age.
- Ensure and expect confidentiality.
- Agree to respect and observe timekeeping, and begin and end the session on time.
- Make sure that everyone has the opportunity to be heard.
- Accept and give critical feedback, taking care not to hurt anyone's feelings.
- Draw on the expertise of other facilitators and the participants.
- Be an active participant.
- Turn off cell phones or put them in vibrate mode.

Instructions

- 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.
- Stress that adherence to the rules the group adopts will help to ensure an effective and enjoyable learning environment!
- Show the slide below, go over the VIPP principles, and discuss each one in turn.

VIPP principles

- Points of confusion should be promptly clarified and noted as (**?**).
- Points of strong consensus should be noted as (**V**).
- Points of disagreement and discomfort should be noted as (**X**).
- Keep it short, using (**T**) to indicate time has run out.

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- Next, using the slide below, introduce the rules of writing VIPP cards. Explain that you will ask the participants to follow these rules during the entire workshop. Do this in a friendly way; it is important that participants are not put off by what they might see as a teacher-pupil style of instruction. Stress that the purpose is to make sure that everyone can read and understand the cards, and that this task is important and not a waste of time.

Rules for VIPP card-writing

- Write only one idea per card.
- Write a maximum of three lines on each card.
- Use key words.
- Write large letters in both upper and lower case.
- Write legibly.
- Use cards of different sizes, shapes, and colours to structure creatively the results of discussions.
- Follow the colour code established by the facilitator for different categories of ideas.

Activity 3.2. Mini lecture: "Matters Arising" board

Instructions

- Show the "Matters Arising" board to the participants and explain that it will remain in the same location at all times so participants can write down any issues that come up during the day that have not been dealt with adequately.

Matters Arising board

- A place for the participants to record any matters arising so that you can address them later in the workshop

- Invite the participants to write down issues as they come up, and inform them that you will remind them throughout the training to use the board.

TIP FOR YOU

Before the training starts, set up the Matters Arising board in a place in the room that is easily accessible by all participants at all times.

Activity 3.3. Plenary presentation and discussion: training programme personal diary

Instructions

- Distribute notepads to all participants and explain to them that the notepad will be their personal diary throughout the workshop.
- Display the slide below and explain to the participants that during the review session of each unit, you will ask each of them to write down three lessons she/he learned from the unit and three things she/he plans to do in her/his work for and with young people. The goal is for everyone to put into practice what they gain from each unit.

Training programme personal diary

- List three important lessons that you learned through participation in this unit.
- List three things that you plan to do in your work for/with young people.
- Share these with your neighbour and the class at the end of the workshop.
- List one service delivery guideline relating to YFHS delivery.

- Explain to the participants that it is important for them to update their diaries daily because they will use that information in Unit 7.

SESSION 4.
PARTICIPANTS' EXPECTATIONS 15 MINUTES

Aims of the session

- To establish a general understanding of participants' expectations of the TOT
- To clarify any misconceptions about the YFHS TOT

Activity 4.1. Individual exercise

Instructions

- Write the questions in the box below on a flip chart page, post it, and read the questions on it.
- Distribute two cards to each participant—each one a different colour. Ask them to use one card to respond to the first question and the other card to respond to the second question.

What are your

- Expectations and hopes?
- Concerns about the training?

- Please note that everyone is to participate in this exercise, including the facilitators, so everyone should have cards and markers.
- Refer everyone to the rules just discussed for writing on the cards, as well as any issues they may already have placed on the Matters Arising board.

Activity 4.2. Plenary feedback

Instructions

- While the participants are writing their cards, put up two flip chart pages—one for hopes/expectations and one for concerns.
- When each person has finished writing, he/she should come forward and tape his/her cards to the appropriate flip chart pages.
- When all the cards are up, read through them, asking for clarification of any statements. Group the cards by common themes.
- Tell everyone that you will refer to these hopes, expectations, and concerns again at the end of the workshop to see to what extent they were justified.

TIP FOR YOU
Where possible, say when you believe the training will be able to meet an expectation. If any expectation seems truly outside of the scope of the training package, then say so—being as helpful as you can about where and how the participants can meet their expectations.

UNIT 1.
GETTING STARTED AND BASICS

SESSION 1.
UNIT INTRODUCTION 10 MINUTES

Aim of the session

- To provide an overview of the unit

Activity 1.1. Unit objectives

Instructions

- Explain that the unit looks at important basic elements for any communication with young people, and at elements key to understanding young people better.
- Display the unit objectives shown below and take the participants through each one. Explanations can be found in the Participants Handbook, additional resource pack (YFHS Strategy, Standards), and Annexes of this manual.

Unit objectives

1. Describe youth-friendly health services (YFHS).
2. Mention the five things to expect from a YFHS facility.
3. Mention the four pillars of good customer service.
4. Describe the characteristics of effective communication.
5. Define empathy.
6. Explain the purpose of values clarification.
7. Describe the six steps of the counselling process.
8. Demonstrate a caring attitude and effective counselling during a classroom exercise.

Activity 1.2. Spot checks

Distribute the spot checks and give participants 10 minutes to complete them. Explain that spot checks are pre-tests of the topic to be presented. Participants will refer to their responses after they have been through the unit and will be able to check their level of knowledge before and after. A spot check is not a test; it is simply a tool for self-appraisal and personal learning. Tell participants to keep their answers for review at the end of the unit.

SESSION 2.
UNDERSTANDING YFHS 35 MINUTES

Aim of the session

- To describe the basics of YFHS

Activity 2.1. Brainstorming

Instructions

- Begin by informing participants that the reason for this workshop is to have a deeper understanding of what YFHS is all about. Inform participants you will introduce the topic of YFHS, and that a more comprehensive discussion will follow on Day 5, when Unit 7 will be discussed.
- Ask participants to brainstorm their understanding of YFHS.
- Put up a flip chart and list what they know.

What do you know about YFHS?

Activity 2.2. Input lecture

Instructions

- After the session, put up the PowerPoint presentation explaining the meaning of YFHS. Participants can refer to their notes on the definition of YFHS.
- The key point to make is that YFHS is an approach meant to provide high-quality services for young people, regardless of gender, marital status, ethnicity, or any other quality. Further explain that YFHS are as follows:
  - **A**ccessible
  - **A**cceptable
  - **A**ppropriate
  - **A**ffordable (free where necessary)
  - **R**ight place
  - **E**ffective
  - **S**afe

- Explain what a young person should expect when visiting a YFHS facility. (Distribute the text below as a handout.) Invite discussion on this handout before moving to the next session.

What to expect in a YFHS facility

- Policies, strategies, and guidelines for delivery of services to adolescents and youths
- Providers and staff who are trained and competent in adolescent and youth development and needs
- Providers who are not judgmental and do not provide unsolicited advice
- Services that are provided in a private and confidential manner
- Drop-in clients welcome and appointments arranged with ease and speed
- Opening and closing hours that are convenient and flexible, especially for adolescents and young people
- A prominent sign posted on the facility clearly advertising the availability of YFHS to the community
- Recreational equipment and infotainment to motivate youth participation and uptake of services
- Referral systems that are in place and entirely confidential
- Planning of health services that involves adolescents, youths, and the community
- Services that all adolescents and young people can afford
- Collection, analysis, and reporting of data to inform improved service provision

SESSION 3.
CUSTOMER CARE AND CUSTOMER SERVICE 30 MINUTES

Aims of the session

- To help participants understand the concept of good customer care
- To help participants understand effective and ineffective communication skills with young people
- To offer an in-depth analysis of values and beliefs that could affect service providers' decisions

Activity 3.1. Brainstorming

Instructions

- Inform participants that in this session we will be discussing issues related to effective communication, customer care, and values as we interact with young people.
- Ask participants to brainstorm what they know about customer care and customer service.
- Put up a flip chart listing the following points:

1. **Who is a customer?**
2. **What do you know about customer care?**
3. **What do you know about customer service?**

Talking points

Customers are people who come to access services from us or would like to use our products or services—for example, those for STIs, family planning, counselling, reporting a sexual or physical abuse case, drug abuse, or stigma.

Customer care is an art of marketing; the focus is on understanding the needs of the customer and striving to satisfy them.

Customer service means anticipating and satisfying the needs of your customers (adolescents and youths) in a consistent and dependable manner. Good customer service entails helping the customer even when the service a customer requests is not available.

- Stress the four pillars of customer service and clearly explain them:
  - Professional service
  - Personal service
  - Warm service
  - Responsive service
- Every provider should know the following:
  - Clients (adolescents and youths) are customers.
  - Effective communication is very important.
  - Our values and beliefs should not affect our professional judgment.
  - Show empathy (put ourselves in their shoes; see through their eyes).

In wrapping up this section on customer care, ask the participants to review the information in the box below (which is also in the *Participants Handbook*).

Customers are

1. The most important people in your workplace
2. Not dependent on you; you are dependent on them
3. Not interruptions to your work; they are the purpose of it
4. There to be served; you are not doing them a favour by serving them
5. Part of your institution
6. Not statistics; they are human beings
7. Not people to challenge by matching wits/intelligence
8. People who have wants; it's your job to fill those wants
9. Deserving of the most courteous and attentive treatment you can give them
10. The lifeblood of every institution; you are there only to serve them

SESSION 4.
EFFECTIVE COMMUNICATION 1 HOUR

Aim of the session

- To discuss and understand effective communication with young people

Instructions

- Inform participants that you will now discuss the concept of effective communication.

Activity 4.1. Role play

Ask for a pair of volunteers to act out effective and ineffective communication.

After the role plays, ask participants to discuss what major differences they saw between effective and ineffective communication. Allow them to analyse how the two volunteers communicated with each other, and the strengths and weaknesses they observed in the two types of communication for dealing with young people.

Activity 4.2. Input lecture

Talking points

Communication involves two or more people. It is a key component of customer care and the single most important element of work with adolescents and youth. As providers work with adolescents and young people, communication serves the following purposes:

- Establishing rapport
- Providing information
- Answering questions
- Clarifying concerns
- Motivating
- Persuading
- Encouraging

Communication as a process entails transmission of information from a **sender** to a **receiver** using a specific **channel** (refer to the **communication cycle**).

After this input lecture, post two flip chart pages and discuss verbal and nonverbal communication. Ask participants to fill in the abbreviations below (they can reference Unit 1 in the *Participants Handbook*).

What is verbal communication?

C – Clarify

L – Listen carefully

E – Encourage

A – Acknowledge

R – Reflect

R – Repeat

Cite examples of good and bad verbal communication. How have they affected effective communication in your work, either now or in the past?

What is nonverbal communication?

R – Relax

O – be Open

L – Lean towards the client appropriately

E – make Eye contact as appropriate

S – Sit comfortably

Cite examples of nonverbal communication. How have these affected effective communication in your current work?

Ask the participants to reflect on how they have used some of these skills in the past and how that has affected their communication with young people.

Talking points

It is very important for participants to understand the primary role communication plays in customer care. When communication is broken, there is no customer care.

The communication cycle hinges on respect from both the sender and the receiver of the communication.

Nonverbal communication often leads to miscommunication. Service providers need to guard against sending conflicting messages through nonverbal communication.

SESSION 5.
DEALING WITH PROVIDER ATTITUDES AND BELIEFS 30 MINUTES

Aim of the session

- To explore provider attitudes and beliefs, and how they affect service delivery

Activity 5.1. Brainstorming

Instructions

- Start this session by asking participants to brainstorm some bad attitudes they have witnessed among service providers.
- Issues related to such attitudes are described in the box below.

How attitudes and beliefs affect communication

1. Providers are likely to be biased and therefore judgmental.
2. Providers might provide counselling based on their own beliefs and attitudes, which could be rejected (unsolicited advice).
3. Providers who communicate their biases are likely to lose the respect and trust of their clients.
4. Clients, in turn, are likely to shun these providers' services.

How to deal with attitudes (self-reflection)

1. Acknowledge the feeling and recognize that it may be influencing your work performance or interactions with others (values clarification).
2. Take some time to reflect on your feelings and attitudes. Consider how these attitudes may have influenced your behaviour.
3. Decide whether you think you can overcome these feelings by yourself.
4. If you don't feel you can overcome these feelings by yourself, decide who you can ask for assistance. Consider colleagues at work or those close to you who could help you have an honest, soul-searching conversation. Possible sources of advice are colleagues, supervisors, friends, and family.

SESSION 6.
EMPATHY 30 MINUTES

Aim of the session

- To understand the concept of empathy and how it can be used to provide quality care

Instructions

- Begin the session on empathy by posting a flip chart page with the following exercise.

Activity 6.1. Exercise

Your own experience

Please think for a moment about the last time you were sick.

- How did you feel?
- What did you do?
- What do you think helped you?
- Would you have preferred anything to have been different in the ways in which people interacted with you?

Talking points

Empathy means putting yourself in someone else's shoes and asking yourself how you would have wanted to be treated in that situation. Imagining yourself to be in a client's situation promotes better understanding of the issues affecting young people and others. This encourages nonjudgmental—and therefore better—delivery of services.

SESSION 7.
VALUES CLARIFICATION 1 HOUR

Aim of the session

- To discuss how we can identify and challenge our values when working with young people

Activity 7.1.Group work

Instructions

- When you begin this session, ask participants to stand up, walk away from their chairs, and gather in a circle. (You may need to find a larger space outside of the workshop room for this exercise.)
- 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.

Barometer of values

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.

Talking points

We all have values, and our values often affect how we make decisions. However, because we work with adolescents and youth, our personal values should not affect our professional service. A values clarification is meant to facilitate an intrinsic awareness of personal values. It entails understanding how our own values and beliefs can affect service delivery. Knowledge of our values can help us to take a more open approach to issues and significantly minimise our judgmental attitudes. Values clarification self-assessment is important for the provision of good customer care.

SESSION 8. COUNSELLING 1 HOUR

Aim of the session

- To gain knowledge and skills in counselling and the counselling process

Activity 8.1. Mini lecture

Instructions

Begin by giving an input lecture on what counselling is all about. Highlight the following:

What counselling is

- The process of providing factual information, professional guidance, and assistance to resolve personal and psychological problems

What counselling is not

- Providing your personal, value-laden opinions and unsolicited advice

Explain to the participants in detail the process of counselling (GATHER), as summarised in the box below. Let them refer to Box 9 in their own manuals or provide the text as a handout.

Table 4. The GATHER counselling process

Step 1. **G**reet your client(s)
Step 2. **A**sk
Step 3. **T**ell
Step 4. **H**elp
Step 5. **E**xplain
Step 6. **R**eassure or return for the next visit

After the lecture, post a flip chart page (as follows), divide the participants into two groups, and ask them to brainstorm the qualities of an effective counsellor and an ineffective counsellor.

Effective vs. Ineffective Counsellor

Effective counsellor	Ineffective Counsellor

Following this exercise, begin a plenary discussion, asking the participants to reflect on when they behaved as an effective counsellor and also as an ineffective counsellor.

Go through the qualities listed in the Participants Handbook and discuss them in detail.

Activity 8.2. Role play

The last activity on counselling is a role play.

Instructions

- Ask a pair of volunteers to act out the roles of an effective and an ineffective counsellor.
- Allow role plays by two or three pairs if time allows.
- Ask the group to provide feedback on each role play and discuss their observations.

Talking points

Given the challenges that adolescents and youth face every day, often they need help in understanding them, and to make informed choices. Counselling is often the best medium for this support. Providers working with adolescents and youth need to understand the basic concepts of counselling in order to meet their clients' needs.

Counsellors need to appreciate that their manner when providing these services could possibly scare young people away.

Summarise this section by highlighting the following

Effective communication is the number one ingredient in work with adolescents. Well-trained providers should be able to appreciate how they can communicate with adolescents and young people. However, providers and others working with young people should have honest self-introspection about their own attitudes, beliefs, and values so these do not affect how they communicate with young people.

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. When providers do self-evaluations and clarify their own values, they stand a far better chance of effectively communicating with young people. When they are challenged by their personal values and beliefs, friends and colleagues are important resources in helping them clarify these challenges.

Counselling can be effective only if service providers have good communication skills, good attitudes, are empathetic, don't allow their values to cloud their judgment, and acknowledge that young people need objective support as opposed to unwelcome advice.

SESSION 9.
UNIT REVIEW 10 MINUTES

Aim of the session

- To reinforce the key principles of learning for the day

Activity 9.1. Review of spot checks

Instructions

- Ask participants to pull out the spot checks they completed in the first session of this unit. Ask them to review their answers to see whether they want to change any of them.
- Go over each answer with the participants, one at a time.

UNIT 1. SPOT CHECKS

1. What do you understand by the term YFHS?

_____

_____

2. Mention five things to expect from a YFHS facility.

_____

_____

_____

3. Mention four pillars of good customer service.

_____

_____

_____

4. CLEARR and ROLES define which different types of communication?

CLEARR: _____

ROLES: _____

5. What is the importance of values clarification?

_____

_____

6. Mention two examples each for effective and ineffective counselling.

Effective counselling: _____

_____

Ineffective counselling: _____

_____

Activity 9.2. Review of the objectives

Instructions

- Display the unit objectives below. Invite the participants to share any last questions or comments, and address them.

Unit objectives

1. Describe YFHS.
2. Mention five things to expect from a YFHS facility.
3. Mention four pillars of good customer service.
4. Describe the characteristics of effective communication.
5. Define empathy.
6. Explain the purpose of values clarification.
7. Describe the six steps of the counselling process.
8. Demonstrate a caring attitude and effective counselling during a classroom exercise.

Activity 9.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and update them.

Activity 9.4. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 2.
ADOLESCENCE AND PUBLIC HEALTH

SESSION 1.
UNIT INTRODUCTION 10 MINUTES

Aim of the session

- To provide an overview of the unit

Activity 1.1. Unit objectives

Instructions

- Explain that the unit looks at the dimensions of young people's lives and their implications for public health.
- Remind participants to raise any issues on the Matters Arising board and encourage them to add to the board during session breaks.
- Display the unit objectives and take the participants through each objective in turn.

Unit objectives

1. Define the following terms: adolescence, young people, and youth.
2. State at least two characteristics of Malawi's youth demographics in relation to population, literacy, employment, or poverty.
3. List at least five priority health problems affecting adolescents in Malawi.
4. Explain the value of investing in adolescents' and young people's health and development.
5. Explain three of the guiding principles for promoting the health and development of adolescents and young people.
6. Describe the six things providers can do to address the needs of adolescents and youth seeking health services.

Activity 1.2. Spot checks

Instructions

- Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

SESSION 2.
WHAT I REMEMBER ABOUT MY ADOLESCENCE 30 MINUTES

Activity 2.1. Individual exercise

Instructions

- Write the sentence in the text box on a flip chart page and post it.
- Explain that you want each participant to write down on a card (in not more than 10 words) one powerful experience that stands out from his or her adolescence. The experience can be positive (happy) or negative (unhappy).
- What matters is that at a particular time in adolescence, the participant felt or thought that way.
- Check that everyone understands what to do.

Write down one experience from **your own adolescence that remains alive** in your memory.

Activity 2.2. Plenary feedback and discussion

Instructions

- While the participants are writing, post a second flip chart and point out that as the responses will be anonymous (the participants don't have to write their names on the card), they need not be concerned about revealing personal or sensitive experiences.
- When everyone has finished writing their cards, ask them to place the cards face down on a table (or on the floor) in the centre of the room.
- Then ask two participants to come forward to help facilitate the activity.

Experiences

Positive/happy experience	Negative/unhappy experience

- Ask one of them to pick up a card and read it to the group. Then ask the group to decide in which category (positive or negative) it belongs.
- Attach it to the chart under the correct heading. Once the process gets going, ask the other participants to do the same to speed it up.
- Address the participants' questions. For the most part, the participants will reach a consensus in assigning the cards to the appropriate category (happy or unhappy). However, be prepared to deal with a lack of agreement in assigning the cards to a category. You may consider adding a new category (e.g., happy/unhappy); better still, ask the participants to suggest one.
- Mark the turning points. You will also find that some experiences, although negative and painful (such as failure in an important examination), spurred someone to work harder and are remembered as an important turning point. Again, ask the participants if they would like to place a mark (such as a star sign) to highlight these cards.
- Ask the participants to respond briefly to the question in the box below:

Are the experiences of adolescents today different from those of adolescents 10–20 years ago?

Please give reasons to support your answer.

- As the participants raise points of similarity or difference, note them on a flip chart.
- Encourage interaction between the participants. Ask them to respond to one another's comments and questions, and stress that by sharing experiences and opinions, they will contribute to one another's learning. Emphasise that the range of possible experiences during adolescence can be attributed to differences in sex, age, family environment, socioeconomic conditions, culture, place of residence, etc.
- To conclude this exercise, thank the participants and highlight the fact that their participation enriched the learning process.

TIP FOR YOU

Note that the exercise may unleash strong feelings (such as sadness or anger). Be on the lookout for this and be prepared to respond if any participants wish to talk about their thoughts and feelings with you.

SESSION 3.
THE NATURE AND SEQUENCE OF CHANGES AND EVENTS TAKING PLACE DURING ADOLESCENCE 35 MINUTES

Aim of the session

- To help participants understand the definitions of terms used to describe young people

Activity 3.1. Mini lecture

Instructions

- For this mini lecture, present the definitions of the terms in the box below. In this training package, these terms are used interchangeably.

Definition of terms

a. **Adolescents**

WHO defines adolescents as individuals ages 10–19. Adolescence, on the other hand, is a developmental phase rather than a fixed period.

b. **Very young adolescents**

Those between the ages of 10–14; now recognized as a specific age group with special programming needs.

c. **Young people**

These are persons ages 10–24.

d. **Youths**

These are individuals ages 15–24.

Talking points

The Malawi National Youth Policy (2013) defines young people "as boys and girls of the age between 10–35 years regardless of marital status, economic status and parity." However, young people targeted for YFHS are those ages 10–24. This age group designation by the MOH follows extensive research showing high negative health outcomes in this group as they transition from childhood to adulthood.

According to the MOH, a life cycle approach has been adopted to streamline interventions in the following groups of young people ages 10–24:

- Early adolescence: ages 10–14
- Middle adolescence: ages 15–17
- Late adolescence: ages 18–21
- Early adulthood: ages 22–24

A number of changes occur in this overall age group that puts them at risk of negative health outcomes. The complete developmental cycle of this age group will be discussed in Unit 3A.

Explain the definitions used by different documents (the MOH defines youth as ages 10–24; the Ministry of Youth defines youth as ages 10–35). Highlight that the MOH has a strong programme for children under 5 and that the MOH's reproductive health strategy takes care of young people ages 8–25. However, children ages 5–8 are not well covered; their problems are mostly in the domain of the Ministry of Gender and Social Welfare.

For the purpose of this training, young people are those ages 10–24.

SESSION 4. DEMOGRAPHIC AND SOCIOECONOMIC INFORMATION ABOUT YOUNG PEOPLE IN MALAWI 35 MINUTES

Aim of the session

- To discuss the demographic and socioeconomic information about young people in Malawi

Activity 4.1. Mini lecture

Instructions

- Present a mini lecture on the key issues related to the demographic and socioeconomic status of young people in Malawi.
- Your lecture should expound on the following areas:

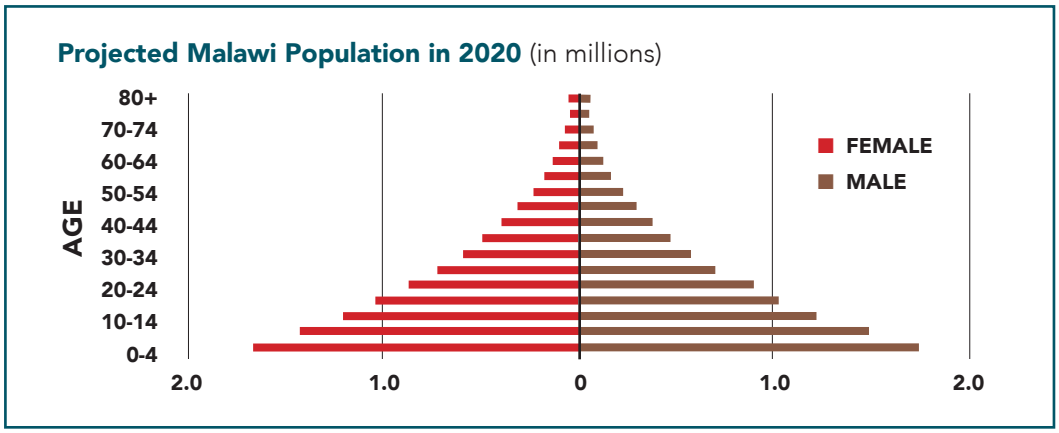
- Population of young people in Malawi
- Literacy/education
- Employment
- Poverty

Talking points

Malawi is one of the countries in the world with a large population of young people, who have the potential to promote great economic and political change. Demographers refer to this phenomenon as the "demographic dividend": the economic growth potential that can result from shifts in population age structure, mainly when the share of the working age population—ages 15–64—is larger than the combined population of those 14 and younger and 65 and older.[2]

As the following graph shows, the majority of Malawi's population is younger than 65 years of age. This presents a great opportunity for development, especially when these young people stay healthy.

[2] UNFPA. 2014. *State of the World Population 2014: The Power of 1.8 Billion*. New York, NY, USA: UNFPA.



Population of young people in Malawi

According to the most recent UNFPA State of the World Population report, as of 2014, there were nearly 1.8 billion young people (ages 10–24) in a world with 7.3 billion inhabitants. In Malawi, the total estimated population was 15.8 million according to 2008 population and housing census report projections. Young people (10–24 years) accounted for 32 percent of Malawi's total population; adolescents (10–19 years) accounted for 24.5 percent as of that year. This means that there are nearly 5 million young people in Malawi in need of YFHS.

Literacy/education

Malawi's literacy rate has improved over time and continues to do so. In 2010, 65 percent of people ages 15 and older were literate. According to Malawi's 2014 endline survey for the Millennium Development Goals, literacy among young people (ages 15–24) was at 75.1 percent (72.4% for females and 77.8% for males).[3] This clearly shows a positive trend in educational achievement in the country.

Employment

With few adolescents able to complete secondary school and gain access to tertiary education, formal employment becomes very challenging. This poses one the biggest barriers to access to SRH services by adolescents and young people because decent work and opportunities are key determinants of young people's SRH, access to services, and self-empowerment.

In Malawi today, unemployment among adolescents and young people is a big challenge. A substantial proportion seeks work in the informal sector. More young men (60.3%) than young women (36.5%) reported being engaged in some form of work. The majority (65.8%) work in the agricultural sector, which is seasonal, low paying, and dangerous. Nearly 40 percent of children and adolescents between the ages 5–17 are child labourers.

Poverty

At least 40 percent of Malawians live at or below the poverty line, with a total annual consumption of K85,852 (US$1 = 714 Malawian Kwacha; 2016). Poverty hits families that have lost one or both parents particularly hard. According to the 2010 Malawi Demographic and Health Survey (MDHS), 18 percent of children and adolescents 18 years of age or younger are orphans. As such, they are likely to live in extreme poverty, making them more vulnerable to such SRH risks as early marriages, unwanted pregnancy, and STIs (including HIV).[4]

[3] National Statistical Office. 2014. *Malawi MDG Endline Survey 2014, Key Findings.* Zomba, Malawi: National Statistical Office.

[4] National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010.* Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

SESSION 5. PRIORITY HEALTH PROBLEMS THAT AFFECT YOUNG PEOPLE 30 MINUTES

Aim of the session

- To familiarise service providers with the health problems affecting young people

Activity 5.1. Brainstorming

Instructions

- Welcome the participants to this session.
- Post a flip chart page listing the questions in the box and ask participants to answer them.
- Allow 15 minutes for this discussion and then close the session by presenting a lecture drawing from the box summarising priority health problems.

- What are the health problems affecting young people in your district or community?
- Is the health problem or problem behaviour a priority for your district or community?
- Who considers it a priority, and why?

Priority health problems affecting young people

Reproductive health problems

- HIV and AIDS (to be discussed in Unit 3G)
- Early and unprotected sex
- STIs (to be discussed in Unit 3F)
- Cancer of the cervix (to be discussed in Unit 3A)
- Adolescent pregnancy and child marriages
- Violence, sexual abuse, and exploitation (to be discussed in Unit 3E)
- Obstetric fistula
- Unsafe abortions (to be discussed in Unit 3D)

Priority health problems affecting young people

Other problems

- General health problems (malaria, urinary tract infections, anaemia)
- Other general health problems common in Malawi such as respiratory tract infections (e.g., pneumonia), skin problems, and diarrhoea
- Substance use and abuse (tobacco, alcohol, and other substances)
- Mental health problems (to be discussed in Unit 6)
- Nutritional problems and eating disorders (to be discussed in Unit 4)
- Endemic and chronic diseases
- Harmful traditional cultural practices

Talking points

Explain that STIs (including HIV), AIDS, cervical cancer, sexual and physical abuse, unsafe abortions, substance abuse, mental health, and nutrition will be discussed in full in subsequent units. However, expound on the following areas:

- Early and unprotected sex
- Adolescent pregnancy and child marriage
- Obstetric fistula
- Traditional cultural practices/harmful cultural practices

Activity 5.2. Group work on traditional cultural practices

Before discussing traditional cultural practices, invite participants to do the following group activity:

- Divide the group by fives and prepare five sets of slips of paper. Each set will have the name of one of the following animals: cow, chicken, goat, dog, or hyena.
- Fold the slips of paper and ask each participant to pick one without unfolding it.
- When everyone has a slip of paper, ask the participants to open them and make the sound of the animal they see listed. Ask them to identify those colleagues making similar sounds and thus form five small groups.
- Ask each group to make a short presentation in plenary.
- After 15 minutes, follow up on this discussion with the talking points on traditional cultural practices discussed below.

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?

Talking points

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).

The Gender Equality Act (2013) prohibits such harmful practices in Malawi. Examples are chiharo (widow inheritance); kulowa kufa (widow cleansing); fisi (initiation sex); chimwanamaye (spouse swapping); and bulangete la mfumu (pimping of a young virgin to a visiting traditional leader).

In Malawi, according to the Gender Equality Act (2013), a person who engages in a harmful practice has committed an offence and is liable to be fined K1,000,000 or given five years of imprisonment!

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.

Draw attention to (or reaffirm) the fact that the adolescents' perspectives on the changes and events they go through are often very different from those of adults.

SESSION 6.
NEEDS OF YOUNG PEOPLE

1 HOUR, 30 MINUTES

Aim of the session

- To discuss the needs of young people and how those needs could be met

Activity 6.1. Brainstorming

Ask the participants to brainstorm the needs of young people and how service providers can respond to those needs.

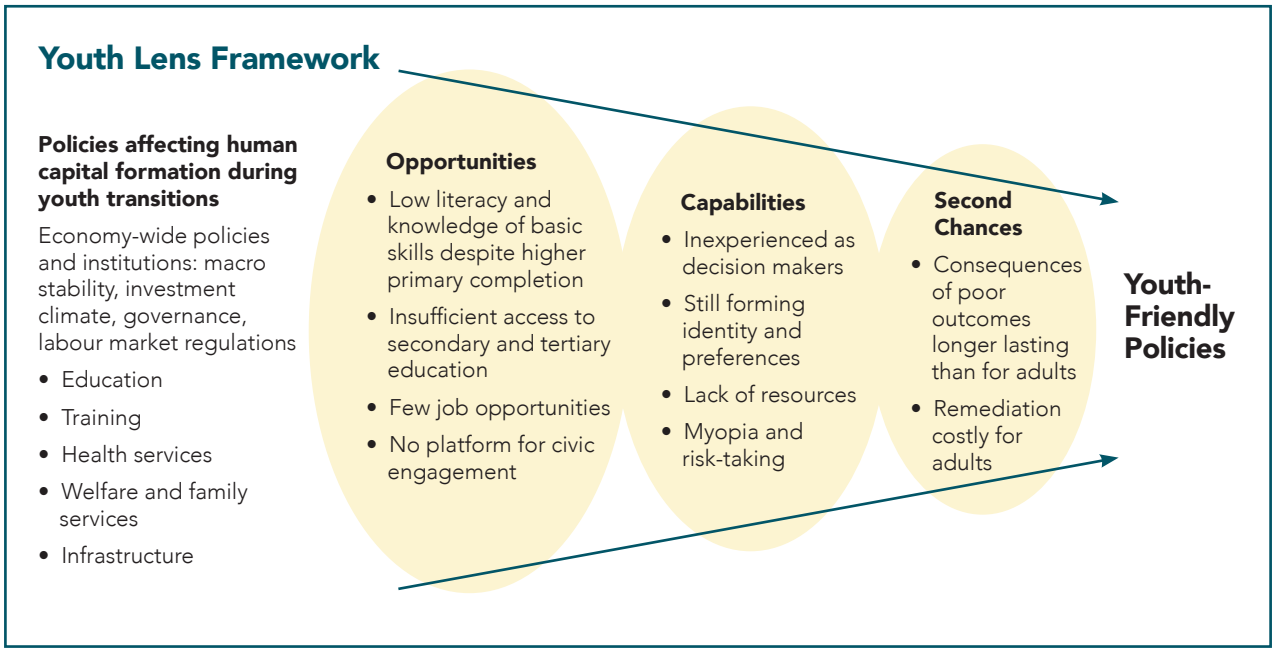
Make a list of these needs on a flip chart page, along with how each one could be met.

Activity 6.2. Mini lecture

Show the slides below and use the accompanying talking points to discuss the needs of young people.

The needs of young people should be considered in terms of

- Offering opportunities
- Enhancing capabilities
- Offering second chances



SOURCE: World Bank. 2007. *World Development Report 2007: Development and the Next Generation.* Washington, DC: The International Bank for Reconstruction and Development/World Bank.

Talking points

It is important to use a "youth lens" to evaluate the needs of young people. This has implications for developing strategies appropriate to youth's life transitions and environments. Are they adequate to serve youth's needs?

The starting point for the assessment is to consider what young people need before adolescence: what opportunities should be afforded to them to grow into healthy, productive adults and to maximise their capabilities. Then consider what opportunities should be provided to youth to maximise their capabilities, and finally, what ought to be done to remedy undesirable outcomes. A framework has been proposed that splits the youth lens into three mutually supportive lenses that focus policies and magnify their impact.

- The first lens focuses on the gaps in *opportunities* for building human capital and on policies that help young people acquire, improve, and deploy their skills.
- The second lens focuses on the *capabilities* of young people as they choose among the opportunities available to them and on policies that dispense the information and incentives to help them make good decisions.
- The third lens focuses on remedying undesirable outcomes and on policies offering *second chances* that put young people back on the path to building their human capital for the future.

Just as the three lenses have to be aligned for an image to be in focus, so policies and services must be well coordinated to have maximum impact. Opportunities can be missed if the capabilities to grasp them are blunted or misdirected. Having better decision-making capabilities (agency) can lead to frustration if the opportunities are far below aspirations. Not having second chances can lead to a free fall in outcomes. Some of the lenses loom larger in some transitions than in others. In the transitions towards sustaining a healthy lifestyle and forming families, for example, outcomes are influenced most by young people's behaviour, so the emphasis would be on capabilities.

The facilitator should summarise the session by referring to the information in the following table; come to an agreement with the participants on which needs apply to which age groups by putting "+" or "-" in each cell. Afterwards, discuss in plenary the lens to which each of these needs applies. A volunteer can write the responses on a flip chart page.

Table 5. Needs of young people

NEEDS	EARLY ADOLESCENCE (AGES 10–14)	MIDDLE ADOLESCENCE (AGES15–17)	LATE ADOLESCENCE (AGES 18–21)	EARLY ADULTHOOD (AGES 22–24)
To love and to be loved				
Information, education, and communication on health				
Educational support (e.g., grants and bursaries)				
Economic support (e.g., loans for income-generating activities)				
Access to social services				
HIV and AIDS prevention				
Life skills				
Vocational skills				
Food security				
Employment				
Hygiene and safe water				
General counselling services				
Recreation: indoor and outdoor games				
Leadership and role models				
Inclusion in decision making				
Information centres (e.g., libraries, internet cafés, etc.)				
Reproductive health needs (e.g., antenatal care, labour/delivery, and postnatal services)				
Healthcare				
Community-based SRH services				

Activity 6.3. Brainstorming

Instructions

- Ask the group to think of young people in special circumstances. (You may give an example of a married adolescent.)
- Then ask the group to come up with young people's needs in special circumstances.
- List the responses on a flip chart page.

Activity 6.4. Plenary discussion

Instructions

- Ask participants to brainstorm some of the referral points available in their communities (including referral points for young people in special circumstances, such as abused young people, orphans, and delinquents).
- 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.

SESSION 7.
WHY INVEST IN YOUNG PEOPLE'S HEALTH AND DEVELOPMENT 1 HOUR

Aim of the session

- To present important reasons for investing in young people's health and development

Activity 7.1. Video (optional) and debate

Instructions

- First, inform participants that you will show a video on why we need to invest in adolescent SRH.

Video

https://www.youtube.com/watch?feature=player_embedded&v=xWMVpjXQWw0

- 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.
- After the video, follow up by asking participants to reflect on it. Whether or not you have shown the video, you can initiate a debate by posing the following question: Is it essential for national and local health leaders, planners, and managers to pay particular attention to young people's health?
- Explain that you would like two groups to prepare a set of arguments for and against this proposition. Allocate one group "for" and the other "against." Tell them that you will want at least three strong arguments—on cards—from each group, and that in five minutes you will ask them to be ready to argue their case.
- Assign a different colour card for each group ("for" and "against"). When the time is up and everyone is ready, ask one person from the "against" group to come forward, post one card at a time, and "defend" its content.
- Someone in the other group must then offer one effective argument against the statement on each card. Note the counter arguments on a flip chart. Then ask for a volunteer from the "for" group. He or she should then post that group's cards and explain their arguments to everyone. Immediately after he/she has finished speaking, encourage the other group to debate the points.

- Point out that it is important for the participants, as people working in the field of young people's health and development, to be fully aware of the public health rationale for this field.
- Stress that the participants must have the data (facts and figures) at hand to support their arguments and must press for attention to and investment in young people's health and development.

Activity 7.2. Plenary review

Summarise the debate and stress that there will always be arguments on both sides. Very few people ask WHY it is important to invest in young people, because the immediate benefits of doing so are apparent. The need to invest in young people's health is not always so immediately apparent, and the participants should be aware of this.

Talking points

Three reasons to invest in adolescent health

1. Health benefits for the individual adolescent regarding his or her current and future health, and the intergenerational effects
2. Economic benefits: improved productivity, return on investment, future health costs averted
3. As a human right: adolescents (like other age groups) have a right to achieve the greatest attainable health

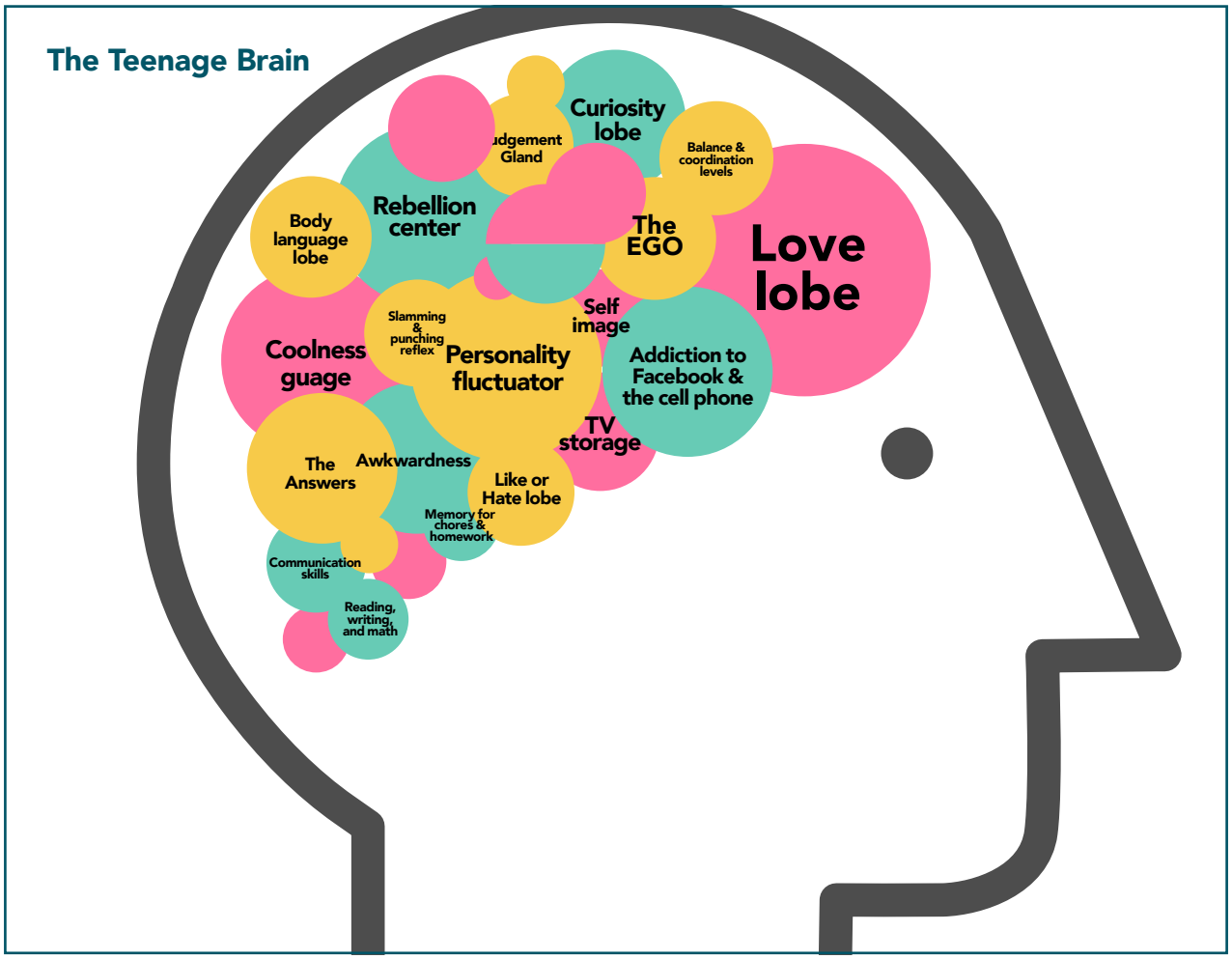
As discussed earlier, adolescence is a healthy period of life. However, some adolescents do lose their lives and many more develop health problems or health-risk behaviours that could lead to disease and premature death in adulthood. In that sense, adolescence is in fact a time of risk, but it is also a time of opportunity for an individual to grow and develop (physically, psychologically, and socially) to his/her full potential in preparation for adulthood.

Young people are not a homogeneous group; their needs for health information and services depend on their age, stage of development, and circumstances. Because of their circumstances, some young people tend to be more vulnerable than others to health and social problems.

The two overlapping goals—promoting healthy adolescent development and preventing and responding to health problems—cannot be viewed as separate and distinct because they are closely linked to each other. The provision of preventive and curative health services for specific health problems is important. However, even more important is the prevention of health problems (and health risk behaviours) through actions to enhance protective factors (such as positive relationships with parents and teachers, and a positive school environment) and reduce risk factors (such as low self-esteem, conflict in the family, and having high-risk peers).

Research shows that the health problems of young people are interrelated. This is because the underlying behavioural causes of many of these health problems are the same. For example, alcohol abuse is associated with STIs, including HIV, and injuries from road traffic accidents; under-nutrition is associated with complications in pregnancy and childbirth.

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." This makes young people more vulnerable to negative health practices and low health-seeking behaviour. Thus, it is important to pass the right information on to all young people in a way that presents positive health behaviours as "cool" and acceptable to all youth. It is also important to provide safe environments where young people can find responses to their doubts and questions without bias that would lead them back to the peer pack.



A safe (free from danger of disease and injury) and supportive (nurturing) environment is critical for an individual to develop to his/her full potential, and for him/her to be healthy. Unfortunately, most young people in today's world are living, studying, and working in unsafe and unsupportive environments, with negative effects on their health and development. A good understanding of the biological differences in the growth and development of males and females (through the years of adolescence) and the different ways in which they are affected by health problems is important. Equally important is a good understanding of the different social and cultural influences on males and females, and how they affect the way in which adolescent males and females view themselves and relate to others.

SESSION 8.
GUIDING PRINCIPLES FOR WORKING WITH YOUNG PEOPLE 30 MINUTES

Aim of the session

To present the guiding principles for working with young people

Activity 8.1. Mini lecture

Instructions

- Point out that several of these principles have already been raised in this unit and that you would like to draw attention to them again to stress their relevance in relation to each of the health issues and problems to be addressed in subsequent units.
- Show the slide and take the participants through each of the principles. Invite comments from the participants.
- Encourage them to share experiences and respond to questions that are raised, rather than responding to all of them yourself; facilitate this by directing some questions to participants who seem knowledgeable about the subject.

- Adolescence is a time of risk and opportunity.
- Not all adolescents are equally vulnerable.
- Adolescent development underlies prevention of health problems.
- Problems have common roots and are interrelated.
- The social environment influences adolescent behaviour.
- Gender considerations are fundamental.

Talking points

Finalise the session by showing the slide below: "Putting adolescents and young people at the centre." Read the points on the slide and invite reactions from the participants, especially on the fourth point. 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. There are no easy solutions here, but health-service providers must face up to them and think them through carefully.

Putting adolescents and young people at the centre

- Regard an adolescent as an individual, not just a case of this or that problem.
- Strive to understand the specific needs of each individual adolescent.
- Acknowledge—and heed—the viewpoints and perspectives of the adolescent in line with his or her evolving capacity.
- Take into primary consideration the best interests of the adolescent when making decisions or taking actions that affect him or her.
- Respect the rights of the adolescent (as laid out in the United Nations Convention on the Rights of the Child*) while at the same time taking into account the rights and responsibilities of parents.
- Strive to prevent personal beliefs and attitudes, preferences, and biases from influencing your professional assessment and actions.

* Office of the High Commissioner, United Nations. "Convention on the Rights of the Child." 1989. Available at: http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx.

SESSION 9.
UNIT REVIEW 10 MINUTES

Activity 9.1. Review of spot checks

Instructions

- Ask participants to pull out the spot checks they completed in the first session of the unit. Ask them to review their answers to see whether they want to change any of them.
- Go over each answer with the participants, one at a time.

Activity 9.2. Review of objectives

Instructions

- Display the unit objectives below, invite participants to share any last questions or comments they might have, and address them.

UNIT 2. SPOT CHECKS

1. Define the following terms:
    - Adolescence

_____

_____

    - Adolescent

_____

_____

    - Young people

_____

_____

    - Youth

_____

_____

2. List five health problems affecting young people in Malawi.

_____

_____

3. What is the fine for committing a harmful cultural practice?

_____

_____

4. Why do you think it's important to invest in young people? Give two reasons.

_____

_____

Unit objectives

1. Define the following terms: adolescent, adolescence, young people, and youth.
2. State at least two characteristics of Malawi's youth demographics in relation to population, literacy, employment, or poverty.
3. List at least five priority health problems affecting adolescents in Malawi.
4. Explain the value of investing in adolescents' and young people's health and development.
5. Explain three of the guiding principles for promoting the health and development of adolescents and young people.
6. Describe the six things providers can do to address the needs of adolescents and youth seeking health services.

Activity 9.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 9.4. Reminders and closure

Instructions

- Ask the participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 3A.

INTRODUCTION TO SEXUAL AND REPRODUCTIVE HEALTH AND YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 10 MINUTES

Aim of the session

- To provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants to the unit. Explain that the unit provides an introduction to SRH and young people. Display the unit's objectives and then read them out in turn.

Unit objectives

1. Define the term sexual and reproductive health.
2. Identify the anatomical structures of the male and female reproductive organs.
3. Describe the physiology of the male and female reproductive organs.
4. Define puberty.
5. Discuss the initiation of sexual activity in young people.
6. Describe how adolescents and young people express sexual feelings.
7. Explain the protective and risk factors influencing sexual behaviour of young people.
8. List the consequences of unprotected sexual intercourse.
9. Explain how sexual behaviour risk factors contribute to the potential for developing cervical cancer.
10. Describe at least three actions that can help young people promote SRH.
11. State what healthcare providers can do to improve adolescents' access to SRH information and services.

Activity 1.2. Spot checks

Instructions

- Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

SESSION 2.
DEFINITIONS OF SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS 20 MINUTES

Aim of the session

- To define sexual and reproductive health and rights

Activity 2.1. Mini lecture

Instructions

- Present definitions of the terms in the slide below. Allow for questions and answers as you go through the presentation.

- Sexual health
- Reproductive health
- Sexual reproductive health rights

Talking points

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. Implicit in this last part of this statement are the rights of men and women on issues of SRH.

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. Another SRHR is the right of individuals to sexual health. A more comprehensive list of SRHR includes the following:

- 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

SESSION 3: ANATOMY AND PHYSIOLOGY OF THE MALE AND FEMALE REPRODUCTIVE ORGANS 50 MINUTES

Aim of the session

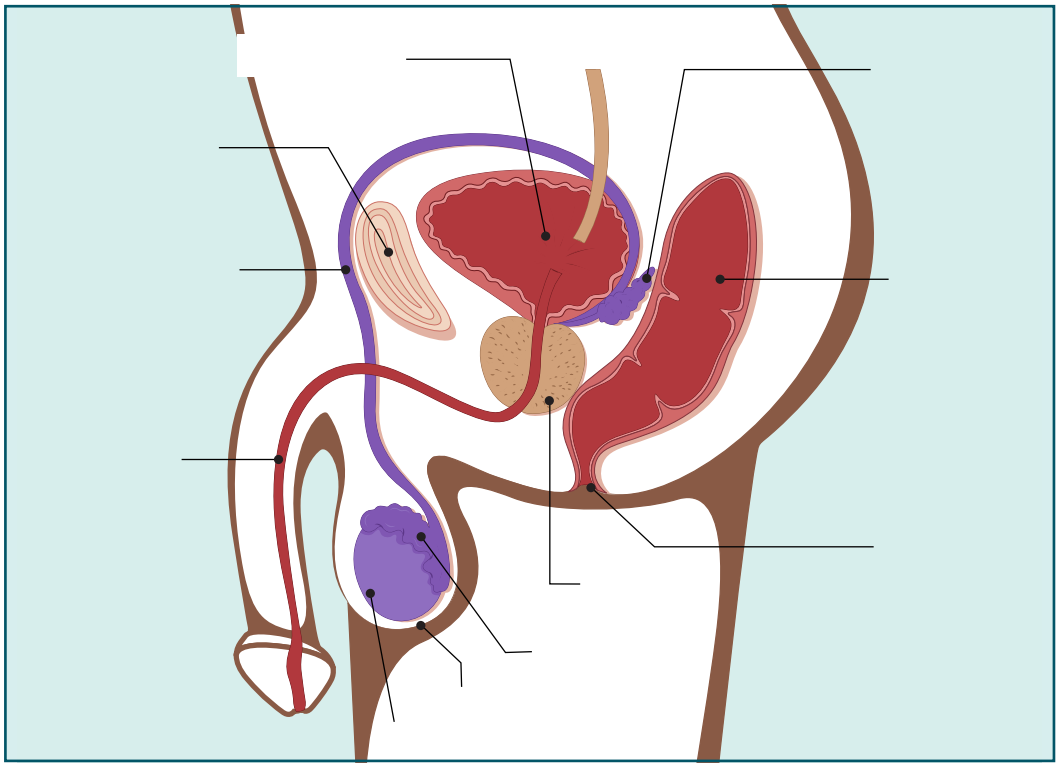
- To describe the male and female reproductive organs and how they function

Activity 3.1. Group work

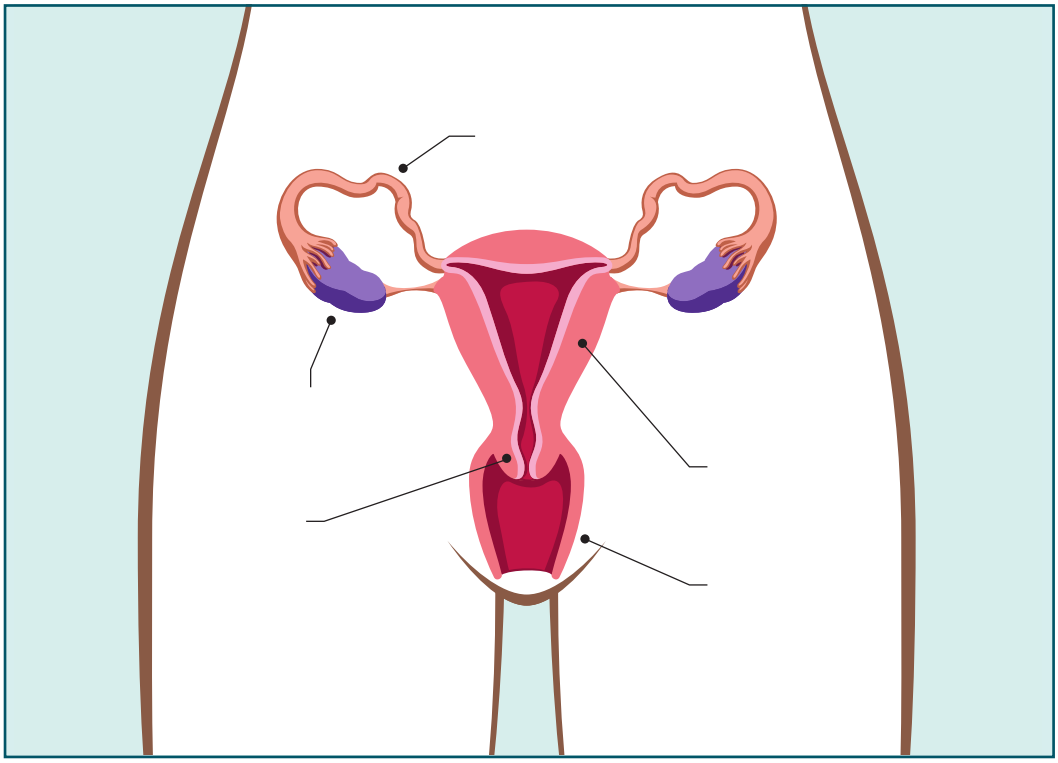
Instructions

- Divide the participants into two groups—males in one and females in the other. Give those in the male group a handout with a diagram showing the female reproductive organs (unlabelled); give those in the female group a handout with a diagram showing the male reproductive organs (also unlabelled).
- Ask the groups to label the parts and discuss each part's function, any role it may have in pregnancy, and the potential for infection.

Male reproductive system and organs



Female reproductive system and organs



Activity 3.2. Mini lecture

Following the group work, present a lecture on the following:

- The menstrual cycle
- What occurs during fertilisation, conception, and implantation

Talking points

As adolescents grow up and reach puberty, several changes take place in their bodies. Most of the time, adolescents do not know when to expect these changes and do not understand how these changes come about. Learning about the male and female reproductive systems, and how they work, are critical steps for them to understand changes in their own bodies and those of their peers.

Although sperm cells usually become capable of fertilisation when a boy reaches the ages of 15–16, sperm production and ejaculation happen around ages 12–14. During this period, boys can experience "wet dreams" (ejaculation at night). Having wet dreams is normal; so is not having them. Sperm can live inside a woman's body (uterus) for 72 hours (three days) from the time of ejaculation.

In girls, the menstrual cycle can begin as early as age 8 and as late as age 16. In each menstrual cycle, eggs can live 12–24 hours from the time of ovulation. Normally, only one egg is fertilised (resulting in pregnancy); if multiple eggs are fertilised, a girl or woman can become pregnant with multiple foetuses. Most girls will have abdominal cramps that can be alleviated by taking analgesics (pain killers). Girls bleed during menstruation, and good hygiene is very important.

SESSION 4.
PUBERTY 50 MINUTES

Aim of the session

- To have an understanding of puberty

Activity 4.1. Mini lecture

Instructions

- Present a mini lecture on what puberty is, drawing from the previous discussion on the male and female reproductive organs and the information in the box below.

- Puberty refers to the physiological changes that occur in early adolescence (sometimes beginning in late childhood), which result in the development of sexual and reproductive capacity.
- Physical growth and development are manifest in a growth spurt, during which there are marked changes in the size and shape of the body.
- Differences between boys and girls are accentuated. For instance, girls experience breast development and hip enlargement, whereas boys develop "man-like" musculature.
- These changes are accompanied by others, such as the appearance of axillary and pubic hair in both boys and girls, changes in the pitch of the voice, and the appearance of facial hair in boys.
- There is rapid maturation of the sexual organs. The onset of menstruation and the initiation of sperm production are important milestones at this time.

Activity 4.2. Group exercise

Instructions

- Explain that in this group exercise, the participants will identify examples of events and/or changes that occur in each of these categories (characteristics): independence, cognitive development, peer group, body image, and sexuality.
- Display a prepared blank table (as follows) on the nature and sequence of changes and events during adolescence.
- Ask the participants to form five small groups. Each group will work on a single characteristic. Allow 15 minutes for the group work.

CHARACTERISTIC	AGES 10–13	AGES 14–16	AGES 17–19	AGES 20–24
Independence				
Cognitive development				
Peer group				
Body image				
Sexuality				

Activity 4.3. Plenary feedback and discussion

Instructions

- Each group should present in plenary.
- Ask the participants for any comments and questions, and encourage a brief discussion before the next group comes forward.

Talking points

Adolescence is a period of transition from childhood to adulthood. It is marked by dramatic physical, psychological, and social changes. The onset of puberty announces an important step on the road to adulthood.

Puberty refers to the physiological changes that occur in early adolescence (sometimes beginning in late childhood) that result in the development of sexual and reproductive capacity. Physical growth and development manifest themselves in a growth spurt, during which there are marked changes in the size and shape of the body.

Differences between boys and girls are accentuated. For instance, girls develop breasts and their hips grow larger; boys develop heavier musculature. These changes are accompanied by others, such as the appearance of axillary and pubic hair in both boys and girls, changes in the pitch of the voice, and (in boys) the appearance of facial hair. Rapid maturation of the sexual organs occurs. The onset of menstruation and the initiation of sperm production are important milestones at this time.

TIP FOR YOU

Some obvious differences between male and female adolescents are likely to be mentioned (for instance, in relation to the onset of puberty). Before starting the exercise, encourage the participants to relate their answers to a "gender perspective" by asking them to explain whether they are referring to male adolescents or female adolescents or both in relation to the events and changes they identified in all five categories.

SESSION 5.
INITIATION OF SEXUAL ACTIVITY AND SEXUAL EXPRESSIONS 50 MINUTES

Aim of the session

- To discuss age of sexual debut and how sexual feelings are expressed

Activity 5.1. Mini lecture

Instructions

- As a preamble to the session, present a lecture on initiation of sexual activity among young people in Malawi, using the text box below to start.

1. Among Malawians ages 20–49, the median age at first sexual intercourse is reported to be age 17.3 for women and age 18.5 for men.
2. Among youth ages 15–24, young women are more likely to start sex earlier (age 17.3) than young men (age 18.5).

Source: MDHS 2010

Talking points

Explain that this slide reflects the trend of increasing age at marriage in both men and women in Malawi. In Malawi and many other countries, the declining age for the onset of puberty has been accompanied by trends in the opposite direction for the age of marriage.

Activity 5.2. Plenary discussion

Instructions

- Invite questions or comments from the participants.
- Do not feel obliged to respond to all of them yourself. Invite other participants to do so, thereby stimulating sharing of opinions, perspectives, ideas, and experiences.
- Share local data from the participants' own area (if any) on the onset of puberty and age of marriage.

Activity 5.3. Group work

Instructions

The following exercise is adapted from Life Planning Education (Advocates for Youth, Washington, DC).

1. Explain that when many people see the words "sex" or "sexuality," they most often think of sexual intercourse. Others also think of other kinds of physical sexual activities. Tell the group that sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who every person is. It includes all of the feelings, thoughts, and behaviours of being female or male, being attracted by and attractive to others, and being in love, as well as being in relationships that include sexual intimacy and physical sexual activity.

2. Write the word *sexuality* on the board and draw a box around the letters *s-e-x*. Point out that *s, e,* and *x* are only three of the nine letters.

3. Display the five circles of sexuality and give each participant the handout on the subsequent page. (When everyone has the handout, continue with Steps 4 and 5).

4. 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.

5. Beginning with the circle labelled *sensuality,* explain each circle briefly. Take five minutes to read the definition of the circle aloud, point out its elements, and ask for examples of behaviours that would fit in the circle. Write the examples in the circle and ask participants to write them on their handouts. Continue with each circle until you have explained each component of sexuality (use the handout that is filled out to explain).

Circles of Sexuality

SENSUALITY
Awareness, acceptance of and comfort with one's own body: physiological and psychological enjoyment of one's own body and the bodies of others

SEXUALIZATION
The use of sexuality to influence, control or manipulate others

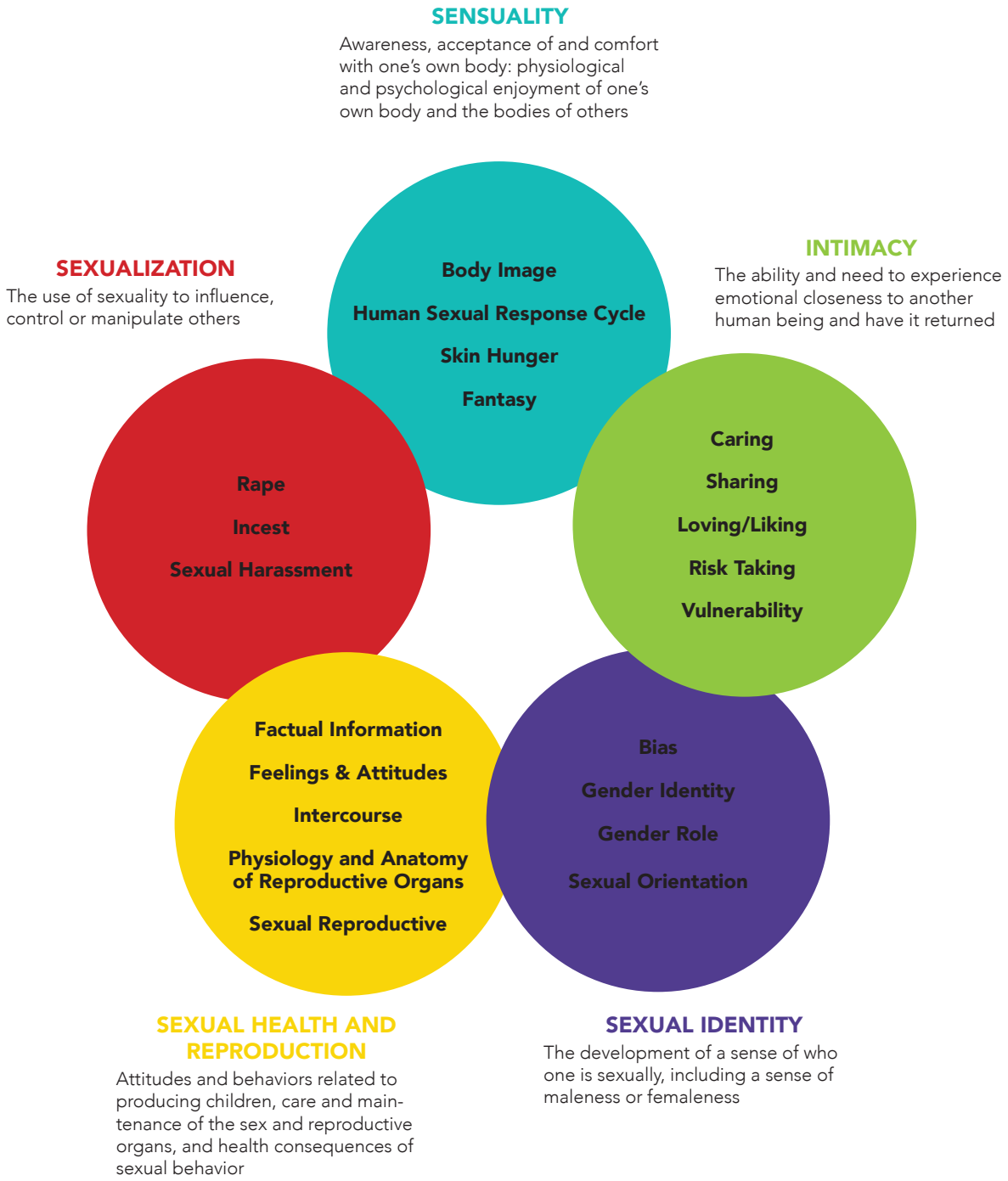
INTIMACY
The ability and need to experience emotional closeness to another human being and have it returned

SEXUAL HEALTH AND REPRODUCTION
Attitudes and behaviors related to producing children, care and maintenance of the sex and reproductive organs, and health consequences of sexual behavior

SEXUAL IDENTITY
The development of a sense of who one is sexually, including a sense of maleness or femaleness

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

Circles of Sexuality



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

6. Ask if anyone has any questions. Then conclude the activity using the discussion questions below.

Activity 5.4. Plenary feedback and discussion

Discussion questions

1. Which of the five sexuality circles feels most familiar? Least familiar? Why do you think that is so?
2. Is there any part of these five circles that you never before thought of as sexual? Please explain.
3. Which circle is most important for adolescents to know about? Least important? Why?
4. Which circle would you feel interested in discussing with your parent(s)?
5. Which circle would you feel interested in talking about with someone you are dating?

Talking points

Refer to Annex 2 for more talking points on this session.

Activity 5.4. Mini lecture

After the discussion above, present a mini lecture on the following:

Protective and risk factors related to early sexual initiation

Invite questions or comments from the participants. Do not feel obliged to respond to all of them yourself. Invite other participants to do so, thereby stimulating sharing of opinions, perspectives, ideas, and experiences.

SESSION 6.
THE CONSEQUENCES OF UNPROTECTED SEXUAL RELATIONS 30 MINUTES

Aim of the session

- To outline the consequences of unprotected sexual relations

Activity 6.1. Brainstorming

Instructions

- Post a flip chart page and brainstorm on the indirect consequences of unprotected sexual relations among young people.

Consequences of unprotected sexual relations

DIRECT CONSEQUENCES	INDIRECT CONSEQUENCES	SOCIAL CONSEQUENCES
Unplanned pregnancy	Too-early pregnancy	Social isolation
HIV infection	Interrupted or premature ending of school attendance	Familial estrangement
Other STIs	Lack of marketable skills for entering the workforce	Stigma, depending on the social norms of the setting
Cervical cancer	Low-paying jobs or unemployment*	

* Among the outcomes of low income are poor nutrition, limited ability to provide for the child as it grows, suboptimal living conditions, and less access to health information and services.

Activity 6.2. Plenary session and discussions

Instructions

- Allow the group to point out what they know and record it on a flip chart. Summarise the points by highlighting the major categories.
- Explain that these consequences are explained comprehensively in the manual as separate units.

SESSION 7. BARRIERS TO YOUNG PEOPLE HAVING ACCESS TO SEXUAL AND REPRODUCTIVE HEALTHCARE

40 MINUTES

Aim of the session

- To highlight barriers that young people face in obtaining SRH information and services, and what could be done to address them

Activity 7.1. Group work and plenary discussion

Instructions

- Divide the participants into two groups. Give each group one of the case studies in Unit 3A, Annex 1, but ask them to read both case studies to prepare for the plenary.
- Tell them that they will have 30 minutes to read and discuss the case studies in the groups, using the questions below as a guide.

> **Case Study 1:** Why did Chimwemwe's status change from that of a bright 14-year-old schoolgirl to that of a 15-year-old single, homeless and destitute young mother of a premature baby?
>
> **Case Study 2:** Why was Malita so unprepared for this important event in her life? What could have been done to enable Chimwemwe and Malita to obtain the SRH information and services they needed?

- Ask each group to cite one action that could have been taken in relation to Chimwemwe and one in relation to Malita, and record the responses on a VIPP card or flip chart page.

Activity 7.2. Plenary feedback and review

Instructions

- Allow each group to present its work and open the floor for discussion.
- Ask each group in turn to briefly explain why they believe the actions they propose could have helped Chimwemwe and Malita. Invite questions, but only for clarification.

- Use the checklist below to highlight the issues raised in the case studies if they have not already been raised by the participants.
- After all of the groups have presented their responses, ask for volunteers to come forward to cluster the cards and develop broad categories. These categories could include different settings where actions could be carried out (such as in the home, school, and health facility) or different people who could carry out these actions (such as parents, older siblings, teachers, and health workers). Once this has been done, open the floor for discussion.

These case studies highlight several issues, including the following:

- Inadequate communication on SRH topics between adolescents on the one hand and their parents and other adults around them on the other
- Inadequate access by adolescents to the reproductive health information and services they need
- Punitive school policies regarding student pregnancy, which are harmful to the affected students at many levels

- In closing, stress that the issues raised—especially findings from the 2014 YFHS evaluation report—will be discussed again in Unit 7.

SESSION 8.
CERVICAL CANCER 35 MINUTES

Aim of the session

- To gain an understanding of cervical cancer

Activity 8.1. Mini lecture

Instructions

- Explain that you will present a lecture on cervical cancer and will allow the participants to offer input as you proceed. Present the slide below.

- Definition
- Scope of the problem in Malawi
- Signs and symptoms of cervical cancer
- Risk factors for cervical cancer
- Interventions addressing cancer of the cervix

Talking points

Recent evidence suggests an increasing number of newly detected cases of cancer of the cervix in Malawi. Cervical cancer is the third most common cancer here for the population as a whole. Among women, it is the most common cancer, accounting for 30 to 45 percent of Malawi women's cancer burden. The risk of onset of cervical cancer is greatest for adolescents (those age 15, on average), and the disease develops and worsens with age. A more robust prevention program in Malawi is needed for girls ages 9–13.

Risk factors

a. Early onset of sexual intercourse (before the age of 20); young women are most vulnerable during adolescence
b. High number of sex partners
c. Male sex partner who has other sex partners
d. Clinical history of such STIs as condylomata acuminate and HPV
e. Infection with HIV
f. Smoking

SOURCE: Hatcher, et al. 2011. *Contraceptive Technology, 20th Revised Edition.* Atlanta: Bridging the Gap Communications. p. 625.

In Malawi, testing services are available in some health facilities and a scale-up is underway. Eligible groups of young women should be provided with information and support to access these services.

Like other cancers, cervical cancer in an advanced stage is incurable. Common treatment options are cryotherapy, surgery, chemotherapy, and radiotherapy.

TIP FOR YOU
Encourage questions and comments as you make the presentation. Encourage those who have participated in cervical cancer management or campaigns to share their experiences.

SESSION 9.
PROMOTING THE SEXUAL AND REPRODUCTIVE HEALTH OF YOUNG PEOPLE 35 MINUTES

Aim of the session

- To discuss how to promote young people's sexual and reproductive health
- To discuss psychological issues that relate to sex and sexuality

Activity 9.1. Buzz groups

Instructions

- Ask the participants to count off from one to five and thus form five groups. Then present this flip chart page.

How can you promote the sexual and reproductive health of young people?

Activity 9.2. Plenary discussion

Instructions

Each group presents in plenary for five minutes only. Allow for a free-flowing discussion. Wrap up the session with the following talking points:

- Information helps adolescents understand how their bodies work and what the consequences of their actions are likely to be. It dispels myths and corrects inaccuracies.
- 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.
- Counselling can help adolescents make informed choices, giving them more confidence and helping them feel more in control of their lives.
- Health services can help well adolescents stay well and ill adolescents get back to good health.

- As adolescents undergo physical, psychological, and social change and development, supportive families and communities can enable them to undergo these changes in safety, with confidence, and with the best prospects for a healthy and productive adulthood.

Activity 9.3. Group discussion

Instructions

- For the next activity, inform participants that you will discuss some psychosocial issues pertaining to sex and sexuality.
- 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. If time does not allow, you can choose at random which issues to discuss.

- I am not ready for sex but how do I say "NO"?
- What if I am being pressured to have sex?
- Is "safe sex" really safe?
- Does sexual intercourse hurt the first time?
- Is there anything wrong with masturbation?
- As a young person, what should I do once I feel sexual desires?
- I think my penis is too small. Should I worry?
- Can a girl get pregnant if a boy pulls out before ejaculation?

SESSION 10.
UNIT REVIEW 10 MINUTES

Activity 10.1. Review of spot checks

Instructions

- Ask participants to pull out the spot checks they completed in the first session of the unit.
- Ask them to review the answers they had recorded to see whether they want to change any of them.
- Go over each answer in the spot checks with them, one at a time.

UNIT 3A. SPOT CHECKS

1. Define the following terms:

- Sexual health

_____

_____

- Reproductive health

_____

_____

- Sexual and reproductive health rights (SRHR)

_____

_____

2. List three sexual and reproductive health rights.

_____

_____

3. What do you understand by the word "puberty"?

_____

_____

4. Explain the following terms:

- Sensuality

_____

_____

- Sexualisation

_____

_____

- Intimacy

_____

_____

- Sexual identity

_____

_____

- Sexual health and reproduction

_____

_____

5. List four consequences of unprotected sexual relations.

_____

_____

6. List any four needs for young people.

_____

_____

7. Mention any two barriers to young people's access to SRH services.

_____

_____

Activity 10.2. Review of objectives

Instructions

- Display the unit's objectives (below), invite participants to share any last questions or comments they might have, and address them.

Unit objectives

1. Define the term sexual and reproductive health.
2. Identify the anatomical structures of the male and female reproductive organs.
3. Describe the physiology of the male and female reproductive organs.
4. Define puberty.
5. Discuss the initiation of sexual activity in young people.
6. Describe how adolescents and young people express sexual feelings.
7. Explain the protective and risk factors influencing sexual behaviour of young people.
8. List the consequences of unprotected sexual intercourse.
9. Explain how sexual behaviour risk factors contribute to the potential for developing cervical cancer.
10. Describe at least three actions that can help young people promote SRH.
11. State what healthcare providers can do to improve adolescents' access to SRH information and services.

Activity 10.3. Training programme personal diary

Instructions

- Ask the participants to bring out their personal diaries and update them.

Activity 10.4. Reminders and closure

Instructions

- Ask the participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 3A.
CASE STUDIES

CASE STUDY 1

Chimwemwe, a 14-year-old girl in Lilongwe, from a rural village in Mchinji, attended a girls' boarding school. Her closest friend Maria was in the same class; they were the two star students. Chimwemwe came from a rural village in Mchinji. Maria was the daughter of a prosperous businessman in Lilongwe. They were both virgins and members of the Student Christian Organisation of Malawi (SCOM). One weekend in their final year in secondary school, they became friends with two boys from the nearby school while attending a student camp. They ended up having sex for the first time. This was one month before the school holidays. The following month they missed their menstrual periods. Could they be pregnant?

Maria's mother, being well to do, took her for an abortion; Maria continued with school.

Chimweme's teachers started suspecting that she might be pregnant. She kept her fear that she was pregnant to herself. She was frequently unwell and moody, and her performance in class deteriorated. The school nurse was summoned to examine her, and the nurse sent her to a clinic. Chimwemwe had to miss class to get to the clinic during working hours. Her pregnancy was confirmed and, according to the school's policy, she was immediately suspended and given a letter to take to her parents. Chimwemwe was devastated. She had no money to go home. Her parents were elders in their church and would be horrified if they knew what had happened.

Terrified, she went to the local clinic to seek help. Being the only young woman in the clinic, she felt self-conscious because all of the adult patients and workers kept staring at her. The health workers said they could not help her. The nurse on duty scolded her for her immoral behaviour and told her that she would not receive any services without her parents' consent. Chimwemwe left school and travelled to Mtandire to see her uncle, a construction worker. When her uncle returned from work in the evening, Chimwemwe feigned sickness and told him that she had been sent away because of school fees. The uncle sympathised with her but could not raise any money. He then sent a letter by post to Chimwemwe's parents, asking them to send the money.

Chimwemwe was now four months pregnant and her condition became more difficult to hide. At six months, her uncle's wife noticed the pregnancy. Her uncle was furious and chased her out of his house. Lonely, with no money and nowhere to go, Chimwemwe accepted accommodation from a young man in the neighbourhood. Two months later, at a nearby health centre, Chimwemwe delivered a boy prematurely. The baby had to be kept in the nursery for two weeks. When Chimwemwe was discharged from the hospital, she found that the young man who had accommodated her had moved. She was now desperate: a 15-year-old with a premature newborn, no money, and homeless. Chimwemwe took refuge in the only place that would accept her. A businesswoman selling gin in a slum employed her to help serve her customers. That became Chimwemwe's life.

CASE STUDY 2

Malita, a 12-year-old girl, lived with two younger brothers and her parents in Blantyre. Hers was a middle-class family, and her parents cared for and loved their children very much. Malita was a happy child. She was a good student and liked by her teachers and her classmates.

One day, when Malita was in class, she noticed that her underpants were wet and she was uncomfortable. When she looked down at her dress, she saw that it was splotched with blood. The girl sitting beside her noticed this, too, and told the teacher about it. The teacher stopped the lesson, took Malita to the staff room, and asked her to use the toilet to clean herself and apply a pad. Malita was bewildered and shocked.

Her teacher explained the situation to the other teachers who were present, told her to sit in a corner of the staff room, and went back to her class. None of the other teachers took any notice of her. Malita sat in silence for two hours till the school day came to an end. She did not know what was happening to her, and prayed hard that there was nothing seriously wrong with her. After all the teachers had left, she tiptoed outside to check if the coast was clear, went to her classroom, took her things, and walked home, covering her soiled dress.

When she reached home, she burst into tears and told her mother what had happened. Her mother signalled her to be silent, shooed Malita's brothers out of the room, and took her to the bathroom. Her mother told her that this was a sign that Malita was no longer a girl. Her mother told her what to do and said that the bleeding would last for a few days. She also told her that this would happen every month for the rest of her life. Malita went to bed with her mind in a whirl. She had many, many questions and decided to speak to Ulemu, a girl in a senior class whom she knew.

UNIT 3B.

PREGNANCY PREVENTION AND FERTILITY REGULATION IN YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 5 MINUTES

Aim of the session

- To provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants to the unit.
- Mention that this unit contains four sessions in addition to the introduction and review, which will explore different aspects of pregnancy prevention and fertility regulation in young people.
- Display the unit objectives and read each one.

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.

Activity 1.2. Spot checks

Instructions

- Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

SESSION 2: DEFINITION OF CONTRACEPTION, CONTRACEPTIVE USE AMONG YOUNG PEOPLE, AND MINIMUM AGE OF CONTRACEPTIVE USE 20 MINUTES

Aim of the session

- To define contraception and the extent of contraceptive use among young people
- To discuss barriers to contraceptive use

Activity 2.1. Mini lecture

Instructions

- Start by making a presentation on the definition of contraception and the extent of contraceptive use among young people. Show the slide below.

- Definition of contraception
- Contraceptive use among young people in Malawi

Talking points

Contraceptive use among young people in Malawi is very low, even though more and more young people are sexually active. In Malawi, the use of contraceptives has been challenging because of erratic availability but also because of some misconceptions surrounding them.

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.

TIP FOR YOU
Minimum age for contraceptive use in Malawi

Emphasise that there is no minimum age for accessing contraceptives. Adolescents and youth can access any contraceptive of their choice at any time.

Activity 2.2. Brainstorming and plenary session

Post a flip chart page and discuss adolescents' barriers to contraceptive use.

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

SESSION 3. PROVIDING ADOLESCENTS WITH CONTRACEPTIVE SERVICES 1 HOUR, 10 MINUTES

Aim of the session

- To discuss contraceptives available to young people in Malawi

Activity 3.1. Group work

Instructions

- 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.*)

Activity 3.2. Plenary discussion

Table 6. Contraception

AVAILABLE CONTRACEPTIVE METHODS	AVAILABLE METHODS OF EMERGENCY CONTRACEPTION
• Abstinence and non-penetrative sex • Male condom • Female condom • Spermicide • Diaphragm with spermicide • Combined oral pill • Progestin-only pill • Combined injectable • Progestin-only injectable • Progestin-only implant • Intrauterine contraceptive device (IUCD) • Fertility-awareness based methods • Lactational amenorrhoea • Cycle beads • Withdrawal • Sterilisation	• Combined oral pills* • Progestin-only pills* • Postinor II

* Note: Combined or Progestin-only oral contraceptive pills need to be taken on the advice of a doctor/nurse for the correct dosage. Branded emergency contraception can be taken as directed on the box/strip.

Talking points

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. This sometimes causes confusion, as providers do not ask young people to bring a parent/guardian and refuse contraception access altogether. It is thus incorrect for providers of such services to refuse any contraceptive based on their personal values or beliefs.

Display the corresponding slide from the slide set and go down the list, beginning with the first item (abstinence and non-penetrative sex), and ask participants to indicate whether or not age restrictions forbid the provision of any of these methods to adolescents.

After this discussion, display the slide shown below and make a presentation.

Medical, service delivery, and counselling considerations for adolescents

Talking points

Age does not constitute a medical reason for withholding the provision of any method. However, age is a factor to be taken into account when considering the use of three methods:

- Sterilisation: Early age is a key risk factor for subsequent regret, both for women and men, because this method ends the ability to have children permanently.
- Intrauterine contraceptive devices (IUCDs) are safe for most women, including adolescents and HIV-positive women. Nulliparous women *may* be at slightly higher risk of expulsion.
- Fertility awareness-based methods (for example, cycle beads) may not be effective for younger women whose menstrual cycle is irregular.

Invite comments and questions on the issue of medical eligibility. Do not feel obliged to respond to all of them yourself. Invite other participants to do so.

SESSION 4.
RESPONDING TO THE SPECIAL NEEDS OF DIFFERENT GROUPS OF YOUNG PEOPLE 40 MINUTES

Aim of the session

- To identify the contraceptive methods most appropriate to the social circumstances and behaviour/lifestyle of different groups of young people

Activity 4.1. Group work

Instructions

- 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.
- Divide the participants into two groups. If youth participants are present, assign at least one young person to each group.
- Assign a different role play (found in Unit 3B, Annex 1 in the *Participants Handbook*) to each group and ask them to consider the questions posed below (displayed on a flip chart page).
- Ask the two groups to read the two role plays quickly, and then focus on the one assigned to them (either Role Play 1 or 2).

- 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?[5]
- Are special considerations regarding its utilisation likely to make it difficult for a young person to use the method?[6]
- Are the side effects of the method likely to hinder its use by a young person?[7]

[5] A clinic visit is required for the insertion and removal of a contraceptive implant. This may pose a problem for some adolescents; therefore, explore this issue with the client.

[6] 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).

[7] For instance, there is an increased risk of expulsion of IUCDs in younger, nulliparous women. However, upon recognized expulsion, another IUCD may be inserted if the client wishes. Therefore, it is important for young women to be taught the signs/symptoms of impending expulsion.

- Allow the groups 15 minutes to carry out the assigned task and write their responses on a flip chart page. Inform them that each group will have about five minutes to present their conclusions.

Activity 4.2. Plenary feedback

Instructions

- Ask each group in turn to report in plenary.
- Invite comments and questions from the other participants.
- As you bring the session to a close, make the point that the session has addressed the choice of the most appropriate method in each of these situations from the viewpoint of a capable and concerned provider. However, it is equally important for the client to be actively involved in this choice. Point out that this issue will be addressed in the session to follow.

SESSION 5.
HELPING YOUNG PEOPLE MAKE WELL-INFORMED AND VOLUNTARY CHOICES 40 MINUTES

Aim of the session

- To identify how health service providers can help young people make well-informed and voluntary choices of the method best suited to meet their special needs and preferences

Activity 5.1. Role play

Instructions

- Invite volunteers for Role Plays 1 and 2.
- Explain to the role players that you want the providers to address the advantages/disadvantages listed below (shown on a flip chart page):

- 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.

Role Play 1

You are a nurse-midwife in a district hospital. Along with the other members of your small obstetrics-gynaecology team, you run a daily antenatal outpatient clinic. One Friday morning as you walk into your clinic, you see two teenage girls huddled together in a corner of the waiting room. One of them is obviously crying, and the other appears to be trying to console her. You say to yourself that this is a sight you have seen several times before—maybe yet another unintended, unwanted pregnancy. When it is their turn, your suspicions are proved right. The two young women are ages 15 and 16. They are students at a nearby secondary school. The one in tears tells you that her period is delayed by four weeks, and she suspects that she is pregnant. On gentle questioning, she tells you that she had unprotected intercourse only once with a young man who is her neighbour. You carry out an examination and request a urine test for pregnancy. You ask them to wait for the results. An hour and a half later, the laboratory results come back. The urine test for pregnancy is negative. You call the two women into the room to share the news with them. Both of them start sobbing in relief.

ROLES: Nurse-midwife, two girls ages 15 and 16

Role Play 2

You are a female clinical officer in your mid-40s. You run a clinic in Zingwangwa township that has been well-established over the past 10 years. One evening, your nurse ushers in a young woman you have not seen before. The woman waits until the door is firmly closed and then leans forward to speak to you in a soft voice that is almost a whisper. She says that she is 19 years old, just married, and has moved into the neighbourhood to live with her husband and his extended family. She smiles when you congratulate her and says that she is happy with her husband but is under a lot of pressure from her in-laws to have a baby as soon as possible. She wants to wait for some time, as she also has just started a new job that promises to send her abroad to study. She seeks your advice. Apparently, her husband agrees but feels unable to resist the pressure of his parents.

ROLES: Doctor, 19-year-old young woman

Talking points

In the discussion that ensues, highlight the following points:

Role Play 1 addresses the contraceptive needs of an unmarried young woman who has had sexual contact only once, and outside of the context of a stable relationship. Her need is to prevent pregnancy and avoid acquiring HIV or another STI.

Role Play 2 addresses the contraceptive needs of a married young person who wants to postpone pregnancy for some period of time.

As you conclude the session, point the participants to Box 9 on the GATHER counselling process and also to Table 7 in their handbooks under this unit: "Special considerations in contraceptive methods counselling."

SESSION 6.
UNIT REVIEW 10 MINUTES

Activity 6.1. Review of spot checks

Instructions

- Ask participants to pull out the spot checks they completed in the first session of the unit.
- Ask them to review the answers they had recorded to see whether they want to change any of them.
- Go over each answer with the participants, one at a time.

UNIT 3B. SPOT CHECKS

1. Which contraceptive methods should be used by adolescents? Please tick all unsuitable methods.

   ❑ Abstinence

   ❑ Male condom

   ❑ Female condom

   ❑ Spermicide

   ❑ Diaphragm with spermicide

   ❑ Combined oral pill

   ❑ Progestin-only pill

   ❑ Combined injectable

   ❑ Progestin-only injectable

   ❑ Progestin-only implant

   ❑ Intrauterine device

   ❑ Fertility awareness-based methods (for example, cycle beads)

   ❑ Lactational amenorrhea

   ❑ Withdrawal

   ❑ Sterilisation

2. Which contraceptive methods are protective against HIV and other STIs? Please write down two examples of each.

    a. Protective

_____

_____

    b. Not protective

_____

_____

3. Which contraceptive methods do not require the cooperation of male partners? Give three answers.

_____

_____

4. Do young people need parental consent to access contraceptives?

    a. Yes

    b. No

5. Are there contraceptives that should not be given to young people?

    a. Yes (if yes, which ones?)_____

    b. No

Activity 6.2. Review of objectives

Instructions

- Display the unit objectives below, invite participants to share any last questions or comments they might have, and address them.

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.

Activity 6.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 6.4. Reminders and closure

Instructions

- Ask the participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 3C.

CARE OF ADOLESCENTS DURING PREGNANCY AND CHILDBIRTH

SESSION 1.
UNIT INTRODUCTION 10 MINUTES

Aim of the session

- To provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants to the unit.
- Mention that this unit contains several sessions, which will explore different aspects of pregnancy care in young people.
- Display the unit objectives and read each one aloud, in turn.

Unit objectives

1. Explain the scope of adolescent pregnancy and childbirth in Malawi.
2. List at least four factors that influence young women's pregnancy.
3. Mention two risk factors associated with pregnancy, childbirth, and the postpartum period in adolescence.
4. Discuss the unique care needs of adolescents during pregnancy, childbirth, and the postnatal period.

Activity 1.2. Spot checks

Instructions

- Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

SESSION 2.
HOW COMMON IS PREGNANCY AND CHILDBIRTH AMONG ADOLESCENTS? 10 MINUTES

Aim of the session

- To discuss how common pregnancy is among adolescents in the region and the country

Activities 2.1. Buzz group

Instructions

- Ask the participants, "How common is adolescent pregnancy and childbirth?" Show the flip chart below and read the question.

How often do you or your health facility provide care for pregnant adolescents?

Very Often Sometimes Never

- Ask each participant to come forward and draw a firm dot on the flip chart next to the responses to indicate how often they—or their health centre—provide care for pregnant adolescents. For example, if someone frequently provides care for pregnant, birthing, or postpartum adolescents, the dot would go, near "Very often." Someone who never does so would place the dot beside "Never," and so on.
- When everyone has done so, count the dots for each response, write the number, and then comment appropriately on how many participants see pregnant adolescents on a regular basis.
- Mention that you will now discuss some Malawi data.

Activity 2.2. Mini lecture

Instructions

- Show the slide below that lists rates of birth and draw participants' attention to the wide variations. (This is Table 8 in the *Participants Handbook*.)

Table 7. Rate of births in Malawi per 1,000 females, ages 15–24

15–19 years	152 / 1,000
20–24 years	269 / 1,000
15–19 years: rural	162 / 1,000
15–19 years: urban	109 / 1,000
20–24 years: rural	285 / 1,000
20–24 years: urban	206 / 1,000

SOURCE: MDHS, 2010.

Talking points

It is evident from the slide that there are wide variations both by age group and urban and rural location. When you look at the total fertility rates for Malawi, you see the same variations observed. The total fertility rate refers to the number of live births a woman would have if she were subject to the current age-specific fertility rates throughout her reproductive years (ages 15–49). Data from the 2010 MDHS show the age-specific fertility rates per 1,000 women ages 15–19 as 109 for urban and 162 for rural women; for ages 20–24, the rates are 206 for urban and 285 for rural women.

SESSION 3: FACTORS INFLUENCING PREGNANCY AND CHILDBIRTH IN ADOLESCENTS 50 MINUTES

Aim of the session

- To examine the factors that influence pregnancy and childbirth in adolescents

Activity 3.1. Brainstorming

Instructions

- Post the flip chart below that contains three broad categories of factors contributing to pregnancy in adolescents.
- Ask participants to form three groups. The first group will deal with biological factors, the second with sociocultural factors, and the third with service delivery factors.
- If you have young participants, they could either form a separate group of their own or join the groups of adult participants. Leave the decision to them.
- Explain that each group's task is to identify a maximum of five factors in relation to the category they have been assigned. In doing so, they must look at the points that have emerged in the previous activity. Give them about 10 minutes to do this task.
- Ask them to write these on separate cards or flip chart pages.
- When the groups are ready, ask the one discussing biological factors to come forward first, post their cards, and explain their responses to the others. Once they have done so, invite comments and questions from the rest of the participants.
- On cards, write down any additional factors highlighted in each discussion and post the cards.
- Follow the same process for the other two groups.
- As the discussion proceeds, ask participants to decide if the factors that have been identified belong to more than one category and also if it would be helpful to create a new category.

TIP FOR YOU
As you wrap up the discussion, it would be useful to ask participants to consider whether factors influencing adolescent pregnancy and childbirth locally are different from those in other areas of the country or in other countries.

Factors contributing to pregnancy in adolescents
- Biological factors
- Sociocultural factors
- Service delivery factors

Activity 3.2. Mini lecture

Instructions

- Take the participants through the three slides below, which summarise the factors that influence adolescent pregnancy and childbirth, using the talking points provided. Many of these points may already have been raised in the discussion. Point to those that have been missed.

Biological factors in pregnancy and childbirth in adolescents

- The declining age of menarche
- Early initiation of sex

Talking points

The age of menarche has declined in developed countries as well as in many developing countries. Studies show that in many African countries, the age of menarche has dropped from age 14 to age 12 in the past two decades.

The trend in the age at first sexual intercourse (where data exist) shows a decrease in several countries. However, it must be pointed out that there is some variation, and instances in which the age at first sexual intercourse remains unchanged or has increased. (Refer participants to the figures you presented in Unit 3A: Introduction to sexual and reproductive health and young people.)

Sociocultural factors in pregnancy and childbirth in young people

- Norms and traditions
  - Child marriage
  - Pressure to have children upon marriage
- Changing circumstances of young people
  - Premarital sexual activity
  - Use of alcohol and other substances
- Vulnerability of young people
  - Sexual coercion
  - Socioeconomic factors

Talking points

NORMS AND TRADITIONS

- Child marriage is still practiced widely in Africa, the Middle East, and parts of Asia. In many places, this is the case even though laws prohibit it.
- In many societies, including Malawi, pregnancy is expected to follow soon after marriage. If age at marriage is early, then early childbirth is almost inevitable.

CHANGING CIRCUMSTANCES OF YOUNG PEOPLE

- The influence of the media, changes in family structure, and growth in opportunities to study and work are changing the age of sexual debut and sexual behaviour patterns in general.
- The use of alcohol and other psychoactive substances can be associated with unprotected sexual activity (and the possibility of unwanted pregnancy).

VULNERABILITY OF YOUNG PEOPLE

- Sexual coercion (including rape): Despite the scarcity of data in these areas, it seems very likely that some adolescent pregnancies are a direct result of such assaults, often by adult men.
- Socioeconomic factors: Economic hardship can force young girls to leave home. Sexual exploitation and prostitution are two frequent consequences, which often lead to early pregnancies.

Service-related factors in pregnancy and childbirth among adolescents

- Lack of access to SRH information and education
- Lack of access to contraceptive information and services
- Lack of services for safe termination of pregnancy

LACK OF ACCESS TO SRH INFORMATION AND EDUCATION

In many places, information and education programmes to help adolescents learn about sexuality and sexual health are generally lacking.

LACK OF ACCESS TO CONTRACEPTIVE INFORMATION AND SERVICES

Adolescent pregnancies (as discussed earlier) tend to be highest in areas with the lowest contraceptive prevalence (fewer than half of those ages 15–19 use contraceptives). Recent gains in contraceptive prevalence in many developing countries have been almost exclusively among older married women, not adolescents. Even where contraceptive services are widely available, they may be inaccessible to adolescents.

LACK OF SERVICES FOR SAFE TERMINATION OF PREGNANCY

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.

After going through the slides, invite comments and questions. Do not feel obliged to respond to all of the issues raised. Encourage other participants to do so. As the discussion tapers off, move to the next session.

SESSION 4.
CONSEQUENCES: WHY IS ADOLESCENT PREGNANCY AND CHILDBIRTH RISKY? 20 MINUTES

Aim of the session

- To identify the reasons why pregnancy and childbirth carry more risks for adolescents than adults

Activity 4.1. Mini lecture

Instructions

- Take the participants through the slide below, using the talking points provided.

Pregnancy complications occurring more commonly in adolescents than in adults

ANTENATAL PERIOD	LABOUR AND DELIVERY	POSTPARTUM PERIOD	FOR THE BABY
Pregnancy-induced hypertension Anaemia during antenatal period STIs, including HIV Higher severity of malaria	Pre-term birth Obstructed labour	Anaemia during postpartum period Pre-eclampsia/ eclampsia Postpartum depression Obstetric fistula	Low birth weight Perinatal and neonatal mortality Inadequate child care and breastfeeding practices High morbidity and mortality rates

Talking points

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.

SESSION 5.
CARING FOR THE PREGNANT ADOLESCENT: THE CRITICAL FACTORS 40 MINUTES

Aim of the session

- To discuss the critical aspects of caring for adolescents throughout pregnancy, labour and delivery, and the postpartum period

Activity 5.1. Group work

Instructions

- Ask the participants to divide themselves into three groups.
- Inform them that you want each group to identify the critical aspects of caring for a pregnant adolescent for each category shown in the slide below.

The critical aspects of caring for the pregnant adolescent

- Early detection of pregnancy
- Antenatal care (including PMTCT)
- Counselling during pregnancy
- Management of labour and delivery
- Postpartum care

- Explain that each group has 15 minutes to read the relevant section of the handout and plan their session, and a maximum of 10 minutes to present their session.
- While the groups are working, move among them. Encourage the participants in each group to consider the questions in the handout and include their responses to the questions in their presentations. Suggest scenarios that could illustrate the points they want to raise.

Activity 5.2. Plenary session

Instructions

- Ask the groups to present in plenary session. Following the presentations, encourage questions.

Talking points

The early detection of pregnancy is an important first step in drawing the adolescent into antenatal care. Healthcare providers, parents, and communities need to be aware that a young adolescent may not know she is pregnant. This may be because she does not remember the dates of her last menstrual period or because her periods are irregular.

Antenatal care is a valuable opportunity to provide the information and counselling support that adolescents and youths need. In Malawi, a "Focussed Antenatal Care" approach is used, wherein a minimum of four antenatal visits for all pregnant women is recommended unless the pregnancy has complications. (Refer to Box 30 in the *Participants Handbook*, "The focused approach to antenatal care," and go through it.)

Pregnant adolescents may have questions and concerns of their own. They must be given an opportunity to raise and discuss these issues. Counselling support should cover such issues as the following:

- Life situation of the adolescent, including her marital status and socioeconomic situation
- Support available to her from her husband/partner, family members, friends, and others
- Options available to her regarding the pregnancy (e.g., in some places, discreet arrangements are available for handing the child over for adoption soon after birth)
- Support that she needs and the social support services for which she is eligible
- Access to health services for routine antenatal care and in case of emergency
- Plans for the delivery
- Plans for the care of the baby
- Plans for continuing with her education or work after the delivery
- Good nutrition
- Malaria prevention
- Cessation of any substance use and abuse
- Family planning
- HIV and AIDS, including HIV testing and counselling

The lactating adolescent needs adequate nutrition to meet her own bodily needs as well as the extra needs required to produce breast milk. Refer to Unit 4 for more discussion on nutrition.

WHO has made recommendations concerning breastfeeding. A young adolescent—especially one who is single—requires extra support to breastfeed successfully.

For an HIV-positive mother, counselling should include information about the risks and benefits of infant feeding options, and specific guidance to select the option most suitable for her situation. The final decision should be made by the woman.

Activity 5.3. Role plays

Instructions

- The focus of this activity is on implementing good practice in adolescent care. Choose two of the scenarios for role plays provided below and in Unit 3C, Annex 1 in the *Participants Handbook*. Invite participants to divide into two groups for the role play.
- Allow 10 minutes for this activity.

Role Play 1

A doctor, the nurse-in-charge, and two other nurses are conducting a ward round in the maternity ward of a government hospital. There are around 25 patients in the ward. About a third of them are adolescents. The team arrives at the bedside of a 14-year-old girl who has been admitted with severe anaemia (complicating her pregnancy). Her haemoglobin is 7 gm/dl.

As they reach the bed, the nurse-in-charge starts berating the girl loudly. "You had no business to have sex before getting married and no business getting pregnant. You play around and we all have to work to take care of you." The girl starts weeping silently. Her mother hangs her head in shame. The doctor is clearly embarrassed by this outburst. He gently tries to intervene…

ROLES: Doctor, nurse-in-charge, 14-year-old girl, mother

Role Play 2

A teacher at a boarding school comes in to the casualty unit of a district hospital with a 16-year-old school girl (who is in school uniform). The teacher says that the girl has been complaining of severe lower abdominal pains and wonders whether she has menstrual cramps.

On examination, the clinical officer on duty confirms a full-term pregnancy. The girl has concealed her pregnancy from her family and the teachers at school by binding her abdomen tightly. The girl is in labour. Her cervix is 4 centimetres dilated. After sending the girl to the labour ward, the clinical officer sends for the doctor on call to help explain matters to the teacher.

ROLES: Doctor, clinical officer, teacher

Activity 5.4. Plenary session

Instructions

- Let the groups present in a plenary session. Make sure each group reads its role play.

Talking points

In the discussion, ensure that the following issues are addressed.

Role Play 1 highlights the following issues:

- The judgmental attitude and disrespect of many healthcare providers towards pregnant adolescents, especially towards those with premarital pregnancies
- The need to be on the lookout for anaemia in pregnancy
- The need to involve families in the discussion of dietary needs

Role Play 2 highlights the following issue:

- Unmarried adolescents often try—and are often successful—in hiding the fact that they are pregnant, at least for some time.

SESSION 6.
UNIT REVIEW 10 MINUTES

Activity 6.1. Review of spot checks

Instructions

- Ask participants to pull out the spot checks they completed in the first session of the unit.
- Ask them to review their answers to see whether they want to change any of them.
- Go over each answer with them, one at a time.

UNIT 3C. SPOT CHECKS

1. Mention three things that contribute to high pregnancy rates among young people.

_____

_____

2. What are the most common complications of pregnancy and childbearing in young adolescents?
    - Antenatal

_____

_____

    - Labour and delivery

_____

_____

    - Postpartum

_____

_____

    - For the baby

_____

_____

3. Mention any two critical things to look for when caring for young people during pregnancy.

_____

_____

Activity 6.2. Review of objectives

Instructions

- Display the unit objectives below, invite participants to share any last questions or comments they might have, and address them.

Unit objectives

1. Explain the scope of adolescent pregnancy and childbirth in Malawi.
2. List at least four factors that influence young women's pregnancy.
3. Mention two risks factors associated with pregnancy, childbirth, and the postpartum period in adolescence.
4. Discuss the unique care needs of adolescents during pregnancy, childbirth, and the postnatal period.

Activity 6.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 6.4. Reminders and closure

Instructions

- Ask the participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 3D.

UNSAFE ABORTION AND YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 10 MINUTES

Aim of the session

- The aim of the session is to provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants to the unit. Mention that its purpose is to explore aspects of unsafe abortion in young people.
- Display the unit objectives below and read them out loud.

Unit objectives

1. Define unsafe abortion.
2. Discuss the scope of unsafe abortion in Malawi, including the legal status of abortion.
3. Mention at least four reasons why adolescents and youths seek unsafe abortion.
4. State the single largest factor in determining the risk of complications and death due to unsafe abortion among young women.
5. Discuss the medical, psychological, and social consequences of unsafe abortion in young women.
6. Describe ways to detect unsafe abortion and how to refer for treatment.
7. Discuss what needs to be done to prevent unsafe abortion.

Talking points

Explain that because abortion is often a controversial subject that provokes strong views and feelings, participants must consider some of the ethical and legal implications, and what they think about them.

Emphasise in the introduction that this topic may be difficult for some participants. Remind them of the confidentiality and right-to-pass rules. This rule means that participants have a right not to comment, thus upholding privacy and confidentiality. Pay special attention to participants' demeanour so you will notice if anyone needs special attention or is showing distress.

TIP FOR YOU

Remind the participants to use the Matters Arising board throughout the unit to record issues they would like to follow up on. Make sure to indicate where the board is located.

SESSION 2.
THE NATURE AND SCOPE OF UNSAFE ABORTION 50 MINUTES

Activity 2.1. Individual exercise

Instructions

- Inform participants that you will start the session with an exercise and want everyone to be as open as possible.

EXERCISE 1

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.

Follow up their choices with the following questions:

What guided your choice for number 1?

_____

_____

What guided your choice for number 6?

_____

_____

Was making your choices difficult or easy for you? Explain.

_____

_____

EXERCISE 2

This exercise helps to identify the areas where participants are most challenged on the issue of abortion. In this exercise, do the following:

- Ask participants to move out of their chairs and form a circle.
- If the room is too small, find a larger place.
- 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?

Activity 2.2. Mini lecture

Instructions

- Display the slide below and take the participants through it.

- Definition of unsafe abortion
- The scope of unsafe abortion in Malawi
- Abortion and the law in Malawi

INDICATOR	STATUS	SOURCE
Unsafe abortion	24.4 abortions per 1,000 women of reproductive age (ages 15–49; 70,000 per year) 50% for those below age 25 7.4% of abortions are among adolescents ages 12–17	MOH, Ipas, and UNFPA. 2010. *Magnitude Study on Abortion – National Estimates.*

Talking points

ABORTION LAW

Under the Malawi Penal Code of 1930 (Sections 149–151), the performance of abortions is legally restricted. A person who unlawfully uses any means with intent to procure an abortion is subject to 14 years' imprisonment. A pregnant woman who unlawfully uses any means or permits the use of such means with intent to procure her own abortion is subject to seven years' imprisonment. A person who unlawfully supplies or procures anything whatever, knowing that it is intended to be unlawfully used to procure an abortion, is subject to three years' imprisonment.

Nonetheless, abortions can be legally performed in Malawi to save the life of the pregnant woman. Section 243 of the Penal Code provides that a person is not criminally responsible for performing in good faith and with reasonable care and skill a surgical operation upon an unborn child for the preservation of the mother's life if the performance of the operation is reasonable. A digest of Malawi's abortion policies can be found at: http://www.un.org/esa/population/publications/abortion/profiles.htm.

In July 2015, a Special Law Commission set up to review Malawi's abortion laws gave the following recommendation.

PROPOSED GROUNDS FOR LAWFUL TERMINATION OF PREGNANCY

The current position of the law is that abortion is illegal in Malawi except where it is performed to save the life of the pregnant woman through a surgical operation. The Special Law Commission resolved and agreed that abortion law in Malawi should be liberalised (that is, conditional relaxation of the restrictions, as opposed to decriminalisation altogether) to allow certain justifiable instances in which termination of a pregnancy would be permissible. Therefore, pregnancy would be terminated under the following conditions: it endangers the life of the pregnant woman; to prevent injury to the physical or mental health of the pregnant woman; where there is severe malformation of the foetus, which will affect its viability or compatibility with life; and where the pregnancy is as a result of rape, incest, or defilement.

Victims of rape, incest, or defilement would be given an opportunity to decide on their own whether to terminate the pregnancy or not. Women who wish to terminate a pregnancy under these circumstances would be required to report the matter of their sexual abuse to the police. The police report would suffice as evidence that the pregnancy was the result of a sexual offence; based on this report, health service providers would be able to terminate the pregnancy without breaking the law.

Malawi has one of the highest adolescent fertility rates in the sub-Saharan region: one in three adolescent girls has begun childbearing, one in four already has a child, and 9 percent are currently pregnant.

The majority of sexually active adolescents have a high unmet need for modern contraception.[8] Unsafe abortion among young girls accounts for 17 percent[9] of Malawi's maternal mortality rate.

According to a 2010 report by the MOH, approximately 70,000 induced abortions occur annually in Malawi, with an induced abortion rate of 24.4 per 1,000 women of reproductive age. The report further states that approximately 50 percent of these are for young women below age 25; 7.4 percent of those seeking this service are ages 12–17.

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[8] National Statistical Office (NSO) and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010*. Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

[9] MOH, Ipas, and UNFPA. 2010. *Magnitude Study on Abortion – National Estimates*. Lilongwe, Malawi: Ministry of Health.

Approximately 29,500 women receive care for induced and spontaneous abortions in health facilities each year.[10] A review of nine Malawian hospitals found that abortion complications accounted for 7 percent of maternal deaths. Studies conducted at the only referral hospital in southern Malawi found that abortion complications accounted for 68.7 percent of all gynaecologic admissions in 1994 and were responsible for 23.5 percent of maternal deaths in 1999–2000.[11]

A study[12] 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.

TIP FOR YOU

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.

Activity 2.3. Group work and plenary feedback

Instructions

- Ask participants to form three or four groups to discuss the question posed on the flip chart page. If there are adolescents in the group, ask if they would prefer to work in a separate group; their understanding of contemporary issues may well shock the adults present!
- Display the flip chart page and read the question aloud.
- Ask each group to come up with as many as five important reasons in answer to the question.
- Ask them to write each answer on a separate card.
- Allow them up to 10 minutes and move around among the groups to see how they are getting on.
- When participants have completed their task, ask them to post their cards on a bulletin board (or on a wall using masking tape).
- Ask a volunteer to read each card out loud. As this is being done, ask the participants to discuss categories for grouping the cards.

Why do adolescent girls often resort to unsafe abortion?

- Possible categories are the following:
  - Social/cultural issues
  - Economic issues
  - Psychological issues

[10] Ibid.

[11] Ibid.

[12] Ibid.

SESSION 3. FACTORS CONTRIBUTING TO UNSAFE ABORTION IN YOUNG PEOPLE 25 MINUTES

Activity 3.1. Group work

Instructions

- Ask participants to form groups of four or five (if participants come from different districts within a country, consider asking them to form area-specific groups).
- Give each group one marker of a different colour from the rest.
- Post the flip chart page shown below.

How do the following factors affect unsafe abortion in young girls in your district?

	NO IMPACT	ADDS TO THE PROBLEM	REDUCES THE PROBLEM
Access to contraceptive information			
Access to SRH information			
Life skills training			
Access to safe abortion practices			
Attitudes and behaviours of healthcare providers			
Community norms			
Laws and policies on SRH of adolescents			
Other factors			

- Explain that each group's task is to decide whether these factors add to or help reduce the problem, or perhaps have little impact either way. This will stimulate discussion, and possibly some debate.
- Allow the groups 10 minutes to complete this activity, and then ask each group in turn to come forward and tick the appropriate columns for each of the factors. Ask them to place the symbol "V" if everyone in the group agrees and the symbol "X" if there is disagreement within the group.
- Wrap up the discussion by going over the slide below.

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

SESSION 4.
THE CONSEQUENCES OF UNSAFE ABORTION 25 MINUTES

Activity 4.1. Mini lecture

Instructions

- Explain that so far we have considered the nature and scope of unsafe abortion and the many contributing factors. We are now turning to the consequences of unsafe abortion.
- Present the next three slides, using the accompanying talking points. Invite the participants to offer comments and questions and encourage everyone to respond to them.

Medical consequences of unsafe abortion in young people

The major short-term complications are

- 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

- Secondary infertility, spontaneous abortion in a subsequent pregnancy, and an increased likelihood of both ectopic pregnancy and pre-term labour

Psychological consequences

- Two to four times more likely to commit suicide
- More likely to have troubled relationships
- Generally in need of more counselling and guidance regarding abortions
- Nearly three times more likely to be admitted to mental health hospitals than women in general

Social and economic consequences

- Leave school and face disapproving attitudes, even ostracism, from their community
- Risk being thrown out by their families
- Spiral of events stemming from obtaining an unsafe abortion, which can greatly reduce a girl's life chances
- Possibility of imprisonment

Talking points

Most unsafe abortions are done during the second or third month of pregnancy, using medication or local injury. In the first month, the usual method is blunt trauma to the abdominal or pelvic area.

COMMON METHODS OF UNSAFE ABORTION

- Abortifacient drugs: Low doses of these drugs are ineffective; high doses result in abortion by poisoning the mother.
- Local abortifacients: These substances are applied in the vagina or onto the cervix; their chemical properties will cause abortion.
- Instrumentation: These methods—douching, syringing, and direct instrumentation—are the most effective.

CAUSES OF DEATH DUE TO UNSAFE ABORTIONS

- Vagal inhibition
- Overdosing
- Haemorrhagic shock
- Septicaemia
- Drug or chemical poisoning
- Air emboli
- Amniotic fluid emboli

MEDICAL CONSEQUENCES

- Risks of mortality and morbidity from unsafe abortion are high for women of all ages, but they are especially high for adolescents, mainly because of the ways in which abortion is induced and because of delays in care seeking.
- In many developing countries, serious complications due to unsafe abortion affect adolescents much more than adults.

Psychological consequences are less well documented than physical consequences but are significant. They include depression and withdrawal.

- In many cases, these problems improve with time; however, in a significant proportion of cases, the condition lingers and requires specialised attention.
- Long-term, abortion-related psychological problems are frequently reported in girls who are pregnant for the first time.

Social consequences are borne by the girl herself and her family. Girls who survive may be forced to leave school. They may face disapproving attitudes—even ostracism. They risk being forced into early marriage or thrown out of their homes. To support themselves, they may take up poorly paid jobs or even prostitution.

TIP FOR YOU

This is a lot of information to digest. Give the participants a few minutes to take in all of this and share their reactions, if any. Then move on to the short- and long-term medical complications of unsafe abortion in adolescents as presented in the next two slides.

Economic consequences are immense, both for the girl and her family, but also for the community and country. An extended hospital stay will cost the family a great deal of money. Likewise, treatment for the sequelae of unsafe abortion drains the resources of hospitals, which are often already in short supply. These include safe blood, other intravenous fluids, and antibiotics. In addition, investments made in the growth and development—including education—of these girls are put at risk.

Major short-term complications

- Tetanus
- Haemorrhage
- Localised or generalised infection
- Injuries (genital lacerations, perforations of organs)

Tetanus can result from the insertion of materials like sticks, metal rods, and other implements into the uterus. It can also result from the use of unsterilised surgical instruments.

Haemorrhage is a common complication leading to or aggravating pre-existing anaemia, and can lead to death.

Postabortion sepsis can rapidly develop into septicaemia and full-blown sepsis.

Physical injuries may vary from small vaginal or cervical lacerations to major perforations involving not only the reproductive organs but also the urinary and gastrointestinal systems.

Major long-term complications

- Chronic pelvic infection
- Secondary infertility
- Subsequent spontaneous abortion
- Increased likelihood of ectopic pregnancy
- Increased likelihood of premature labour

Long-term medical complications are those that happen a month or more after abortion takes place. Many of these are exceptionally heavy lifelong burdens, particularly in Malawi, where a woman's status depends on her ability to bear children.

Activity 4.2. Plenary review

Instructions

- Lead a plenary review by asking the questions listed on the flip chart page below. You could ask a volunteer to note important ideas or points in the participants' responses on another flip chart page.

Unsafe Abortion

- Which of the listed consequences apply in your community?
- Are influential gatekeepers (such as political and religious leaders) aware of these consequences?
- If they are aware, what if anything are they doing to reduce the occurrence of unsafe abortion?

SESSION 5. MANAGEMENT OF UNSAFE ABORTION IN YOUNG PEOPLE 40 MINUTES

Activity 5.1. Mini lecture

Instructions

- As you go through the next two slides, refer to key points brought up in the discussion.

Compared with adults, young people with an unsafe abortion are more likely to

- Delay seeking help
- Come alone, or with a friend, rather than a partner
- Have ingested substances that interfere with treatment
- Have more entrenched complications

Compared with adults, young people with an unsafe abortion are more likely to

- Be unmarried and outside of a stable relationship
- Be pregnant for the first time
- Have a longer gestation up to the time of abortion
- Have used dangerous methods to terminate pregnancy
- Have resorted to illegal providers

TIP FOR YOU
Stress that the session does not provide details about clinical management. That is beyond the scope of the unit.

Talking points

To wind up the discussion on detection, stress that it may be useful to keep the following points in mind:

- Adolescents may find it hard to describe their problem. This is especially true if they are accompanied by their parents or other relatives.
- Even if they want to, adolescents (especially younger ones) may be unable to provide an accurate history.

Activity 5.2. Group work: role plays

Instructions

- Direct the participants to the role plays in Unit 3D, Annex 1 of their *Participants Handbook* (these role plays also appear below).

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

Role Play 2

A young woman (age 18) has died in a hospital while under the care of a certain middle-aged male doctor. The cause of death was septic incomplete abortion (performed elsewhere). Two months before her death, the woman had come to the hospital seeking an abortion. She had met with this doctor, who had told her that he could not perform the procedure because it was illegal. This doctor now has to break the news of her death to the family and he has both her parents and her sister in his office.

The sister breaks down sobbing and angrily reveals what had happened two months earlier when her sister came to the hospital for help.

The doctor wants to comfort the family but of course his own part in the matter makes this difficult. He feels torn between his own guilt, his genuine sympathy for the family, and his real concerns about safeguarding his position.

ROLES: The doctor, the young woman's parents, and the 21-year-old sister

Role Play 1 raises the following issues:

- Whether abortion is legal in this setting
- What is in the best interests of the adolescent
- The rights of the adolescent to self-determination and the rights of parents to know about the health and well-being of their children
- The tension between having strong viewpoints and value systems, and imposing them on others

Role Play 2 raises the following issues:

- Many young women seek abortion whether or not it is legally available.
- In many places where abortion is illegal, there are many providers—both qualified and unqualified—who provide the service for a heavy fee.

Briefly conclude this session on managing unsafe abortion in adolescents by highlighting some of the key points raised in the discussions.

SESSION 6. PREVENTING UNSAFE ABORTION 30 MINUTES

Aim of the session

- To discuss prevention strategies for unsafe abortion

Activity 6.1. Group work

Instructions

- Explain that this session of the unit returns to some of the content covered earlier in the unit on pregnancy prevention and fertility regulation.
- Ask the participants, still in their small groups, to discuss how unsafe abortion among young people could be prevented.
- Allow 15 minutes for the group discussions.
- Ask a representative of each group to summarise the points raised for presentation in a plenary session that will follow.

Activity 6.2. Plenary discussion

Instructions

- Ask each group to present their perspectives and then to respond to questions and comments that other participants raise.
- Wind up the session, pointing both to the major challenges that exist and the possible ways of addressing them that participants have proposed.

SESSION 7.
UNIT REVIEW 10 MINUTES

Aim of the session

- To review and discuss answers to the spot checks completed during the first session
- To review the unit's objectives and provide a summary of key points
- To give participants an opportunity to reflect on—and write down in their personal diaries—the messages they are taking away from the unit

Activity 7.1. Review of objectives

Instructions

- Display the unit objectives in the slide below, invite participants to share any remaining questions or comments they might have, and address them.
- Summarise the key messages of this unit, going over the slide presented below.

Unit objectives

1. Define unsafe abortion.
2. Discuss the scope of unsafe abortion in Malawi, including the legal status of abortion.
3. Mention at least four reasons why adolescents and youths seek unsafe abortion.
4. State the single largest factor in determining the risk of complications and death due to unsafe abortion among young women.
5. Discuss the medical, psychological, and social consequences of unsafe abortion in young women.
6. Describe ways to detect unsafe abortion and how to refer for treatment.
7. Discuss what needs to be done to prevent unsafe abortion.

Activity 7.2. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.
- Thank them for their participation in the unit and their contributions to the discussion.

Activity 7.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 7.4. Reminders and closure

Instructions

- Ask the participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 3E.

SEXUAL ABUSE AND PHYSICAL ABUSE AND YOUNG PEOPLE

This section is an adaptation of the Malawi *National Guidelines for Provision of Services for Physical and Sexual Violence*. Some sections inserted here have been copied verbatim from the guidelines.

SESSION 1.
UNIT INTRODUCTION 10 MINUTES

Activity 1.1. Unit objectives

Instructions

- Welcome participants to this unit of the training.
- Explain that the aim of the unit is to provide an overview of sexual abuse in young people.
- Display unit objectives in the slide below and read them aloud.

Unit objectives

1. Define the terms "sexual violence" and "sexual assault."
2. Discuss the scope of sexual and physical abuse in Malawi.
3. Enumerate the health consequences of sexual and physical assault.
4. Explain the legal implications of sexual assault and rape.
5. Describe service provision to survivors of physical and sexual assault.
6. State treatment and prophylaxis protocols for survivors of sexual assault and rape.
7. Describe the procedures for reporting to the police.

SESSION 2. UNDERSTANDING SEXUAL VIOLENCE AND SEXUAL ASSAULT 40 MINUTES

Aim of the session

- To gain a deeper understanding of what constitutes sexual violence and assault

Activity 2.1. Mini lecture

Instructions

- Explain that you are beginning the mini lecture by looking at the definition of sexual assault and the scope of the problem of sexual assault nationally.
- Emphasise that this topic may be difficult for some participants. Remind them of the confidentiality and right-to-pass rules. Remain alert to anyone showing distress and needing special attention.
- Show the slides and go over the talking points presented below.

Definition of sexual violence

Sexual violence: (synonymous with sexual assault); a term covering a wide range of activities, including rape, indecent assault, and sexually obsessive behaviour.

Sexual assault is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work." (WHO, 2003, *Guidelines for Medico-Legal Care for Victims of Sexual Violence*)

Definition of rape

Rape is defined as "physical forced or otherwise coerced penetration—even if slight—of the vulva or anus, using a penis, other body parts or an object" (WHO, 2003).

Defilement is unlawful sexual intercourse with a young person under the age of 14.

LGBT

"LGBT" refers to persons who are lesbian, gay, bisexual, or transgender.

LGBT persons have much higher rates of depression and suicide because of the 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.

In Malawi, many LGBT persons are discriminated against and sometimes charged under various laws. It is not legal to treat those who are LGBT with violence, and all LGBT persons have the right to provision of services.

Persons with disabilities

Persons with disabilities include those who have long-term physical, mental, intellectual, or sensory impairments, which in interaction with various barriers in the community, may hinder their full and effective participation in society on an equal basis with others.

When we work with persons with disabilities, it is important to focus on their abilities. We should not define people by their disabilities, and we should not be dismissive of their claims of abuse; they are full and equal citizens.

Activity 2.2. Exercise

Instructions

- Inform participants that they will now do a value clarification exercise.
- Before the session, print three signs or make them using cardboard and markers. The first will say AGREE, the second will say UNSURE, and the third will say DISAGREE. Post the signs on the wall in three different parts of the classroom.
- Explain to the class that this activity is about values and that they will be asked to express their feelings about LGBT people. Emphasise that no one is going to judge them, and that they should be as honest as possible. At the same time, they should not judge others and should respect everyone's input.
- Show participants where you have posted the three signs. Tell them that you will read several value statements. After each statement, they should think carefully about how they feel about it and move to the sign in the room that matches their personal beliefs and feelings.
- Tell them that you will ask for volunteers to describe how they feel about each statement. Remind them that they can say anything as long as they do so respectfully. Everyone has a right to express an opinion, and no one will be put down for having an opinion different from others. Be sure to mention that participants have the right to pass if they would rather not explain their stance on a particular value statement. However, passing is not the same as being unsure.

- Also say that they are free to change their stance and move to another sign in the room at any time. For example, someone may change their mind after hearing another learner's argument for a particular value.
- 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.
    - Providers must report LGBT youth to the authorities.
- Ask the class to go back to their seats and reflect on the exercise for five minutes.
- Conclude the exercise with the following discussion questions:
    1. What do you think was the point of this exercise?
    2. What did you learn about yourself?
    3. Was it difficult to express disagreement with another person's values? Why or why not?
    4. Were there any times when you felt unable to stand up for your values? Why do you think that was so?
    5. Can you think of situations at work or elsewhere where you have felt unable to express your values or opinions? Why was this?
    6. In your community, do you think unpopular values or ways of life are dismissed, ignored, or silenced? Why?
    7. What can we do about this? How can we protect people and prevent violence? How can we intervene in a safe way?

Talking points

Sexual abuse is a form of gender-based and domestic violence.

Sexual abuse of a young person happens when an adult or older child uses a younger child for sexual stimulation. The stimulation may take the form of sexual fondling, handling of genitals, attempted penetration, penetration, oral sex, or intercourse. It may or may not be accompanied by physical abuse.

It may involve pressuring or forcing the partner to have sex against his or her will; perform certain sexual acts, such as anal or oral sex, against his or her will; or intentionally inflict pain during sex.

- Example: A father watching his teenage daughter undress and taking a shower is a kind of sexual abuse.

The facilitator should note that sexual abuse may happen to us within relationships and/or be done by people we know.

The perpetrator of sexual assault may be an acquaintance, a friend, a family member, an intimate partner, or a complete stranger.

Most young girls report having had their first sexual intercourse with a man older than themselves; in most cases, such an encounter is not voluntary.

Below are highlights from a study conducted in 2013 on the scope of sexual and physical abuse against children and young women in Malawi.[13]

Table 8. Sexual abuse before age 18

SEX	AGE RANGE	SEXUAL ABUSE BEFORE AGE 18	MULTIPLE INCIDENTS	AVERAGE AGE	REPORTED?	RECEIVED PROFESSIONAL HELP?
Female	18–24	21.8%	68.4%	14.3	61.2%	9.0%
Male	18–24	14.8%	74.4%	13.9	64.7%	5.9%

SOURCE: Ministry of Gender, Children, Disability and Social Welfare, et al., 2014

[13] Ministry of Gender, Children, Disability and Social Welfare, et al. 2014. *Violence Against Children and Young Women in Malawi: Findings From a National Survey, 2013.* Available at: http://www.unicef.org/malawi/MLW_resources_violencereport.pdf.

Table 9. Prevalence and patterns of sexual and physical abuse in Malawi

TYPE OF ABUSE, BY AGE GROUP	FEMALES (%)	MALES (%)
18- to 24-year-olds reporting experiencing any sexual abuse before age 18	21.8	14.8
18- to 24-year-olds reporting experiencing any unwanted attempted sex before age 18	11.5	9.7
18- to 24-year-olds reporting experiencing physically forced sex before age 18	5.1	1.0
18- to 24-year-olds reporting experiencing any pressured sex before age 18	1.9	1.0
18- to 24-year-olds reporting experiencing any unwanted completed sex before age 18	6.7	1.9
18- to 24-year-olds reporting that first incident of sexual intercourse was unwanted before age 18	37.7	9.8
13- to 17-year-olds reporting experiencing any sexual abuse in the past 12 months	22.8	12.7
13- to 17-year-olds reporting experiencing any sexual touching	10.5	6.8
13- to 17-year-olds reporting experiencing any unwanted attempted sex	13.1	7.8
13- to 17-year-olds reporting experiencing any physically forced sex	2.0	0.3
13- to 17-year-olds reporting experiencing any pressured sex	1.8	1.0
13- to 17-year-olds reporting experiencing any unwanted completed sex in the past 12 months	3.4	1.4
13- to 17-year-olds who had ever had sex reporting that first incident of sexual intercourse was unwanted	52.0	16.8

SOURCE: Ministry of Gender, Children, Disability and Social Welfare, et al., 2014

Activity 2.3. Plenary discussion

Instructions

- Present the question below to the participants on a flip chart page.
- Invite the participants to state and explain their viewpoints, and ask them to illustrate their views with examples.
- Ask for a volunteer to write the key points on a flip chart page.

What are your personal professional experiences of the magnitude of sexual assault?

TIP FOR YOU

Keep an eye on the time. If it seems to you that the participants have covered the main issues, end the session by reviewing the key points raised. If the discussion is proceeding animatedly and the time allocated is running out, you can gently end the discussion and point out that there will be opportunities to discuss these matters later in the unit.

SESSION 3. FACTORS CONTRIBUTING TO THE PROBLEM OF SEXUAL ASSAULT 30 MINUTES

Aim of the session

- To discuss factors contributing to sexual assault

Activity 3.1. Brainstorming

Instructions

- Divide the participants into groups of three by counting off one, two, and three. Ask them to discuss the factors contributing to sexual assault. Allow 10 minutes for the activity. Inform them that they should write their ideas on VIPP cards and that they will report back in a plenary session. Give them several options for reporting back to plenary.

Activity 3.2. Plenary discussion and review

Instructions

- After the participants are through with the brainstorming, allow them to present their discussion in plenary. Invite comments from the other groups.
- Ask for a volunteer to record the main points from the discussion.
- It may be worthwhile to consider classifying the factors contributing to sexual assault along these lines:
  - Biological
  - Social
  - Cultural
  - Behavioural
  - Economic
- When the discussion slows down, wrap up the session by summarising the key points raised.

SESSION 4. CONSEQUENCES OF SEXUAL ASSAULT FOR YOUNG PEOPLE 35 MINUTES

Aim of the session

- To discuss the consequences of sexual assault

Activity 4.1. Brainstorming

Instructions

- Ask participants to brainstorm the consequences of sexual abuse.
- Record the answers on the flip chart.

Activity 4.2. Mini lecture

Instructions

- Explain that you will now describe the consequences of sexual abuse.
- Put up the next three slides and go through each point, explaining as you go along.
- Allow the participants to interrupt and comment as you go along.

Health consequences of sexual assault

- Unwanted pregnancy
- Unsafe abortion
- STIs, including HIV
- Sexual dysfunction
- Infertility
- Pelvic pain and urinary tract infections

Genital injuries

Typical genital injuries include

- Tears
- Ecchymosis
- Abrasions, redness, and swelling of the genitalia

In men, injuries are generally located around the anus and perineum.

Non-genital injuries

Physical

- Bruising
- Lacerations
- Pattern injuries
- Bite marks

Psychological

- Depression
- Anxiety
- Phobia
- Suicidal behaviour

Talking points

The consequences of sexual violence and assault can be overarching and long-lasting. They may affect young people for the rest of their lives, so they must not be taken lightly.

Effects such as HIV and STI infection, an unwanted pregnancy that one cannot legally abort, sexual dysfunction, or physical and psychological trauma could lead to depression and isolation.

Because sexual violence is illegal, all perpetrators should be brought to the courts for justice. Both the Child Care, Protection and Justice Act No. 22 of 2010 and the Protection of Domestic Violence Act, Parts X and XI consider the key roles of the police, the courts, and witnesses in assisting children and adult survivors of sexual assault and domestic violence.

According to the Medical Council Act and Nurses & Midwives Act (1995), all healthcare workers registered either at the Medical Council or the Nurses and Midwives Council are competent to write and provide a medical report in cases of sexual assault and rape, which can be considered a legal document in court.

Therefore, it is important to derail perpetrators by reporting cases of sexual violence and assault.

Inform participants that they now will look at the services available to young people who are sexually assaulted.

SESSION 5.
SERVICE PROVISION TO SURVIVORS OF PHYSICAL AND SEXUAL ASSAULT 35 MINUTES

Aim of the session

- To discuss options available to young people who have been sexually assaulted or violated

Activity 5.1. Mini lecture

Instructions

- Tell participants that government and non-state actors have agreed upon a number of services for responding to victims of sexual violence. Among these are health services to manage HIV and other STIs and unwanted pregnancy, and also to manage psychological trauma and get justice. The slides below summarise the available services and where to get them.

Domestic violence

- Making arrangements for the survivor of domestic violence to find suitable temporary shelter and to obtain medical treatment, as needed
- Ensuring that the survivor of domestic violence has access to information about the range of service providers and the kinds of support that any service provider can offer

Treatment and prophylaxis options available for survivors of sexual assault and rape

EMERGENCY CONTRACEPTION	SEXUALLY TRANSMITTED INFECTIONS (STIS)	POST-EXPOSURE PROPHYLAXIS (PEP)
Unless the survivor is currently using contraceptive methods or pregnant, post-coital oral contraception (emergency contraception) should be issued as soon as possible; this should be done within 72–120 hours of the assault to be effective.	Survivors of sexual assault may have contracted an STI, including HIV. Routine presumptive therapy after sexual assault is recommended because follow-up on the survivor can be difficult, and the survivor may be reassured if offered treatment for possible infection.	PEP refers to treatment of hazardous exposures using antiretroviral therapy (ART). This therapy, if started immediately after exposure to HIV, may prevent acquisition of the virus, although this protection is not 100 percent. Treatment should be initiated as soon as possible and must begin within 72 hours of exposure.

Counselling

Be empathetic. Advise the person about post-traumatic symptoms (such as guilt, fear, shame, anger, insomnia, nightmares, mood swings, suicidal thoughts, or self-destructive behaviour) that she/he may experience.

The GATHER process should be used in this counselling process. Refer participants to Box 9 in their handbooks.

Reporting to police

- It is the responsibility of any professional (healthcare provider, teacher, police officer, etc.) to protect children from further sexual abuse.
- If the guardians of a child survivor do not wish to pursue a case, it is the responsibility of the healthcare provider to report the case to the police.
- Determining whether or not abuse/rape has occurred is the responsibility of the police and its investigators, not the person who reports the alleged crime.
- Police should encourage and assist all survivors presenting at the police station to go to the nearest healthcare facility as soon as possible, preferably before legal processes commence, because both PEP and emergency contraception become less effective over time.
- It is also suggested that the police open a case even before the survivor is seen at a hospital. The case can then be followed up and confirmed using the medical record.
- An individual responsible for the interface between hospital and survivor should collect the appropriate form, either from the police or hospital, and facilitate processing of the case.

Follow-up care

Follow-up is always necessary to identify things which might have been missed on the initial visit, as well as other infections that have a long incubation period: syphilis, Hepatitis B, and HIV sero-conversion.

Activity 5.2. Plenary discussion

Instructions

- During the presentation, allow participants to comment and describe their own experiences in providing services to victims of sexual violence. Follow up this discussion with the next session on how people who are sexually assaulted may be treated.

Talking points

Violence, abuse, neglect, exploitation, and discrimination affect women and children across all social strata in Malawi, greatly endangering their safety and security and at the same time limiting their opportunities for development. Women and children are exposed not only to physical violence and abuse but also psychological and economic abuse. Fortunately, opportunities exist to support the victims and deal with the perpetrators.

SESSION 6.
HOW ARE PEOPLE WHO HAVE BEEN ASSAULTED CURRENTLY DEALT WITH? 25 MINUTES

Aim of the session

- To understand the support mechanism for people who have been assaulted

Activity 6.1. Group work

Instructions

- Divide the participants into three groups to discuss the following case studies.
- Allow them 10 minutes to complete the activity.

CASE STUDY 1.
How the police deal with people who have been sexually assaulted

Linda is a 20-year-old third-year student at a college in Blantyre. She is popular and bright, and likes going out to local entertainment places. Linda also likes to have a few alcoholic drinks when she is relaxing. One day, a group of boys from her class organised a small party in one of their rooms and invited Linda and her best friend, Memory.

After a few hours of drinking and dancing, Memory left the party to go to sleep but Linda stayed. At about 2 a.m., Linda came back to the room crying inconsolably, her mini-skirt torn. Memory asked her what had happened, and Linda explained that after Memory had left, she was alone with two boys who then forced themselves on her and took turns having sexual intercourse with her. She tried to call out for help but could not be heard over the loud music. Memory consoled her friend, called a taxi, and convinced Linda to go to the nearest police station. At the station, they met a male police officer who immediately started berating Linda for drunkenness and dressing provocatively. "You brought it upon yourself," he said. "What were you doing dressed like that in a man's room?"

CASE STUDY 2.

How healthcare workers deal with people who have been sexually assaulted

Linda is a 20-year-old third-year student at a college in Blantyre. She is popular and bright, and likes going out to local entertainment places. Linda also likes to have a few alcoholic drinks when she is relaxing. One day, a group of boys from her class organised a small party in one of their rooms and invited Linda and her best friend Memory.

After a few hours of drinking and dancing, Memory left the party to go to sleep but Linda stayed. At about 2 a.m., Linda came back to the room crying inconsolably, her mini-skirt torn. Memory asked her what had happened, and Linda explained that after Memory had left, she was alone with two boys who then forced themselves on her and took turns having sexual intercourse with her. She tried to call for help but could not be heard over the loud music. Memory tried to console her friend, but saw that she was bruised and bleeding from the mouth. Memory took Linda to the nearest hospital. There the nurse on duty refused to help until she had obtained a police report.

CASE STUDY 3.

How family members deal with people who have been sexually assaulted

Lusungu is a 14-year-old girl from Mzimba. Her parents are poor and have asked her uncle, who lives in Blantyre, to employ her as a housemaid. Every month, Lusungu has been sending money to her parents to help with the farming at home. After staying with her uncle for six months, her aunt was sent abroad to study. At about the same time, her uncle started forcing her to have sexual intercourse with him. Every time this happened, he threatened that he would send her home if she revealed what was happening. This went on for some time, and Lusungu missed her period for two months. One day, her uncle, who was quite a heavy drinker, came home late and wanted to have sexual intercourse with Lusungu. When she refused, he beat her and expelled her from the house with only transport money. She went to her village, where she explained her predicament to her mother. Her mother was very angry that Lusungu had been fired and shouted at her.

Activity 6.2. Plenary discussion and review

Instructions

- Ask participants to highlight key issues arising from these case studies.
- Allow them to ask questions but do not feel obliged to answer all of them.
- Tell them that some of the issues coming up now will be addressed in the next session.

SESSION 7: HOW SHOULD HEALTH WORKERS AND OTHERS DEAL WITH PEOPLE WHO HAVE BEEN SEXUALLY ASSAULTED? 30 MINUTES

Aim of the session

- To discuss roles and responsibilities of health workers in dealing with people who have been sexually assaulted

Activity 7.1. Brainstorming

Instructions

- Ask participants to brainstorm the role of the health worker in managing young people who have been abused. Record the answers on a flip chart page.
- Ask for four volunteers to act out the roles of a medical assistant, mother, girl, and health centre person in-charge, using the role play below.
- Give the volunteers copies of the role play. Let them have 10 minutes to prepare and another five minutes to role play in class.

Role Play 1

An 11-year-old girl is brought to a rural health centre by her mother because she noticed that her daughter had genital sores. No meaningful history can be obtained from the mother or the child on how and when the sores started. The girl is examined behind a screen while her mother sits in the same room. Examination reveals that the child has florid vulval condylomata, strongly suggestive of syphilis. The nurse-in-charge, a mature and experienced woman, takes the girl into another room and probes the matter gently. After several minutes of gentle but persistent probing, the girl tells the nurse that her uncle has been "playing" with her and warned her that if she told anyone he would kill her.

Question to pose: If you were faced with such a situation in this setting, how would you deal with it?

Activity 7.2. Plenary discussion

Instructions

- First allow participants to comment on the role play. Write all of the comments on a flip chart page.
- Conclude the session using the following **talking points**:
  - Sexual abuse can be perpetrated by people whom the young person knows. As a result, the young person may think the abuse is normal.
  - Girls are more likely to be victims of sexual abuse than boys.
  - Involve boys in the fight against sexual abuse. Boys are the perpetrators of most sexual abuse in schools.
  - Young people may not report abuse early enough due to threats by the perpetrators.
  - Parents need to observe their child's behaviour and investigate when something seems wrong.
  - Sexual abuse is punishable by law—report evidence of abuse to the police.
  - Sexual abuse may lead to STIs, including HIV; early pregnancies; and unsafe abortions.
  - Young people may not be aware of other SRH problems following sexual abuse.
  - Health workers need to handle young people in a gentle and friendly manner when probing about sexual abuse.
  - Privacy is very important when managing sexually abused young people.
  - Refer to the Participants Handbook, Unit 3E, on the management of sexually and physically abused young people.

Activity 7.3. Group discussion

Instructions

- Pose the following question to the participants. What do you think your role is in managing a young person who has been sexually assaulted?
- Ask a volunteer to record the responses on a flip chart page.
- Allow for a discussion of the points being raised.
- After 10 minutes of discussion, display the following slides and go through each of the points.

TIP FOR YOU

Tell participants that when assisting an abused young person, they should do the following:

- Believe what the young person says.
- Be empathetic and gentle as you probe the young person's history.
- Explain that the abuse is not her/his fault.
- Let the young person know you are sorry it happened.
- Reassure the young person and counsel accordingly.

Role of health workers

- Screen to rule out complications, such as physical injury and STIs.
- If screening reveals evidence of sexual abuse, report the matter to police.
- Treat any complications, such as physical injuries, bruises, or STIs.
- Provide counselling to reduce feelings of guilt, self-blame, shock, or fear.
- Refer for other services, such as PEP, emergency contraception, and psychosocial counselling.
- Link to other support centres, such as legal services, a victim support unit, law enforcers, human rights organisations, livelihood or life skills programmes.

All cases of sexual violence and assault need to be reported to the police.

Role of health workers

- Follow up on the client with a home visit or outreach services.
- Increase awareness among young people (especially boys), parents, and the entire community of the effects of sexual abuse.
- Sensitise untrained service providers on the prevalence of sexual abuse and how to handle sexually abused young people.
- Conduct or participate in operational research to improve the quality of management of sexually abused young people.
- Advocate stiffer punishment of perpetrators of sexual abuse and reporting of sexual abuse to the police.
- Sensitise parents to be on the lookout for and observe symptoms of sexual abuse in their children and report evidence of abuse to the police.

SESSION 7.
UNIT REVIEW 10 MINUTES

Activity 7.1. Review of spot checks

Instructions

- Ask participants to pull out the spot checks they completed in the first session of the unit.
- Ask them to review their answers to see whether they want to make any changes.
- Go over each answer with the participants, one at a time.

UNIT 3E. SPOT CHECKS

Instructions

1. All of the statements below could define sexual abuse except one. Circle all of the statements you think are correct.

- Sexual abuse is domestic violence involving adults.
- Sexual abuse is when an adult or older child uses a younger child for sexual stimulation.
- Sexual abuse is sexual fondling, handling of genitals, attempted penetration, and oral or vaginal intercourse.
- Sexual abuse is pressuring or forcing a partner to have sex against his or her will.

2. List three things that constitute sexual abuse.

_____

_____

_____

_____

3. What are the consequences of sexual abuse?

_____

_____

_____

_____

4. What are the four most important roles of health service providers in managing young people who have been sexually assaulted?

- ☐ Screening to rule out complications such as STIs, physical injury, and so forth
- ☐ Counselling
- ☐ Sensitising young people on their SRHR
- ☐ Referring them to other services, such as PEP, emergency contraception, and legal services
- ☐ Linking them to other support services, such as life skills and livelihood programmes

Activity 7.2. Review of objectives

Instructions

- Display the unit objectives below, invite participants to share any last questions or comments they might have, and address them.

Unit objectives

1. Define the terms sexual violence and sexual assault.
2. Discuss the scope of sexual and physical abuse in Malawi.
3. Enumerate the health consequences of sexual and physical assault.
4. Explain the legal implications of sexual assault and rape.
5. Describe service provision to survivors of physical and sexual assault.
6. State treatment and prophylaxis protocols for survivors of sexual assault and rape.
7. Describe the procedures for reporting to the police.

Activity 7.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 7.4. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.
- Remind them that the "National Guidelines for Provision of Services for Physical and Sexual Violence" provides more information on this topic.

UNIT 3F.

SEXUALLY TRANSMITTED INFECTIONS AND YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 5 MINUTES

Aim of the session

- To provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants to the unit.
- Mention that this unit contains eight sessions (in addition to this introduction and the review), which will explore aspects of STIs in young people.
- Display the unit objectives and read each one aloud.

Unit objectives

1. Define STIs in an exercise.
2. State the magnitude of STIs among adolescents and young people.
3. Explain the factors contributing to STIs in young people.
4. In an exercise, list the signs and symptoms of common STIs in Malawi.
5. Discuss the consequences of STIs among adolescents and young people.
6. Discuss treatment and referral options for a young person with an STI.
7. Discuss prevention and recurrence of STIs.
8. Mention the factors that hinder young people's prompt access to STI treatment.
9. Describe STI referral and linkages with the community or outreach programmes.
10. In a role play, demonstrate how best to respond to the psychological and social needs of young people dealing with STIs.

Activity 1.2. Spot checks

Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

SESSION 2. DEFINITION AND MAGNITUDE OF SEXUALLY TRANSMITTED INFECTIONS 30 MINUTES

Aim of the session

- To define and present the magnitude of STIs among young people nationally

Activity 2.1. Mini lecture

Instructions

- Explain that you will begin the mini lecture by defining STIs and looking at the magnitude of STIs in Malawi.
- Display the two slides below. Do not read them aloud; instead, go over the talking points that follow.

Definition of sexually transmitted infections

- STIs are infections transmitted from one person to another, primarily by sexual contact.
- Some STIs can be transmitted by exposure to contaminated blood or from a mother to her unborn child.

National data on self-reported STIs among young people in Malawi (2010 MDHS)

- Among those ages 15–19, 0.7% of females and 0.4% of males report having symptoms of STIs.
- Among those ages 20–24, 1.4% of females and 2.2% of males report having symptoms of STIs.
- The prevalence of STIs is essentially the same in rural areas (3.8%) and urban areas (3.7%).
- The prevalence of STIs is higher in the southern region (13%) and central region (12%) than in the northern region (6%).

Talking points

STIs present a major threat to the health of sexually active adolescents. The estimates for Malawi provided in the slides highlight the scope of the problem. Global and national estimates show much variation in STI prevalence, both between and within countries. Age- and sex-specific data on STIs among adolescents—especially males—in Malawi and other developing countries are very limited.

STIs facilitate HIV transmission between sexual partners, especially infections causing genital ulcers.

Activity 2.2. Plenary discussion

Instructions

- Post the flip chart page, read the question posed, and ask the participants to respond to it.

What do local data show about STIs among adolescents in your community?

- Ask the participants to share any information they may have on the prevalence of STIs in young people locally. One or more of them may have some data to present. Write down the key points they make on a flip chart page as they speak.
- Invite questions and comments. It is likely that a general consensus will emerge through the discussion; if it does not, acknowledge the different points of view that have been stated.

SESSION 3. FACTORS CONTRIBUTING TO STIs IN YOUNG PEOPLE 30 MINUTES

Aim of the session

- To identify the factors that contribute to STIs among young people

Activity 3.1. Mini lecture

Instructions

- Start your mini lecture by explaining that the factors contributing to STIs in young people are broadly similar to those contributing to too early and unwanted pregnancies in adolescent girls, which were discussed in Session 6 of Unit 3A.
- Use the information in the slide below.

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

Talking points

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.

Show the following slide and explain that adolescent girls are thought to be more susceptible to STIs than older women, and are more vulnerable to infection than boys. Ask participants to brainstorm why this is the case.

Why are young girls especially vulnerable?

Activity 3.2. Plenary discussion

Instructions

- Present the above question to the participants. Invite the participants to state and explain their viewpoints, and ask them to illustrate their views with examples.
- Ask for a volunteer to write the key points on a flip chart page.

Talking points

Young girls are more vulnerable than young men and adults because of biological, social, cultural, and economic factors.

BIOLOGICAL FACTORS

- Inadequate mucosal defence mechanisms and the immature lining of the cervix provide poor barriers against infection
- The thin lining and relatively low acidity in the vagina render it more susceptible to infection

OTHER FACTORS

There is growing recognition that adolescent girls are more vulnerable than men of all ages and adult women for social, cultural, and economic reasons. For instance, they may be coerced into having sex by adults who interact with them, such as relatives, family friends, or others.

SESSION 4.
SIGNS AND SYMPTOMS OF COMMON STIs IN MALAWI 40 MINUTES

Aim of the session

- To discuss the signs and symptoms of common STIs in Malawi

Activity 4.1. Exercise

Instructions

- Write the names of STIs from the list on the slide below on separate sheets of paper.
- Tape these sheets of paper to the backs of participants.
- Tell these participants to ask the other participants questions to try to guess what STI they have taped on their back. (All of them can do this at the same time.)
- Review the list below.
- Allow 10 minutes in the plenary.

Common STIs in Malawi

- HIV
- Gonorrhoea
- Syphilis
- Chancroid
- Genital herpes
- Genital HPV
- Trichomoniasis
- Bacterial vaginosis
- Candida albicans
- Lymphogranuloma venereum
- Scabies
- Hepatitis B

Activity 4.2. Plenary session and discussions

Allow participants to comment and ask questions. Those who do not have a medical background may have many questions about STIs.

Activity 4.3. Mini lecture

Instructions

- Display the slide listing common STIs in Malawi (see Activity 4.1).
- Inform participants that it is important for young people and those helping young people to understand these STIs and where and how to seek treatment.
- Refer the participants to Table 12 in Unit 3F in their handbooks; this table lists the signs and symptoms of these STIs.

Talking points

Early diagnosis and treatment are key to a quick and better recovery from most STIs. Note that HIV and genital herpes are viral infections; to date they can be treated but not cured. For HIV, ART has proven to significantly improve quality of life. Drugs also exist to treat genital herpes, but the virus will remain in the body and outbreaks can always recur.

SESSION 5: THE CONSEQUENCES OF STIs FOR YOUNG PEOPLE 20 MINUTES

Aim of the session

- To present the consequences of STIs for young people

Activity 5.1. Mini lecture

Instructions

- Show the slide below and go over the talking points regarding the consequences of STIs.

Consequences of STIs in young people

1. Blinding eye infections (chlamydia, gonorrhoea) or sepsis, meningitis in newborns (gonorrhoea)
2. Chronic abdominal pain or infertility in women (gonorrhoea and chlamydia)
3. Spontaneous abortion (syphilis)
4. Ectopic pregnancy (gonorrhoea and chlamydia)
5. Cervical cancer (HPV)
6. Infertility in men (gonorrhoea and chlamydia)
7. Increased risk of HIV infection (most ulcerative STIs)
8. Irreversible damage to brain and heart (late in the course of acquired syphilis)
9. Extensive organ and tissue destruction in newborns (congenital syphilis)
10. Social disruption (e.g., divorce of infertile wives; spousal abuse related to learning that partner is infected)
11. Death (AIDS and untreated syphilis)

Activity 5.2. Plenary session and discussions

Instructions

- During the discussion, allow participants to comment and ask questions. Those who do not have a medical background will have many questions. Expound on the consequences of STIs but also allow some participants in the group to make comments based on their own knowledge.
- Wrap up the session by informing participants that you will now look at how best to strengthen access to treatment so the consequences can be prevented.

SESSION 6.
TREATING, REFFERAL, AND MANAGEMENT OF YOUNG PEOPLE WITH STIs 40 MINUTES

Aim of the session

- To discuss treatment and referral options for a young person with an STI

Activity 6.1. Mini lecture

Instructions

Emphasise to the participants that managing young people with STIs is not different from managing adults. Service providers must note the signs and symptoms of different STIs to be able to facilitate referral. The same principles of syndromic approach to the management of STIs apply, as follows:

- Standardised clinical management
- Based on signs and symptoms
- Laboratory diagnosis not required

Important factors to consider when managing young people with an STI

- Be aware of care-seeking practices
- Establish rapport; elicit information about the nature of the problem
- Carry out a physical examination
- Arrive at a diagnosis
- Communicate the diagnosis and its implications, discuss treatment options
- Provide treatment
- Respond to psychological needs and help the individual deal with any social implications of the problem
- Prevent a recurrence
- Notify partners

Talking points

- Examine the matters that health service providers should be aware of and pay attention to when managing young people with STIs.
- When dealing with young people, healthcare providers should be guided in their words and actions by respect for young people, acknowledgement of their need for—and right to—health information and services, and concern for their well-being.
- In Malawi, all young people have the right to ask for and receive the health services they need. In STI management, syndromic case management is used, whereby partners of those with an STI are also requested to receive treatment.
- 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.
- In counselling young people with STIs, always use the GATHER process for a more thorough consultation process.
- YOU DO NOT NEED TO BE A HEALTH WORKER TO REFER A YOUNG PERSON WITH AN STI. YOU DO NEED TO KNOW THE SIGNS AND SYMPTOMS.

Activity 6.2. Group work

Instructions

- Divide the participants into four groups. If there are adolescent participants in the workshop, ensure that at least one young person is in each group.
- Give each group a case study (two case studies to be shared by four groups), and ask them to respond to the question posed, which requires them to specify exactly what they would do if they found themselves in the given situation and explain why they have chosen that course of action.
- Ask the groups to work separately for 15 minutes to complete this task. Tell them to prepare a three-minute presentation to share their impressions.

CASE STUDY 1

A 16-year-old woman has come to the clinic in the district hospital of a semi-urban area because she has a vaginal discharge and some painful sores around the vagina. She is received curtly by the duty nurse, who briefly examines the young woman and asks her a few questions. She then calls in a junior female doctor. As the nurse moves around the examination room, slamming drawers and banging metal trays, she mutters quite audibly: "Shameless girl, stealing husbands, deserves her punishment." The patient remains silent and starts weeping silently. The doctor is appalled by the nurse's brusque manner and harsh words. As she completes the examination, she is gentle and courteous with the young woman, which appears to inflame the nurse further. The doctor gives the client the appropriate medication and asks her to come back for review in a week.

Question to pose: If you were the junior doctor, how would you deal with this situation?

CASE STUDY 2

An 11-year-old girl is brought to a peri-urban clinic by her mother because she has noticed that her daughter has genital sores. No meaningful history can be obtained from the mother or the child on how and when the sores started. The girl is examined behind a screen while her mother sits in the same room. Examination reveals that the child has florid vulval condylomata—strongly suggestive of syphilis. The nurse-in-charge, a mature and experienced woman, takes the child into another room. After several minutes of gentle but persistent probing, the girl tells the nurse that her uncle has been "playing" with her and warned her that if she told anyone he would kill her.

Question to pose: If you were faced with such a situation in this setting, how would you deal with it?

Activity 6.3. Plenary discussion

Instructions

- Ask each group in turn to share their conclusions and respond to any comments or questions that others pose. As the feedback and question-and-answer session proceeds, have someone record the key points on a flip chart page.
- Invite comments and questions. Respond to questions yourself and encourage other participants to share their comments. As you lead the discussion, please keep in mind the following points:
  - *Case study 1*

    This case study clearly highlights the challenge of helping colleagues to see the advantages of a courteous and respectful approach in interacting with clients or patients, even when one does not endorse their lifestyles or actions.
  - *Case study 2*

    This case study touches on the extremely difficult problem of child and adolescent abuse (including sexual abuse). It also presents the challenge of finding ways and means of dealing with it effectively in collaboration with other agencies, such as law enforcement agencies, government bodies, and NGOs that provide social services.
- Wrap up the session and highlight the key points raised in the discussion.

SESSION 7.
PREVENTION OF STIs IN YOUNG PEOPLE 25 MINUTES

Aim of the session

- To highlight the important contributions of health service providers in preventing STIs among young people

Activity 7.1. Mini lecture

Instructions

- Explain that this session will focus on the special contributions that health service providers can make when working with young people.
- Point out that planning, implementation, monitoring, and evaluation of strategies to prevent STIs among young people at the national and local levels are extremely important.
- Display the slide below.

Strategies for preventing acquisition of STIs

- Promoting abstinence among young people
- Promoting safer sex practices
- Promoting partner notification

Talking points

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).

Partner notification is the process of contacting the sexual partner of an individual infected with an STI and advising that he/she has been exposed to infection. It can be done by the client, the healthcare provider, or both.

Activity 7.2. Role plays

Instructions

- Invite two participants to volunteer to act in Role Play 1.
- Go through the role play and then facilitate a debriefing session.
- Repeat the process with Role Play 2. Ensure that you allocate enough time for each.
- Wrap up the discussion by highlighting key points made in relation to each of the role plays.

Role Play 1

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.

Role Play 2

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.

SESSION 8.
FACTORS HINDERING PROMPT AND CORRECT DIAGNOSIS OF STIs IN YOUNG PEOPLE 30 MINUTES

Aim of the session

- To discuss challenges that health service providers face in providing young people with prompt and effective treatment

TIP FOR YOU
If there are young participants, this session provides them with an opportunity to describe what people like themselves do when they have or suspect they have an STI. It will also be an opportunity for the healthcare providers who are present to express "their side of the story" (the challenges they face in providing STI management services to adolescents).

Activity 8.1. Group work

Instructions

- Divide the participants into two groups, with the young participants in one and the adults in another.
- Pose the question below and ask the groups to respond to it.
- Tell the groups they will have 15 minutes to complete their task. Also, tell them to be prepared to make a three-minute presentation to share their impressions.

In your opinion, what do young people do when they know or suspect that they have an STI?

Activity 8.2. Plenary feedback and discussion

Instructions

- Ask each group in turn to share their conclusions. Encourage the participants to share their comments and raise questions.
- Wrap up the session by highlighting the main points of the discussion, using the following slides.

Factors affecting prompt access to STI treatment and diagnosis of STIs

- Fear of being tested for HIV. (STI clients are often asked if they know their HIV status; if they do not, they are asked if they can be tested. This can be intimidating to young people.)
- Embarrassment—they do not want to be seen by people they may know.
- Fear of negative reactions from healthcare workers.
- Lack of information about available services—for example, youth may not know of existing clinics or YFHS centres, where and when STI services are provided, or how much the services cost.
- Lack of knowledge about the asymptomatic nature of some STIs and—especially among young women—the difference between normal and abnormal discharges; these gaps in knowledge prevent young people from seeking help.
- Asymptomatic and mildly symptomatic STIs can be missed.
- Healthcare providers lack adequate clinical skills to diagnose symptomatic STIs.

Talking points

Healthcare providers may miss asymptomatic or mildly symptomatic STIs when they use the syndromic approach for diagnosis and management. Healthcare providers may lack adequate clinical skills (including communication and history-taking skills with adolescents) for diagnosing an STI. Give the participants a few minutes to raise any questions they may have before you proceed to the next session.

SESSION 9: RESPONDING TO PSYCHOLOGICAL AND SOCIAL NEEDS TO HELP YOUNG PEOPLE DEAL WITH STIs 30 MINUTES

Aim of the session

- To discuss how to respond to the psychological needs of young people who have been affected by STIs

Activity 9.1. Brainstorming

Instructions

- Ask participants to brainstorm some strategies they can use to help young people who have been affected by an STI.
- Allow 10 minutes for this task and wrap it up with a mini lecture.

Activity 9.2. Mini lecture

Instructions

- Present the slide on how to respond to psychological needs, expanding on the following components.

Responses to psychological needs

- Information
- Counselling
- Follow-up

Talking points

- Counselling aims to help people deal with problems by enabling them to understand their situation, examine the available options, and make sound decisions accordingly.
- Counsellors should be trained to help clients make decisions about life situations, including how to avoid STIs.
- One need a counsellor can address is to arrange for the youth to return to the health facility to be assessed regarding the effectiveness of the treatment.
- Counsellors should provide information on other forms of assistance that are available, such as referral to other agencies or organisations providing social support.

SESSION 10.
UNIT REVIEW 10 MINUTES

Activity 10.1. Review of spot checks

- Ask participants to pull out the spot checks they completed in the first session of the unit. Ask them to review their answers to see if they want to change any of them.
- Go over each answer with the participants, one at a time.

UNIT 3F. SPOT CHECKS

1. What should healthcare providers do to prevent STIs among young people? (*Please tick the three most important ways.*)

- ☐ Stress to all young people that they should abstain from sex until marriage.
- ☐ Stress faithfulness to sexually active young people.
- ☐ Give condoms and information on how to use them to those who have more than one partner.
- ☐ Make STI services adolescent friendly.
- ☐ Ensure that all young people know about STIs and all of the ways of avoiding them.
- ☐ Make condoms and information available to all adolescents.

2. Mention two factors contributing to STIs among young people.

_____

_____

_____

_____

3. How can you know that the presenting ailment is an STI?

_____

_____

_____

_____

4. Mention any three consequences of an untreated STI.

_____

_____

_____

_____

5. Why are young girls much more susceptible to STIs than adult women?

_____

_____

_____

_____

6. Factors that hinder adolescents from seeking prompt STI treatment.
(Please tick three of the most important factors.)

- ☐ STIs are often asymptomatic (no clear signs).
- ☐ Adolescents do not have information about existing services.
- ☐ They do not have money to pay for services.
- ☐ They fear stigma and embarrassment.
- ☐ They fear being scolded by health workers.

Activity 10.2. Review of objectives

Instructions

- Display the unit objectives below. Invite participants to share any last questions or comments, and address them.

Unit objectives

1. Define STIs in an exercise.
2. State the magnitude of STIs among adolescents and young people.
3. Explain the factors contributing to STIs in young people.
4. In an exercise, list the signs and symptoms of common STIs in Malawi.
5. Discuss the consequences of STIs among adolescents and young people.
6. Discuss treatment and referral options for a young person with an STI.
7. Discuss preventing infection and recurrence of STIs.
8. Mention the factors that hinder young people's prompt access to STI treatment.
9. Describe STI referral and linkages with the community or outreach programmes.
10. In a role play, demonstrate how best to respond to the psychological and social needs of young people dealing with STIs.

Activity 10.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 10.4. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 3G.

HIV AND AIDS AND YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 5 MINUTES

Aim of the session

- To provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants to the unit.
- Display the slide showing the unit objectives. Read the objectives aloud or ask a participant to read them.

Unit objectives

1. Describe the HIV situation in Malawi.
2. State the risks of and protective factors against HIV transmission.
3. Explain young women's vulnerability to HIV.
4. List the five key HIV prevention strategies young people can access through health services.
5. Discuss the roles various people can play in HIV prevention advocacy.
6. List any three of the five questions health workers should ask when planning HIV prevention services for young people.
7. Explain the role of VMMC in HIV risk reduction.
8. Discuss youth-focused strategies to promote HIV testing and counselling.
9. Discuss the role of health personnel in supporting young people living with HIV to maintain optimal health.
10. Describe positive prevention for these young people.
11. State the key information that health personnel can provide when addressing psychosocial issues pertinent to these young people.
12. Discuss effective ways to help young people living with HIV transition to adult services.

- Ask if there are any questions on the objectives, and then move on.

SESSION 2.
THE HIV SITUATION AMONG YOUNG PEOPLE 20 MINUTES

Aim of the session

- To review the HIV situation among young people

TIP FOR YOU
A guest who is an expert on HIV and AIDS can present this session. Remember to introduce him or her before the lecture starts.

Activity 2.1. Mini lecture

- The aim of this presentation is to show that HIV is an important health issue for young people in this country.
- Show the slides on regional and national statistics on HIV and AIDS, or ask the guest presenter to make a 20-minute presentation.

HIV in sub-Saharan Africa

- In 2013, there were 24.7 million people living with HIV.
- Women account for 58 percent of the total number of people living with (PLHIV).
- In 2013, there were an estimated 1.5 million (1.3 million–1.6 million) new HIV infections.
- Sub-Saharan Africa accounts for almost 70 percent of the global total of new HIV infections.
  - 1.1 million (1.0 million–1.3 million) people died of AIDS-related causes in 2013.
- Treatment coverage is 37 percent of all PLHIV in sub-Saharan Africa.
- 67 percent of men and 57 percent of women were not receiving ART in sub-Saharan Africa in 2013.
- Three out of four people on ART live in sub-Saharan Africa.
- There were 210,000 (180,000–250,000) new HIV infections among children in sub-Saharan Africa in 2013.

SOURCE: National AIDS Commission and UNAIDS. 2013. *Modes of Transmission Study – Know your Epidemic.* Lilongwe, Malawi: Ministry of Health.

HIV in Malawi

- According to the 2010 MDHS, the national adult HIV prevalence is 10.6 percent.
- As of 2013, there were an estimated 1 million PLHIV in Malawi.
- An estimated 850,000 adults ages 15 and up are living with HIV.
- An estimated 170,000 children ages 0–14 are living with HIV.
- The estimated number of new HIV infections (all ages) in Malawi is now at 34,000 annually.
- As shown in the 2010 MDHS, HIV prevalence was 14.5 percent in the southern region, 7.6 percent in the central region, and 6.6 percent in the northern region.
- HIV prevalence is higher in urban areas (17.4%) than in rural areas (8.9%).
- As of 2013, 48,000 deaths in Malawi were due to AIDS.
- An estimated 790,000 children ages 0–7 have been orphaned by AIDS.

SOURCE: (unless otherwise noted): National AIDS Commission and UNAIDS. 2013. *Modes of Transmission Study – Know your Epidemic.*

HIV Among Youth in Malawi

- The share of those ages 15–19 ever tested for HIV is 44.1 percent (MDHS 2010).
- Overall, 4 percent of youth ages 15–24 have tested positive for HIV.
  - 2.7 percent of those ages 15–19
  - 4.7 percent of those ages 20–24
- Prevalence is higher among young women (5%) than among young men (2%).
- HIV prevalence increases with age, from 3 percent among youth ages 15–19 to 4 percent among youth ages 20–22 to 6 percent among youth ages 23–24.
- For young women, HIV prevalence increases from 3 percent among women ages 15–17 to 6 percent among women ages 18–22 to 8 percent among women ages 23–24.
- For young men, the increase in HIV prevalence is not linear. Prevalence is 2 percent for men ages 15–17, decreasing to less than 1 percent for men ages 18–19. Prevalence then increases to 2 percent among men ages 20–22 and continues to increase to 5 percent among men ages 23–24.

SOURCE: (unless otherwise noted): National AIDS Commission and UNAIDS. 2013. *Modes of Transmission Study – Know your Epidemic.*

TIP FOR YOU

- Encourage a relaxed environment to allow participation of all participants.
- Encourage participants to share any facts and figures they have, as well as their opinions, views, and impressions.
- If any participants are from NGOs, a network of PLHIV, or AIDS activists, you can ask them to bring their knowledge to this discussion, which focuses on young people and HIV locally.

- Ask participants if they have any questions on the local situation regarding HIV among young people. Ask them to share any information they may have on this situation. Let the participants control the direction of the discussion but, if necessary, ask questions that build on the discussion. For example:
  - Are there specific groups of young people who are more likely to acquire HIV?
  - Is there a difference between rural and urban situations for young people?
  - Is there a difference in the issues for young men and young women?
- Thank the guest presenter (if one was invited).

Wrap-up

Tell participants that in this session, we have seen that young people are central to the HIV epidemic. They are now aware of the HIV situation among young people in sub-Saharan Africa, Malawi, and locally. Fortunately, most young people are not HIV positive. In fact, during adolescence, Malawi's HIV rates are the lowest of any period in the population life cycle. The challenge is to keep these young people HIV free and help the rest to live with HIV positively. Focusing on young people is likely to be the country's most effective approach in confronting the epidemic.

SESSION 3.
RISK FACTORS AND PROTECTIVE FACTORS FOR HIV TRANSMISSION AMONG YOUNG PEOPLE 20 MINUTES

Aim of the session

- To discuss risk factors and protective factors for HIV transmission among young people

Activity 3.1. Mini lecture

Instructions

- Tell the participants that we are now going to talk about risk factors and protective factors for HIV transmission among young people.
- Ask them to define:
  - Risk factors
  - Protective factors
- Then show the slide below and go through the talking points.

RISK FACTORS	SIGNIFICANT PROTECTIVE FACTORS	OTHER PROTECTIVE FACTORS
• Lack of information • Unprotected sex (anal and vaginal) • Sex work • Becoming a sex worker at an early age • Multiple and concurrent sexual partners • Current or past history of genital ulcers • Current or past history of STIs • Early age of sexual debut • Having sex with older men • Being sexually violated • Living on the street • Being a migrant worker • Living without parental support • Being orphaned as a child or affected by HIV • Being caught in disaster-prone and disaster-affected areas • Being born of an HIV+ mother	• Consistent and correct use of condoms • Having a partner who has undergone VMMC • Reduced number of sexual partners	• Getting tested for HIV • Positive relationships with parents, teachers, and other adults in the community • Feeling valued • Positive school environments • Exposure to positive values, rules, and expectations • Having spiritual beliefs • Having a sense of hope for the future

Talking points

1. Risk factors are individual and contextual influences that either encourage or are associated with behaviours that might lead to a negative health outcome. Risk factors can also discourage behaviours that might prevent a negative health outcome.

2. Protective factors are individual and contextual influences that discourage one or more behaviours that might lead to negative health outcomes, or encourage behaviours that might prevent negative health outcomes. Protective factors can lessen the likelihood of negative consequences from risk factors.

For example, a negative health outcome is acquiring HIV. The risk factors are the influences that encourage behaviours that might lead to HIV transmission (e.g., influences that encourage early and unprotected sex, encourage young people to have many sexual partners, or encourage injecting drugs) and discourage behaviours that might prevent HIV (e.g., discourage condom use or make it difficult to delay sexual debut).

Another risk factor for HIV is the lack of knowledge about HIV transmission. This may be because sexuality is not discussed in the family, because there is no teaching about sexuality in the school, or because a young person receives inaccurate information from peers.

Ask if there are any questions, and respond accordingly. Then show the next slide and go through the talking points.

Vulnerability to HIV

When there is

- Inability to control the risk of acquiring HIV
- Absence of choice to engage in behaviour that puts one at risk of acquiring HIV
- Increased likelihood of negative health outcomes

Talking points

1. Vulnerability is a measure of an individual's or community's inability to control the risk of infection.

2. Vulnerability recognizes that young people may not have a choice as to whether they engage in behaviour that puts them at risk of acquiring HIV.

3. Vulnerability increases the likelihood of negative health outcomes. There are social and contextual risk factors that make many young people vulnerable to HIV. Among these are gender norms, sexual relations between different age groups, racial and other social or cultural norms and value systems, location, and economic status.

For example, women—especially young women—may be less able than men to avoid non-consensual sexual relations, thus increasing their vulnerability to acquiring HIV.

Refer the participants to **Box 46 in the unit on HIV and AIDS in their handbook** (presented here as well for the convenience of facilitators).

Gender and HIV

In heterosexually driven HIV epidemics, as in Malawi, young women are disproportionately affected due to biological as well as socially defined gender differences. Gender norms allow men and boys to have multiple concurrent sexual partners and accept or encourage older men to have sexual relations with younger women, leading to HIV prevalence rates that are much higher among young women than young men.

Gender power imbalances, patterns of sexual networking, and age mixing are all important factors in HIV transmission, especially for young women. As a result of traditions, young women may remain ignorant of the facts of sexuality and HIV because they are not "supposed" to be sexually knowledgeable, whereas young men may remain ignorant because they are "supposed" to be sexually all-knowing.

Young women often lack the power to negotiate safer sex. Young women (who are often more socially, economically, and physically vulnerable to HIV than men) may be unwilling to learn their HIV status or share that information for fear of violence and/or abandonment if the test result is positive.

Societies must address issues that affect the vulnerability of women and girls (e.g., gender-based violence, poverty, property rights, and education) and also issues that affect the vulnerability of boys and young men (e.g., visits to sex workers, poverty, injecting drug use, and negative attitudes related to sexuality).

Healthcare workers have a role in developing programmes that empower women and girls and reduce their vulnerability to and risks for HIV. These should be part of comprehensive SRH strategies.

SOURCE: Adapted from the World Health Organization.

Activity 3.2. Mini lecture (biological susceptibility)

Instructions

- Tell the participants that we will now look at biological susceptibility.
- These are the biological factors (factors about the youthful body) that can decrease a young person's defences against HIV transmission following exposure through sexual intercourse. In other words, this discussion refers to the ease with which the HIV virus can enter the cells of a person following his or her exposure to the virus.
- Show the following slide; instead of reading it aloud, lead the participants through the talking points.

Biological issues that increase the likelihood of HIV transmission in young people

Upon exposure to HIV, young people are more likely to acquire HIV for the following reasons:

- Immature genital tract in young girls
- Undeveloped genitalia, which are more easily damaged during forced sex
- Presence of an STI

Talking points

In young girls, inadequate mucosal defence mechanisms and the immature lining of the cervix are poor barriers against exposure to the virus. Once exposed, girls and young women are more susceptible to infection than young men or adults, owing to the anatomy of the developing cervix and vagina. Also, in young girls, the thin lining and relatively low acidity in the vagina facilitate transmission.

Non-consensual sex with a girl with undeveloped genitalia can lead to trauma and therefore increase the chance of transmission following exposure to HIV. In many settings, young girls are subjected to a high rate of coerced sex.

STIs among sexually active people increase the chance of contracting and transmitting HIV.

Ask if there are any questions about the information on this slide and then respond.

SESSION 4.
KEY HIV PREVENTION STRATEGIES AMONG YOUNG PEOPLE 30 MINUTES

Aim of the session

- To discuss key HIV prevention strategies among young people

Activity 4.1. Buzz group

Instructions

- Ask participants to form groups of three members each and have them identify HIV prevention strategies for young people. Ask participants to write their responses on a flip chart page or VIPP cards and select one representative from each group to present in plenary.

Activity 4.2. Plenary feedback and discussion

Instructions

- Allow the groups to present their discussions. Summarise the discussion using the following information.
- Display the slide below.

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

- Conclude the session by going over the following talking points.

Talking points

Young people need more information and education on sexuality and HIV prevention to help them practice responsible sexual behaviour. Postponing the first sexual activity (for young people who are not yet sexually active) and reducing the number of sex partners can significantly protect young people from HIV. The messages and the way the messages are given are very important. Young people do not want to hear only what they cannot do, but also what they can do.

In some settings, health workers have held group counselling sessions for both HIV-positive and -negative young people to discuss difficult situations in the area of HIV prevention. This method can create a good interaction because the group will look for solutions to these situations, thus taking the focus away from the individual.

Provider-initiated HIV testing and counselling needs to be available in all health services and in the community. Client-initiated or voluntary counselling and testing services are also needed.

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.

Some STIs greatly facilitate HIV transmission between sexual partners. Effective prevention and early, correct treatment of STIs are essential parts of HIV prevention for young people.

Since 2007, WHO and UNAIDS have recommended VMMC as an additional important strategy for HIV prevention, particularly in settings with high HIV prevalence and low levels of male circumcision, where public health benefits will be maximised. In Malawi, the national VMMC program was formally launched in 2012 to expand male circumcision services. VMMC reduces the risk of female-to-male sexual transmission of HIV by approximately 60 percent. A one-time intervention, VMMC provides men with lifelong partial protection against HIV as well as other STIs. It should always be considered as part of a comprehensive HIV prevention services package and used in conjunction with other methods of prevention, such as female and male condoms.

SESSION 5.
VOLUNTARY MEDICAL MALE CIRCUMCISION (VMMC) AND ITS ROLE IN HIV PREVENTION 40 MINUTES

Aim of the session

- To discuss the concept of voluntary medical male circumcision and its role in HIV prevention

Activity 5.1. Mini lecture

Instructions

- Present the following slides as part of your lecture on VMMC.

Definition of VMMC

Circumcision is the surgical removal of the foreskin—the fold of skin that covers the head of the penis. Widely practiced for religious and traditional reasons, it may also be performed for medical reasons to treat problems involving the foreskin.

Minimum age for VMMC: Any person age 17 and above can elect to have the procedure; boys between ages 10–17 must have the consent of a parent or guardian.

How circumcision is performed

The foreskin is freed from the head of the penis (glans) and removed. Superficial wound healing after circumcision in adults generally takes five to seven days. However, about four to six weeks are needed for the wound to heal fully.

Male circumcision and HIV infection

The foreskin contains a high concentration of cells of Langerhans, which have receptors for HIV entry.

Circumcision reduces the risk of HIV acquisition by taking off these cells through the removal of the non-keratinised skin that makes up the foreskin (also called the prepuce).

Circumcision also reduces HIV transmission by reducing the risk of acquiring STIs and by reducing micro trauma and abrasions.

BENEFITS	RISKS
• It is easier to keep the penis clean. • There is a reduced risk of acquiring HIV. • There is a reduced risk of some STIs, especially ulcerative diseases, such as chancroid and syphilis. • There is a reduced risk of cancer of the cervix in female sex partners. • There is a reduced risk of penile cancer. • There is a reduced risk of urinary tract infections in childhood. • Circumcision prevents inflammation of the glans (balanitis) and the foreskin (posthitis). • Circumcision prevents the potential development of scar tissue on the foreskin, which may lead to phimosis (inability to retract the foreskin) and paraphimosis (swelling of the retracted foreskin, resulting in inability to return the foreskin to its normal position).	• Pain • Bleeding • Haematoma (formation of a blood clot under the skin) • Infection at the site of the circumcision • Increased sensitivity of the glans penis for the first few months after the procedure • Irritation of the glans; meatitis (inflammation of the opening of the urethra) • Adverse reaction to the anaesthetic used during the circumcision

Talking points

- Malawi has adopted VMMC as a key strategy for HIV prevention, especially among young people.
- Adolescents ages 10–17 years need the consent of a parent or guardian to undergo VMMC. Any person age 17 and older can make a voluntary choice to have the procedure.
- Male circumcision does not provide full protection against HIV but appears to reduce the risk of infection by 50–60 percent.
- It gives little or no protection against STIs that affect the urethra, such as gonorrhoea and chlamydia.
- It provides no protection against acquisition of HIV from unsafe injections or infected blood products, or through receptive anal intercourse. It also does not prevent pregnancy.
- To reduce the risk of STIs, including HIV, and unwanted pregnancy, comprehensive education and information programmes are needed, as well as services for contraception and STI prevention and management.
- In many societies where male circumcision is performed as a rite of passage to adulthood, the circumcision festival period also can be used to educate young men about health and social issues. These cultural traditions can be harmonised with modern clinical practice to ensure the safety of circumcision and educate young men about a number of SRH issues.

Activity 5.2. Brainstorming

TIP FOR YOU
Invite a young person to share his experience of the circumcision process.

Instructions

- Ask participants to brainstorm on local myths and misconceptions (what people say) surrounding VMMC. Let them bring out rumours and stories about VMMC that people pass around in their communities.

What do people (especially young people) say about VMMC—myths and misconceptions about VMMC?

- Allow 15 minutes for discussion.

Talking points

Trained providers and people working with young people should always dispel these rumours and beliefs because they are misleading and can prevent young people from accessing services.

A possible consequence of promoting male circumcision for HIV prevention is that circumcised men may perceive themselves as immune and subsequently increase their exposure to HIV, ignoring other important strategies to reduce risk.

Activity 5.3. Group exercise

Instructions

- Divide the participants into four buzz groups and ask them to work on the question in the box below. Allow 5 to 10 minutes for the discussion.

What is the cultural view of male circumcision, and has that view changed as a result of evidence linking it to HIV prevention?

- Let each group present in plenary for two minutes. Wrap up the session by summarising the inputs from all of the groups.

SESSION 6. YOUNG PEOPLE LIVING WITH HIV 20 MINUTES

Aim of the session

- To discuss the meaning of positive living and the care and support of young people living with HIV

Activity 6.1. Brainstorming

Instructions

- Ask participants to brainstorm on the meaning of positive living and the care and support required for young people living with HIV to live positively.
- Put the responses on a flip chart page or let participants write their definition on the VIPP cards. Post these to a wall.
- Once all responses are posted, ask the participants to group them by common themes.

Activity 6.2. Mini lecture

Instructions

- Conclude the session by displaying the slides below.

Positive Living

Young people living with HIV can delay the onset of AIDS and prolong their lives by making positive choices to care for their mental and physical health. Examples of these choices are the following:

- Stay healthy and live positively.
- Adhere to treatment and care.
- Disclose HIV status.
- Cope with stigma and discrimination.
- Practice risk-reduction behaviours; avoid smoking and drinking alcohol.
- Exercise regularly.
- Get adequate rest; enjoy leisure.
- Avoid stress and worry; spend time with friends.

Talking points

1. **Living positively.** Positive living can help all PLHIV to live full and healthy lives. Counselling and support can help them to stay healthy and improve their self-esteem and confidence, with the aim of protecting their own health and avoiding transmission to others.

2. **Support.** This is the emotional, psychosocial, spiritual, and material support that will enable PLHIV to live positively. Support is often provided by peers, family, and community, as well as the health services. This support can be given only when HIV status is known and when the people who are able to give this support know that the person is HIV positive. Thus, it is important, when possible, to disclose one's HIV status.

3. **Care.** ART is provided to PLHIV to boost their immune systems. Adherence to ART is important for the health of the individual and to reduce the risk of drug resistance. However, many young people living with HIV will remain asymptomatic for long periods after an HIV-positive test result. These young people may require care and treatment for opportunistic infections, STIs, and so forth over the years; for many of them, however, ART will be required only after many years of living with HIV, when the immune system has substantially deteriorated.

4. **Positive prevention.** This comprises all strategies that increase the self-esteem, confidence, and preventive actions of PLHIV, with the aim of protecting their own health and avoiding transmission. Examples are safer and healthier sex, harm reduction, PMTCT, and management of STIs. Positive prevention can also include provision of safe drinking water, insecticide-treated bed nets, and chemoprophylaxis (e.g., co-trimoxazole and isoniazid preventive therapy). Counselling is an integral part of all these services.

5. **Transitioning to adult services.** General principles for effective transitioning are the following:

    - Individualise the approach used.
    - Identify adult care providers who are willing to care for adolescents and young adults.
    - Begin the transition process early and ensure communication between the paediatric/adolescent client and adult care providers before and during transition.
    - Develop and follow an individualised transition plan for the client in the paediatric/adolescent clinic; develop and follow an orientation plan in the adult clinic. Plans should be flexible to meet the adolescents' needs.
    - Use a multidisciplinary transition team, which may include peers who are themselves in the process of transitioning or who have transitioned successfully.
    - Address the psychosocial and financial aspects of transitioning.
    - Allow adolescents to express their opinions.
    - Educate HIV care teams and staff about transitioning.

SESSION 7. PSYCHOSOCIAL ISSUES FOR YOUNG PEOPLE LIVING WITH HIV 40 MINUTES

Aim of the session

- To discuss the psychosocial issues of young people living with HIV

Activity 7.1. Group discussion

Instructions

- Tell participants that they will now discuss some difficult situations that young clients often find themselves in, as indicated in the box below. Divide participants into smaller groups and ask the groups to explain how they can support young people living with HIV on the following issues.

- Will anyone want to have sex with me if they know I am HIV positive?
- Will I be able to have children?
- Will I die early?
- I am too young to have a chronic disease.
- I can't tell anyone that I am HIV positive
- I am afraid that people will reject me, shun me, or be violent towards me.
- Can I still smoke, drink, go out, and have fun like my friends?

- Allow 20 minutes for participants to complete the task.

Activity 7.2. Plenary feedback and discussion

Instructions

- Bring participants back to plenary to present their consensus.

Talking points

- Will anyone want to have sex with me if they know I am HIV positive?
  - Yes, but condom use is very important.
- Will I be able to have children?
  - Like all people, young people living with HIV have the right to have children.
- Will I die early?
  - People with HIV might never develop AIDS, and in any case can live a healthy life. HIV is not a death sentence. Following guidance on proper adherence to drugs and nutrition and taking advantage of services for support and care can help one live a longer, healthier life. Emotional and spiritual support are also key.
- I am too young to have a chronic disease.
  - Adolescence is a special time in people's lives. All people have dreams for the future, so to learn that you must live with HIV is shocking news at any age. However, counselling and support will help you live your life positively.
- I can't tell anyone that I am HIV positive.
  - It is very difficult for people to disclose their HIV status, especially when stigma and discrimination are strong in some societies. Again, generally young people are healthy, so sharing one's HIV-positive status could be shocking for peers. Nevertheless, evidence shows that disclosure has many advantages over nondisclosure.
- I am afraid that people will reject me, shun me, or be violent towards me.
  - Young people living with HIV may have feelings of loneliness and isolation. They may lose friends because they are HIV positive. They may also be wary of revealing their status to anyone (sex partner, peers, family members, school officials, etc.) for fear that disclosure will ruin their image, plaguing them with the stigma associated with HIV. Although this may be true for anyone, young people have heightened difficulty because, to a certain extent, they base their self-worth on what other people think of them. Stigma and discrimination are serious barriers to HIV prevention.
- Can I still smoke, drink, go out, and have fun like my friends?
  - Young people living with HIV should be encouraged to live the same life as their friends, but they may need to be more aware of maintaining their good health and avoiding activities that jeopardise it. Alcohol intake and smoking may need to be significantly reduced or stopped altogether. These habits will need to be replaced with exercise and good nutrition.

SESSION 8.
UNIT REVIEW 10 MINUTES

Activity 8.1. Spot checks

Instructions

- Ask the participants to pull out the spot checks they completed earlier. Go over each of the spot checks with them.

UNIT 3G. SPOT CHECKS

1. In Malawi, what percentage of all new HIV infections per year includes young people?

_____

_____

2. Why are young people more likely to be exposed to HIV? List three reasons.

_____

_____

3. Why are girls and young women biologically or culturally/socially vulnerable to HIV acquisition upon exposure? List three reasons.

_____

_____

4. How does VMMC help reduce HIV acquisition?

_____

_____

5. How confident do you feel about working with young people on the issues of HIV?

a. Not confident b. Not very confident c. Confident d. Very confident

6. Mention four HIV prevention strategies for young people.

_____

_____

_____

_____

Activity 8.2. Unit objectives

Unit objectives

1. Describe the HIV situation in Malawi.
2. State the risks and protective factors in HIV transmission.
3. Explain young women's vulnerability to HIV.
4. List the five key HIV prevention strategies young people can access through health services.
5. Discuss the roles various people can play in HIV prevention advocacy.
6. List any three of the five questions health workers should ask when planning HIV prevention services for young people.
7. Explain the role of VMMC in HIV risk reduction.
8. Discuss youth-focused strategies to promote HIV testing and counselling.
9. Discuss the role of health personnel in supporting young people living with HIV to maintain optimal health.
10. Describe positive prevention for these young people.
11. State the key information that health personnel can provide when addressing psychosocial issues pertinent to these young people.
12. Discuss effective ways to help young people living with HIV transition to adult services.

Activity 8.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 8.4. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 4.
NUTRITION AND YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 15 MINUTES

Aim of the session

- The aim of the session is to provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants and inform them that the unit consists of five sessions in addition to the introduction and unit review; the sessions will explore different aspects of nutrition in young people.
- Display the unit objectives below and read each one aloud.

Unit objectives

1. Explain the importance of good nutrition.
2. Describe the state of nutrition in Malawi.
3. Enumerate the six groups of food necessary for good nutrition.
4. Explain the linkage between nutrition and HIV.
5. List the signs and symptoms of malnutrition.
6. Discuss the consequences of poor nutrition among adolescents and young people.
7. Discuss how you would promote good nutrition among young people.

Activity 1.2. Spot checks

Instructions

- Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

SESSION 2. IMPORTANCE OF GOOD NUTRITION 15 MINUTES

Aim of the session

- To discuss the importance of good nutrition among adolescents and young people

Activity 2.1. Mini lecture

Instructions

- Explain that you will define nutrition and then discuss the importance of good nutrition.
- Present information showing the importance of good nutrition. Do not read this aloud; instead, go over the talking points presented below.

- Definition of good nutrition
- Status of nutrition in Malawi
- Benefits of good nutrition

Talking points

DEFINITION OF NUTRITION

- Nutrition is generally defined as the process by which a living organism takes in and uses food. Food is anything that a person eats or drinks.
- It is from this food that we get nutrients. Nutrients are necessary for life and health.

STATUS OF NUTRITION IN MALAWI

Information on the status of adolescent nutrition in Malawi, as in many other parts of the world, is limited because it is not routinely collected. Nonetheless, nutrition indicators in the under-five age category suggest that Malawi faces a big problem. According to the 2010 MDHS:

- 47 percent of children under age five are stunted (too short for their age)
- 20 percent of children are severely stunted
- 4 percent of children are wasted or too thin
- 13 percent are underweight

Stunted growth of children is an indicator of under-nutrition and is typical of poor nutrition experienced over a long period.

GOOD NUTRITION

- Good nutrition means that the food and drink consumed provide the essential nutrients needed for an individual's good health and survival.

Benefits of good nutrition

- Promotes good physical and mental growth and development in all stages of life
- Boosts body immunity to protect against infection (most antibodies are formed from proteins)
- Supplies vitamins, which form enzymes, which in turn help in metabolising
- Promotes optimal brain functioning
- Facilitates good functioning of all body systems: digestive, reproductive, nervous
- Supports regeneration of body cells
- Develops and maintains healthy bones and skin

TIP FOR YOU

Encourage questions and comments. Do not feel obliged to respond to all of them yourself. Invite other participants to respond. This will help the participants to relax and feel comfortable about sharing any information they have and—more important—about voicing their thoughts and feelings.

- There are two overall benefits of good nutrition for young people: maintaining good health and protecting against infection.
- The immune system is made up of antibodies that fight disease. Antibodies are largely formed from proteins. Thus, good nutrition enhances the body's capacity to fight infection.

Activity 2.2. Plenary discussion

Instructions

- Ask participants to write on a flip chart page what they think could be additional benefits of good nutrition for young people. Also ask them to relate the importance of good nutrition for young people living with HIV. Invite questions and comments and write down key important elements.

SESSION 3.
GROUPS OF FOOD NECESSARY FOR GOOD NUTRITION 1 HOUR

Aim of the session

- To present the six groups of food necessary for good nutrition (the Malawi balanced diet)

Activity 3.1. Exercise

Instructions

- Divide participants into groups of five and ask each group to create menus for the week or the day. Then let each group present their menus in plenary.
- Allow for critiquing to see how the menus align with "ideal" nutrition standards—especially incorporating all six food groups. Allow 20 minutes for discussion.
- Follow up with the mini lecture below.

Activity 3.2. Mini lecture

Instructions

- Start by giving a mini lecture on the six food groups in Malawi.
- Display the six food groups listed below.
- After the session, supplement this information by referring participants to their handbook, where the food groups are discussed in more detail.

SIX FOOD GROUPS

- Vegetables
- Fruits
- Legumes and nuts
- Meat from food animals
- Fats and oils
- Staples

Talking points

- It is very important for young people to maintain a balanced diet in their daily food intake. A balanced diet entails consumption of all six food groups in meals throughout the day.
- Each food group can be found locally and at reasonable prices. Thus, it is possible to maintain a balanced diet despite low household economic status.

GROUP	MAIN NUTRIENT	EXAMPLES OF FOODS	THEIR ROLE IN THE BODY
Vegetables	Vitamins and minerals	Greens: bonongwe, chisoso, luni, Chinese cabbage, mpiru Fruits: pumpkin, tomatoes, peppers Roots: onion, garlic Mushrooms Flowers: pumpkin flowers	Fight infections
Fruits	Carbohydrates and vitamins (water and fibre)	Sweet or tangy fruits, often eaten raw Fruits (except for ones in the fats or vegetables groups): papaya, guava, lemon, tangerine, banana, mchisu, granadilla Honey and sugar cane (these provide vitamins and carbohydrates)	Aid in food digestion and help form enzymes
Legumes and nuts	Protein and carbohydrates (minerals, vitamins, fibre, fats)	Legumes are seeds in a pod Beans and peas: hyacinth beans (khungudzu), ground beans (nzama), soybeans, pigeon peas (nandolo), peas (nsawawa), mucuna (kalongonda) Nuts: mtedza	Body maintenance Muscle and tissue development
Food from animals	Protein and fats (minerals and vitamins)	Flesh, blood: mice, chicken, pigeon, pig, goat, fish, cow, lamb, ngumbi (flying ants), caterpillars Eggs Milk and milk products: milk, chambiko, cheese	Energy-giving foods Body maintenance
Fats and oils	Fats (minerals, vitamins, proteins)	Foods that feel "fatty" in your mouth Oilseeds: pumpkin seeds, sesame seeds, sunflower seeds, cooking oils Fruits: avocado pears, coconut flesh Animal fats: butter, lard	Energy-giving foods
Staples	Carbohydrates (protein, minerals, vitamins)	Seeds without a pod and starchy roots Grains: rice, wheat, sorghum, millet, maize Starchy roots: yams (chilazi, viyao), sweet potatoes, Irish potatoes, cassava	Energy-giving foods

SESSION 4. LINKAGE OF NUTRITION TO HIV AND AIDS 30 MINUTES

Aim of the session

- To explain the relationship between nutrition and HIV and AIDS

Activity 4.1. Mini lecture

Instructions

- Present the recommendations from the *National Nutrition Guidelines for Malawi* (2007) on how people, including young people living with HIV, can maintain a high standard of health.

Essential actions to improve the nutritional status of PLHIV

- Eat a variety of foods from the six food groups every day.
- Eat foods that are not highly refined: for example, eat whole wheat brown bread rather than white bread, and use mgaiwa rather than white maize flour.
- Eat fermented foods such as chambiko, yoghurt, and thobwa.
- Eat small, frequent, and diversified meals throughout the day (at least six times a day).
- Eat a lot of fruits and vegetables every day.
- Eat boiled, steamed, or roasted foods rather than fried foods (they are more easily digested).
- Observe all hygiene rules to avoid germs that may cause diseases. For example, prepare food in a clean environment; ensure that fruits and vegetables are washed well.
- Drink at least two litres of clean, safe water every day.
- Exercise every day to keep fit.
- Get treatment for any illness as soon as possible because each infection weakens your immune system.
- Eat food with less sugar added. Sugar encourages the growth of yeast and can cause thrush (candidiasis), for example.
- Reduce the intake of coffee and tea because they deplete water and reduce the absorption of such nutrients as iron.
- Avoid alcohol and tobacco because they suppress the immune system.
- Include foods that are rich in selenium, vitamin A, zinc, vitamin B complex, vitamin C, folic acid, magnesium, iron, calcium, vitamin E, and iodine.
- Eat micronutrient-rich foods such as whole grains, roots, fruits, vegetables, legumes, and nuts.
- If digesting milk is a problem, avoid it.

Talking points

- Research has shown an important link between HIV and AIDS and nutrition. Adequate nutrition is necessary to maintain the immune system, manage opportunistic infections, optimise response to medical treatment, sustain healthy levels of physical activity, and support optimal quality of life for PLHIV and young people living with HIV.
- Studies suggest that good nutrition may help to slow the progression of HIV.
- With high poverty levels among young people in Malawi, poor nutrition among young people living with HIV is a major concern.
- Postponing interventions until PLHIV or their families become malnourished or food insecure can be counterproductive and costly. Thus, maintaining adequate nutrition and food security can be instrumental in mitigating the impact of HIV and caring for PLHIV, their affected households, and their communities.

Activity 4.2. Plenary discussion

Ask the participants to give their personal experiences on what they have observed in their places of work or communities when they were caring for people living with HIV. Did they observe any potential linkage between HIV and nutrition and food security? Ask them to share their experiences with their colleagues and invite someone to take notes on a flip chart page.

Wrap-up

Summarise the discussion in the plenary and inform the participants about the need to include nutrition in their HIV and AIDS programming with adolescents and young people. This can mitigate the impact of HIV and AIDS on the individuals, families, and communities.

SESSION 5. CONSEQUENCES OF POOR NUTRITION 15 MINUTES

Aim of the session

- To discuss the effects and consequences of poor nutrition among adolescents and young people

Activity 5.1. Buzz groups

Instructions

- Divide the participants into groups of three.
- Ask them to brainstorm in their respective groups and come up with what they think are the consequences of poor nutrition.
- Ask them to write their answers on VIPP cards. Give them 15 minutes to complete this task.
- Ask participants or display the question below to start the buzz groups on the effects and consequences of poor nutrition.

What could be the effects and consequences of poor nutrition among adolescents and young people?

Activity 5.2. Plenary feedback and review

Instructions

- Ask each group to come to the front and make their presentation. Advise the groups to post their idea cards on the board and present their conclusions one by one.
- After they have finished their presentations, open the floor for discussion. Ask participants to prioritise the grave consequences of poor nutrition for adolescents and young people that need immediate attention in their respective communities.
- Ask the participants to keep these consequences somewhere safe because we will come back to them in Session 6.

Activity 5.3. Mini lecture

Instructions

- Wrap up the session by giving the following mini lecture.

Consequences of poor nutrition

- Obesity
- Anaemia (in pregnancy, it can lead to such complications as maternal death, low birth weight, and foetal death)
- Risk of developing such conditions as diabetes, high blood pressure, and joint problems (gout)
- Growth retardation (stunting)/under-development
- Poor physical and mental development
- Poor wound healing
- Bone malformation
- Increased susceptibility to infections (due to weak immunity)

Talking points

- Obesity refers to weight more than 20 percent above the standard for one's height. Some of the predisposing factors to obesity are high intake of fatty foods and unregulated intake of carbohydrates.
- Diabetes mellitus (DM) is a chronic, lifelong condition that affects the body's ability to use food energy. The body normally breaks down sugars and carbohydrates into a sugar called glucose, which fuels cells in the body. For this to happen, the body uses insulin. When the body does not produce enough insulin, or the insulin produced cannot be used, there is a build-up of sugar in the blood. High levels of blood sugar damage tiny blood vessels, the kidneys, the heart, the eyes, and/or the nervous system. Common signs and symptoms of diabetes are dehydration, a flushed face, nausea and vomiting, fruity breath odour, and lethargy, among others.
- Blood pressure measures how hard the blood pushes against the walls of the arteries as it moves through the body. High blood pressure (hypertension) is a consistent systolic blood pressure of more than 140 mmHg and or a consistent diastolic blood pressure of more than 90 mmHg. Risk factors for developing hypertension are a high-salt diet, obesity, excessive alcohol intake, ageing, family history, and emotional stress.
- Gout is a metabolic disorder that causes extreme pain, swelling, and erythema of the involved joints. Prolonged hyperuricaemia (elevated uric acid) is caused either by synthesising purines or poor renal excretion of uric acid. Unregulated intake of excess proteins is a risk factor.
- Stunting refers to the condition of being too short for one's age; it is a common measure of chronic malnutrition among children under the age of five. According to the MDHS (2010), 47 percent of children under age 5 are stunted (too short for their age). This has negative implications in adolescence and later in life.
- Adolescent malnutrition has not yet been exhaustively studied in Malawi. However, it is an important component of physical and mental growth.

SESSION 6. PROMOTING NUTRITION AMONG ADOLESCENTS AND YOUNG PEOPLE 15 MINUTES

Aim of the session

- To identify and discuss how to promote good nutrition among adolescents and young people

Activity 6.1. Brainstorming

Instructions

- To begin this session, ask participants to recall the discussion on nutrition (Unit 4, Session 2).

How can we promote good nutrition among adolescents and young people?

- Ask participants to write down what they recall on the subject.
- Once the participants finish writing, ask them to post their responses on a flip chart page and then discuss the suggested responses.
- Discuss the slide below, along with the points raised by participants.

- Eat a variety of foods.
- Eat locally available foods.
- Avoid eating too many saturated fats and cholesterol-rich foods.
- Eat food with adequate starch and fibre.
- Avoid eating too much processed sugar.
- Avoid eating too much sodium/salt.
- Reduce intake of alcohol.

SESSION 7.
UNIT REVIEW 10 MINUTES

Aim of the session

- To review and discuss the answers to the spot checks completed during the first session
- To review the unit objectives and summarise what has been discussed

Activity 7.1. Review of the objectives

Instructions

- Display the unit objectives once more and go over them with the participants. Find out if the participants feel they were met.

Unit objectives

1. Explain the importance of good nutrition.
2. Describe the state of nutrition in Malawi.
3. Enumerate the six groups of food necessary for good nutrition.
4. Explain the linkage between nutrition and HIV and AIDS.
5. List the signs and symptoms of malnutrition.
6. Discuss the consequences of poor nutrition among adolescents and young people.
7. Discuss how you would promote good nutrition among young people.

Activity 7.2. Review of the spot checks

Instructions

- Ask participants to go over the spot checks they completed at the beginning of the session. Go over each question with them and ask them to make any corrections they wish.

UNIT 4. SPOT CHECKS

1. What is the definition and importance of good nutrition among young people in Malawi?

_____

_____

_____

2. What effects would you see among young people with poor nutrition?

_____

_____

_____

3. Explain the links that exist between HIV and AIDS and nutrition.

_____

_____

_____

4. How would you advise a young person to promote his/her nutrition?

_____

_____

_____

5. List the six groups of foods.

_____

_____

_____

Activity 7.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 7.4. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 5.
SUBSTANCE ABUSE AND YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 5 MINUTES

Aim of the session

- The aim of this session is to provide an overview of the unit and outline unit objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants. Inform them that this unit contains seven sessions (in addition to the introduction and unit review), which will explore different aspects of substance abuse in young people.
- Display the unit objectives listed below and read them aloud.

Unit objectives

1. Explain substance abuse and its magnitude in Malawi.
2. Explain reasons why young people misuse drugs in Malawi.
3. Discuss myths and misconceptions about substance abuse.
4. List the most commonly abused substances among young people in Malawi.
5. Describe how you would prevent substance abuse while working with young people.

Activity 1.2. Spot checks

Instructions

- Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

SESSION 2.
DEFINITION OF SUBSTANCE ABUSE AND ITS SCOPE AMONG YOUNG PEOPLE IN MALAWI 10 MINUTES

Aim of the session

- To define substance abuse
- To describe the scope of substance abuse among young people in Malawi

Activity 2.1. Mini lecture

Instructions

- Explain that you will define the following concepts to be used in this unit: "psychoactive substance" and "substance abuse."
- Display the slide below, which defines these concepts. Do not read this text aloud. Instead, go over the talking points presented below.

Definition of psychoactive substance and substance abuse

- Psychoactive substance: a substance that, when taken or administered into one's system, affects mental processes, such as cognition, which in turn affects other social and biological dimensions of human life
- Substance abuse: excessive use of a psychoactive substance

- Allow participants to comment on the definitions. Invite questions and comments and write important elements on a flip chart page. Refer participants to their handbooks for more definitions of concepts pertaining to psychoactive substances.

Talking points

Note that psychoactive substance abuse is a less common term in day-to-day language. Often people say "substance abuse" or "drug and/or alcohol abuse." Explain that these terms may be used interchangeably in this unit and outside of the training.

There is a paucity of data on the magnitude of substance use and abuse among young people in Malawi. However, if one visits drinking places and social events, one sees evidence that the youth use alcohol and other substances on a wide scale. Moreover, mental health institution records show that the majority of mental disorders attributed to psychoactive substance abuse are among young people.

SESSION 3.
WHY YOUNG PEOPLE IN MALAWI ABUSE SUBSTANCES 10 MINUTES

Aim of the session

- To discuss reasons why young people in Malawi abuse substances

Activity 3.1. Mini lecture

Instructions

- Ask participants to brainstorm reasons why young people use and abuse psychoactive substances. Write the responses on a flip chart page.
- Summarise the reasons that emerged in the brainstorming session. Then show the ones on the slide below.

Reasons why young people abuse drugs and other substances

- Peer pressure
- Easy to get/access due to ease of drug availability
- To seek peer approval
- Rapid social changes
- Stress and anxiety
- To relieve pain/use as a painkiller
- To stay awake when studying
- Emotionally deprived and lonely
- Frustrations
- Rejection by parents
- Idleness, boredom
- To diminish shyness and gain confidence
- Lack of knowledge about the dangers of drug use
- Poverty
- Over-indulged; have too much cash
- Curiosity about experimenting with drugs
- Some religious beliefs, such as the Rastafarian movement, which extols the virtues of cannabis
- To exercise their "democratic rights"
- Breakdown of cultural values

Talking points

Peer pressure is when young people do something just because their friends are doing it. They feel that they do not want to be left behind and desire their friends' approval.

Most young people in Malawi abuse drugs because they lack parental guidance and support. They may be from child-headed households or may not get adequate support from parents and significant others. Thus, they seek solace in using and abusing illicit drugs and other substances.

TIP FOR YOU
Note that these reasons will help in formulating prevention strategies in Session 7. Peer pressure is usually strongest among young people, so there is a need to get workable strategies from the participants for countering peer pressure.

Activity 3.2. Plenary discussion

Instructions

- Ask participants to comment on the reasons why young people abuse substances in their communities.
- Find out if the reasons mentioned are common in their communities.
- Ask for a volunteer to write down additional reasons. Keep this list for reference during Session 7, when we will discuss prevention of substance abuse.

SESSION 4.
MYTHS AND MISCONCEPTIONS ABOUT SUBSTANCE ABUSE 20 MINUTES

Aim of the session

- To discuss myths and misconceptions about substance use and abuse

Activity 4.1. Plenary session

Instructions

- Divide participants into two teams. One team will be "judges." Hand the judges statements about substance abuse drawn from Table 10. There should be a mix of true and false statements. The judges will read each statement aloud and both teams will take turns deciding whether it's a myth or not. Teams win points for right answers, and the team with the highest number wins.
- Allow 30 minutes for this activity. Then make a mini presentation with some explanations of the myths and facts of substance abuse.

Activity 4.2. Mini lecture

Instructions

- Talk about the myths and misconceptions about drugs and substance abuse listed in Table 10. (This is Table 16 in the *Participants Handbook*.)
- Compare the myths on your slides with those discussed in Activity 4.1.
- Encourage discussion about all of the points raised by this activity, and ask participants to share their experiences regarding this topic.

TABLE 10. Myths and facts about psychoactive drugs and substance abuse

ITEM	MYTH	FACT
1	Alcoholism is a condition that is difficult to cure.	Alcoholism is a condition that responds to treatment, which includes eliminating all alcohol consumption and taking advantage of psychosocial counselling.
2	Alcohol and chamba are the only drugs used by young people.	Alcohol and chamba are not the only abused drugs in Malawi. Examples of other drugs are tobacco, mandrax, glue, cocaine, heroin, and petrol.
3	Alcohol is not a drug. It is just an addictive substance.	Alcohol is both a drug and an addictive substance. It affects the mind, body, and social relationships with others.
4	Drinking alcohol among young people is hereditary.	Most young people are initiated into drug and alcohol use by their peers.
5	Driving after using chamba is not as dangerous as driving after drinking alcohol.	Like alcohol, chamba affects motor coordination, slows reflexes, and affects perception (the way we see and interpret events around us). All of these changes increase the likelihood of an accident while driving.
6	It is rare for a teenager to be an alcoholic.	Many teenagers abuse alcohol, and many are addicted.
7	Cigarette smoking is fashionable and not addictive.	Cigarettes contain nicotine and other added substances that are addictive. Cigarette smoking is harmful to your health. Smoking is associated with lung cancer. Smoking is especially dangerous for pregnant women because it affects the lungs and breathing of the foetus as well as the development of its brain.
8	Alcohol and drugs help young people handle their problems better.	Alcohol and drugs make young people temporarily forget about their problems. Their problems do not go away, however. In essence, alcohol and drug abuse alters cognitive functioning, consequently compromising the capacity of the young person to effectively solve his/her problem.
9	Substances such as glue (inhalants) are basically harmless, even though adults make a big deal about them.	Substances such as glue or petrol can be extremely dangerous. Unlike most drugs, inhalants can cause permanent damage to the liver, lungs, brain, or other organs.
10	A cup of coffee and a cold shower will sober a drunken person.	Drinking coffee and taking a cold shower will not sober a drunken person. One becomes sober only with the passage of time. It takes one hour for the liver to process one gram of pure alcohol.
11	Alcohol is a sexual stimulant.	Alcohol, like cocaine and other drugs, can actually depress a person's sexual desire and response. The drug may lessen inhibition with a sexual partner but it causes problems such as inability to have an erection, loss of sexual feeling, and inability to have an orgasm.
12	When people stop smoking cigarettes, they cannot reverse some of the damage to the body.	If there is no permanent heart or lung damage, the body begins to heal itself when a person stops smoking. Some cells can regenerate. The health-associated risks from smoking gradually decrease over time.
13	Cigarette smoking every now and then is not harmful.	As soon as people start smoking, they experience yellow staining of teeth, bad breath, and a shortness of breath that may affect their physical performance. Addiction to nicotine is very rapid. People who smoke for any period increase their risk of cancer and other lung diseases, cancer of the tongue and throat, and heart diseases. Every cigarette smoked damages the body.
14	Chamba is not harmful. It helps adolescents and young people study; become less shy; and be strong, powerful, and intelligent.	Chamba has long-term effects, such as a decrease in motivation, memory loss, damage in coordination, impaired judgment, damage to the reproductive system, and throat and lung irritation.

SOURCE: Adapted from FORUT and Malawi Girl Guides Association. n.d. "Drug and Alcohol Abuse Prevention Among Young People." (leaflet)

SESSION 5.
THE MOST COMMONLY ABUSED SUBSTANCES AMONG YOUNG PEOPLE IN MALAWI 30 MINUTES

Aim of the session

- To discuss the most commonly abused substances among young people in Malawi

Activity 5.1. Brainstorming and mini lecture

Instructions

- Tell participants that you are now going to discuss the substances most commonly abused by young people in Malawi, and their effects.
- Start the lecture with a brainstorming session. Ask participants what drugs and psychoactive substances are commonly used or abused by young people in their localities. Write the responses on a flip chart page. Take a few minutes for participants to describe the effects of each substance they mention.

TABLE 11. Commonly abused substances and their effects

Alcohol, especially spirits in sachets and small bottles	Alcohol is a depressant drug with adverse effects to one's health if taken in excess. It is the substance most commonly abused by adolescents and young people in Malawi.	Euphoria (exaggerated feeling of well-being) Intoxication Ataxia (staggering gait) Over-consumption leading to death, domestic violence, and unplanned sexual encounters Inflammation of the liver (liver cirrhosis)[14] Drains money from the individual and family Slurred speech Diminished ability to perform tasks (mind is clouded) Could lead to head trauma Nutritional deficiency
Tobacco products, including cigarettes	Tobacco is mostly used by young people. Tobacco contains nicotine, a tranquilising drug that is addictive. Nicotine is found in cigarettes.	Smoking over a long period increases the smoker's risk of lung cancer and heart attacks. Other systemic effects are reduced libido, respiratory infections, and low birth weight or premature babies.
Chamba	A dried plant called cannabis sativa. It is known by different names among young people in various parts of the country: marijuana, fodya wamkulu, Malawi gold, ganja, jah, kanundu, nanzi, weed.	Throat irritation Dry mouth Bloodshot eyes Increased appetite for food Drowsiness Disruption of thought and speech Addictions Untidiness Knee-jerk reflex
Sedatives	Commonly referred to as sleeping tablets, manufactured for medical use. Meant to reduce tension and anxiety, and induce sleep and calmness. Mostly sold on the black market.	Can trigger suicidal thoughts. An increased dosage can result in dependency. An increased dosage may be fatal because it depresses vital organs, such as the lungs and heart.

SOURCE: Adapted from Ministry of Youth, Sports, and Development. 1999. *Life Planning Skills Manual: A Training Manual for Young People in Malawi.*

[14] Cirrhosis is a slowly progressing disease in which healthy liver tissue is replaced with scar tissue, eventually preventing the liver from functioning properly. The scar tissue blocks the flow of blood through the liver and slows the processing of nutrients, hormones, drugs, and naturally produced toxins.

Talking points

- Alcohol is the substance most commonly abused by young people in Malawi.
- Euphoria is an exaggerated feeling of well-being that comes after one has been intoxicated.
- Alcohol abuse drains money from the individual and the family.
- Tobacco contains nicotine, an addictive drug. Tobacco contains chemicals that predispose the smoker to developing lung cancer if used for a long time.
- Chamba, a dried form of a plant called Cannabis sativa, is known by different names in Malawi.
- Chamba increases the appetite for food and disrupts thought and speech.
- Sedatives, commonly referred to as sleeping tablets, are meant to reduce tension and anxiety and induce sleep. An increase in dosage can result in overdependence.

Activity 5.2. Plenary discussion

Instructions

- After the presentations, allow the participants to make comments. Lead them to share their personal experiences of what is happening in their communities regarding substance abuse.
- During the plenary, recap the substances most commonly abused by young people in the participants' communities and the names by which they are called there. Write these names on a flip chart page and post it.

SESSION 6. CONSEQUENCES OF SUBSTANCE ABUSE 30 MINUTES

Aim of the session

- To discuss the consequences of substance abuse among young people

Activity 6.1. Group discussions

Instructions

- Divide participants into three groups. You can use any approach, such as having the participants count off a number from one to three and then putting all the ones, twos, and threes in separate groups.
- Ask the participants to discuss in their groups the consequences of substance abuse for young people.
- Assign the consequences of substance abuse to each group according to one of the following dimensions of human life: biological or physical (referring to consequences affecting the body, such as malnutrition due to an inability to eat or acquisition of an STI during casual sex); psychological (referring to consequences affecting the mind, such as loss of memory); and social (referring to consequences affecting relationships or aspects of socioeconomic development, such as dropping out of school).
- Ask each group to discuss these consequences for about 10 minutes, noting their responses on a flip chart page to present in plenary.

What are the biological, psychological, and social consequences of substance abuse among young people?

Activity 6.2. Mini lecture

Instructions

- Summarise the consequences of substance abuse in each of the three dimensions, drawing from the box below.

Biological consequences

- May lead to the acquisition of an STI, including HIV, due to injecting drug use; or an unplanned pregnancy due to casual sex
- Malnutrition due to inability to eat adequately
- Liver damage (e.g., liver cirrhosis)
- Cancers

Psychological consequences

- Mental illness
- Loss of memory
- Loss of motivation
- Suicidal thoughts/ideas

Social (socioeconomic) consequences

- Young people become less productive (impaired academic performance, inability to work efficiently)
- Drop out of school
- Fall into poverty
- Disruption in family and social relationships

Talking points

- A human being is a bio-psychosocial being, and substance use and abuse affect all dimensions of human life.
- Substance abuse is one of the leading causes of mental illness and disorders among young people.
- When young people become intoxicated by drugs, their reasoning capacity is affected and they do things without thinking them through. As a result, they might have sex with someone without protection and then regret it when they sober up.
- Alcohol addiction occurs easily. Because of this, many young people who plan to drink only now and again slide into alcoholism. It depletes their financial resources, making them less productive and causing them to live in poverty.

SESSION 7. PREVENTION OF SUBSTANCE ABUSE 40 MINUTES

Aim of the session

- To discuss substance abuse prevention strategies among young people

Activity 7.1. Individual work

Instructions

- Ask each participant to write down three strategies that have worked well in preventing substance abuse among young people.
- Ask them to write each strategy on a VIPP card.

What workable strategies have you used or know about to prevent substance abuse by young people?

- After the exercise, ask the participants to post their cards and go over them one by one.

Activity 7.2. Mini lecture

Instructions

- To consolidate the discussion above, tell participants that we are going to look at some of the strategies that have worked in preventing substance abuse among young people. Show the information in the box below.

Strategies for prevention of substance abuse

- Engagement of young people, giving them a role to play
- Engagement of guardians and parents
- Information, education, and communication (IEC)
- Life skills education
- Community mobilisation
- Counselling young people on the dangers of substance abuse
- Policy advocacy to strengthen bans on young people purchasing drugs (i.e., chamba, alcohol, and cigarettes)

Talking points

- It is very important for young people to realise that they need to take a leading role in discussing the use of harmful substances with their peers because it directly affects their well-being.
- Parents and guardians are often the preferred sources of information. They can exploit this comparative advantage to provide counselling and information to young people.
- Young people need to understand the dangers of the substances they are abusing if they are to make decisions to change their behaviour. This is why correct IEC materials on substance abuse need to be readily available.
- The community should report people who promote the use of harmful substances by young people to relevant authorities (the police).
- Providing correct information on the available harmful substances in each community, and their consequences if young people abuse them, will help the community to take a leading role in preventing young people from using these harmful substances.
- Life skills will strengthen the capacity of adolescents and young people to learn how best to withstand peer pressure, be assertive, and make informed choices so they are not easily coerced into using harmful substances.
- Guidance and counselling of young people is a strategy that needs to be strengthened to help young people who are using drugs realise the far-reaching consequences.
- Advocating the development and enforcement of policies and legislation that prevent substance use among young people can be effective. Such legislation and policies can ban young people's access to drugs (i.e., by prohibiting those under age from buying alcohol and cigarettes, and entering clubs and bars; and by enforcing legislation that prohibits the production of small, cheap alcohol sachets with high alcohol content).

TIP FOR YOU

It is very important to emphasise that these strategies cannot work in isolation—hence the need for synergies in implementation. Other strategies that have worked elsewhere but do not appear in this session also should be included in programming for prevention of substance abuse.

SESSION 8. PSYCHOSOCIAL ISSUES PERTAINING TO SUBSTANCE ABUSE 40 MINUTES

Aim of the session

- To discuss how best to support young people who abuse drugs and other substances

Activity 8.1. Group work

Instructions

- Divide participants into buzz groups based on the issues on the slide below.
- Ask the participants to discuss how they can help young people who come to them, using the questions on the slide.

- Can you become addicted if you use drugs for only a short time?
- How can one avoid drugs and still be "cool" at parties?
- Can my body build a tolerance to drugs?
- I am only using one drug after all, so I won't really have consequences, right?
- I am addicted. I have tried to stop, and I have failed. Should I just give up?

Activity 8.2. Plenary presentations

Instructions

- Following the group work, allow each group to make a five-minute presentation on how they plan to help a young person who asks these questions. Encourage debate but also the sharing of experiences.

SESSION 9.
UNIT REVIEW 10 MINUTES

Activity 9.1. Spot checks

Instructions

- Go over the spot checks that the participants wrote at the beginning of the unit.
- Tell them to make any corrections and additions they wish.

UNIT 5. SPOT CHECKS

1. What is substance abuse?

_____

_____

_____

2. Why do young people misuse drugs and other substances in Malawi?

_____

_____

_____

3. Brainstorm the substances most commonly abused by young people in Malawi and their effects.

_____

_____

_____

4. Based on the common myths that you brainstormed, what facts would you tell young people about those myths?

_____

_____

_____

5. How can abuse of psychoactive substances affect the sexual health of young people?

_____

_____

_____

Activity 9.2. Wrap-up with unit objectives

Instructions

- Go over the slide covering the unit objectives and ask whether participants feel the unit covered all of them.

Unit objectives

1. Explain substance abuse and its magnitude in Malawi.
2. Explain reasons for young people misusing drugs in Malawi.
3. Discuss myths and misconceptions about substance abuse.
4. List the most commonly abused substances among young people in Malawi.
5. Describe how you would prevent substance abuse while working with young people.

Activity 9.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 9.4. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.

DAY 4.
FIELD TRIP TO A YOUTH-FRIENDLY FACILITY

Plan to visit a nearby facility providing YFHS (preferably one that is YFHS accredited). Consider the following before the trip:

Preparation

- Call the facility in advance and inform them that you are coming and how many participants will be with you.
- Prepare them by explaining that you want to learn more about how they are providing YFHS.
- Distribute the YFHS accreditation tool (collected from the RHD) no less than two days before the scheduled visit, so that participants can become familiar with its content and how to use it. Make time during a session before the visit to guide participants on the use of this tool.

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).
- Remember, you are not there to nit-pick mistakes, but rather to learn how the facility is performing.
- 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 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.
- Once you are back at the workshop space, review the visit and discuss what the facility is doing well and what it can improve.
- As a group (each group sharing their assigned observations), write a short report (one to two pages) on your observations and share it with the facility. Most important, thank the facility for giving you the opportunity to learn.

UNIT 6.
MENTAL HEALTH AND YOUNG PEOPLE

SESSION 1.
UNIT INTRODUCTION 10 MINUTES

Aim of the session

- The aim of the session is to provide an overview of the unit, including the objectives

Activity 1.1. Unit objectives

Instructions

- Welcome the participants and describe the unit's objectives, listed in the box below.

Unit objectives

1. Define mental health.
2. Discuss the particular importance of mental health among young people.
3. List the factors that influence mental health.
4. Describe the consequences of poor mental health.
5. Brainstorm strategies to promote optimal mental health among young people.

Activity 1.2. Spot checks

Instructions

- Distribute the spot checks for Unit 6 and give participants 10 minutes to answer them. Ask them to keep their answers to share at the end of the unit.

SESSION 2. DEFINITION OF MENTAL HEALTH 10 MINUTES

Aim of the session

- To explain the definition of mental health

Activity 2.1. Mini lecture

Instructions

- Start by telling participants the importance of mental health—especially that it affects all dimensions of human life. WHO says, "There is no health without mental health."[15]
- Mental health is vital to our survival; we use our brains every day to think concretely and abstractly.
- In defining mental health, display the information in the box below.

Definition of mental health

- Mental health is an essential dimension of WHO's definition of health.
- Mental health can be conceptualised as a state of well-being in which the individual realises his or her own abilities, can cope with normal stresses of life, can work fruitfully, and is able to make a contribution to his or her community.
- It also relates to one's ability to manage and cope with feelings that may arise as a result of one's understanding or experience of social, physical, or psychological events.

Activity 2.2. Plenary discussion

Instructions

- Allow participants to comment on the definitions.
- Invite questions and comments, and write key elements on a flip chart page.

[15] WHO. 2016. "Mental Health: Strengthening Our Response." Available at: http://www.who.int/mediacentre/factsheets/fs220/en/.

SESSION 3.
WHY IS MENTAL HEALTH OF PARTICULAR IMPORTANCE TO YOUNG PEOPLE? 20 MINUTES

Aim of the session

- To brainstorm the importance of mental health among young people

Activity 3.1. Buzz groups

Instructions

- Divide the participants into groups of three and ask them to brainstorm the topic on a flip chart page.
- After the discussion, refer the participants to Unit 6 in the *Participants Handbook* on the "importance of mental health to young people."
- Give the participants at least 10 minutes to brainstorm.
- Ask them to use VIPP cards and make presentations.

Why is mental health of particular importance to young people?

Activity 3.2. Plenary discussion

Instructions

- Ask the participants to share their discussions during plenary.
- As the groups are presenting, ask a participant to write down important points. Ask the groups to explain their points so that others can understand. If questions are raised and the participants do not have answers, make sure you respond.
- Consolidate the session by looking at factors that influence mental health.
- Wrap up the session by highlighting key points that came up during the discussions.

SESSION 4.
FACTORS THAT INFLUENCE MENTAL HEALTH 40 MINUTES

Aim of the session

- To discuss factors that influence mental health among young people

Activity 4.1. Brainstorming

Instructions

- Introduce the topic and inform participants that you would like the group to brainstorm factors that they think influence mental health.

What are the factors that influence mental health?

- Give the participants 30 minutes and encourage everyone to share their own experiences. Use the talking points below to beef up the discussion and then move to the next session.

Talking points

The health and well-being of young people cannot be complete if they are psychologically disturbed or mentally unstable. The influence of drugs can worsen mental illness.

Physical, psychological, and social factors can have positive or negative influences on mental health. For instance, early and forced marriages, unplanned pregnancies, abortions, and unsupportive parents will all have a negative influence on young people's mental health.

As providers, your assessment of young people should be comprehensive enough to identify potential influences on mental health. Young people should be supported in managing negative influences, taught coping skills, and encouraged to maintain and strengthen positive influences.

SESSION 5.
CONSEQUENCES OF POOR MENTAL HEALTH 40 MINUTES

Aim of the session

- To discuss the consequences of poor mental health

Activity 5.1. Mini lecture

Instructions

- Start by explaining that poor mental health will likely lead to mental illness and disorder among young people. We need to know what consequences will probably arise if we do not comprehensively address the mental health needs of young people in our communities.
- Display the information in the box below and expound on each item as an expression of poor mental health.

- Anxiety and stress
- Depression
- Deliberate self-harm
- Eating disorders
- Obsessive-compulsive disorder (OCD)
- Psychosis
- Schizophrenia

Talking points

Young people experience **anxiety and stress** due to the challenges they face every day.

- **Anxiety** is a general term that refers to a mental disorder that causes apprehension, fear, nervousness, and worrying, ultimately affecting how one behaves. Anxiety may also exhibit physical symptoms.
- **Stress** refers to a state of mental or emotional tension resulting from adverse or very demanding circumstances. Examples of signs of anxiety and stress are feeling sad and low; loss of appetite; difficult in sleeping; being fearful, tense, or panicky; frequent urination.

Depression refers to a mental disorder characterised by low mood swings and a decrease in functional activity. Its key manifestations are loss of interest or pleasure; feeling sad or empty; experiencing a marked decrease or increase in appetite; difficulty in sleeping or oversleeping; tiredness or loss of energy; feelings of worthlessness or guilt; difficulties in concentrating or thinking; and recurrent thoughts of death.

Deliberate self-harm among young people sets in when they feel completely lost, abandoned, sad, distressed, anxious, confused, ashamed, and guilty, and see no meaning in life. It builds from failure to cope with negative experiences, such as unexpected pregnancy, drug abuse, loss of loved ones, neglect, and stigma and discrimination. Self-harm usually takes the form of cutting oneself but may also manifest as scratching, biting, picking at the skin, and pulling out hair. Following each episode, the negative feelings may subside, so that self-harm becomes a ritual of release. Young people who attempt self-harm can get therapeutic support through counselling and guidance to help them develop healthy coping skills in dealing with the stress, anxiety, and negative social events they may experience every day.

Eating disorders can be loosely defined as eating less than necessary or eating too much. Eating disorders are linked to a combination of factors, such as family relationships, psychological problems, and genetics. Particularly for adolescents, it may be linked to low self-esteem and preoccupation with having a thin body (depending on social norms). The person tends to project anger on food, thus eating too much or too little. Extreme eating disorders that are common in female adolescents are anorexia nervosa or bulimia nervosa. These can result in cessation of menstrual periods due to inadequate intake of proteins and, ultimately, death.

Obsessive compulsive disorder is a debilitating condition characterised by repeated unwanted thoughts. To get rid of these thoughts, the person takes repetitive actions, such as frequent handwashing or checking repeatedly that doors are locked. The exact cause of this disorder is not known. The symptoms may come and go over time, and range from mild to severe. Anxiety and fear are common symptoms. Its management involves medication and counselling.

Psychosis refers to an abnormal mental condition in which one loses contact with reality and exhibits personality changes and thought disorders. A psychotic person may exhibit one or more of the following symptoms: hallucinations (especially hearing voices); delusions (especially persecutory delusions—believing people intend one harm); a state of agitation due to loss of contact with reality; and disordered thoughts.

Schizophrenia is a severe mental disorder characterised by abnormal psychosocial behaviour, inability to manage emotions, difficulty in thinking clearly, and inability to recognize what is real in the environment. The cause of schizophrenia is not well-known, but factors include genetics, altered brain chemistry, or problems during gestation that alter the brain's development and the nervous system. Key manifestations are hallucinations, disorganised thoughts and speech, delusions, and inability to recognize the environment (people, place, and time).

SESSION 6.
PROMOTING MENTAL HEALTH AMONG YOUNG PEOPLE 40 MINUTES

Aim of the session

- To discuss strategies on how to promote mental health among young people

Activity 6.1. Group discussions

Instructions

- Divide the participants into groups of five and let them discuss the topical question presented below.
- Allocate 10 minutes for this discussion.
- Ask participants to write their responses on a flip chart page. Supplement this information by referring the participants to information on promoting mental health in young people presented in Unit 6 of the *Participants Handbook*.

What strategies are being used in your area to promote mental health among adolescents and young people?

Activity 6.2. Plenary discussion

Instructions

- After the group discussions, allow the participants to make presentations.
- Allocate three minutes to each presentation. Note comments and questions coming from the participants. You may not want to comment very much on this discussion because you will be wrapping up the session with a mini lecture.

Activity 6.3. Mini lecture

Instructions

- Wrap up the session by discussing the strategies on the slide.

Strategies for promoting mental health

- Power of communication
- Holding boundaries
- Asking questions
- Emotional literacy and self-awareness
- Exploring options versus giving advice
- Challenging
- Knowing your limitations
- Giving constructive criticism

Talking points

Interventions need to start in early childhood—in primary schools. Interventions could also occur beginning with women of childbearing age. Home visits to pregnant women should go a long way towards challenging mental illness among adolescents.

Mental health programmes in schools can be implemented easily. For example, the availability of sporting facilities is a good strategy to make a school child friendly. Training teachers in counselling and guidance while reducing any risk of sexual relationships between teacher and pupil would help to promote mental health among the pupils.

Current violence prevention programmes (community policing) in Malawi are receiving good support. However, such programmes need to be owned by the community and strengthened.

SESSION 7.
UNIT REVIEW 10 MINUTES

Aim of the session

- To review the session on mental health and young people

Activity 7.1. Spot checks

Instructions

- Refer to the spot checks you gave to participants at the beginning of this unit.
- Allow them to change their spot checks and discuss any concerns they might have.

UNIT 6. SPOT CHECKS

1. Define mental health.

_____

_____

_____

2. What factors influence mental health?

_____

_____

_____

3. Discuss why keeping young people mentally healthy is important.

_____

_____

_____

4. If young people's mental health is not given priority, what are the problems you are likely to see among young people in your health facility, area, community, youth centre, or school?

_____

_____

_____

5. What can a health provider do to promote the mental health of young people?

_____

_____

_____

Activity 7.2. Wrap-up

Instructions

- Display the unit objectives and go through them, making sure that they were met. If there are no questions, ask participants to clap for themselves, and then close the unit.

Unit objectives

1. Define mental health.
2. Discuss the particular importance of mental health among young people.
3. List the factors that influence mental health.
4. Describe the consequences of poor mental health.
5. Brainstorm strategies to promote optimal mental health among young people.

Activity 7.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 7.4. Reminders and closure

Instructions

- Ask the participants to review the issues listed on the Matters Arising board and add any new ones.

UNIT 7.

PROVIDING YOUNG PEOPLE WITH THE HEALTH SERVICES THEY NEED

SESSION 1.
UNIT INTRODUCTION 5 MINUTES

Aim of the session

- To help service providers examine what makes it difficult for young people to access the health services they need and consider what should be done to address this issue

Activity 1.1. Unit objectives

Instructions

- Begin by welcoming participants to this unit.
- Display the unit objectives and take the participants through each one.

Unit objectives

1. Describe of the concept of YFHS in Malawi.
2. Describe the health services that young people need.
3. Detail the minimum package for the delivery of YFHS.
4. List at least six barriers to young people's access to YFHS.
5. Discuss the YFHS standards and accreditation process.
6. List the ways services can best be delivered to young people.
7. Discuss how to best empower young people to demand health services.
8. Brainstorm how to initiate changes to improve provision of YFHS.

Activity 1.2. Spot checks

Distribute the spot checks and give participants 10 minutes to complete them. Tell them to keep their answers for review at the end of the unit.

Talking points

The term ***health services*** refers to a clinical service, which often includes some information provision and advice, that is aimed at preventing health problems and detecting and treating those that may arise. The term ***health facility*** refers to a recognized institution that provides health services, ranging from small clinics providing a limited range of primary-level services to large hospital complexes providing a range of tertiary-level health and social services.

The term ***gatekeepers*** refers both to those who interface with young people on a regular basis, such as their parents, teachers, and youth leaders, and those who do not, such as policymakers and administrators. Identifying and working with these ***gatekeepers*** is an essential part of any public health initiative, especially those that address young people.

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.

SESSION 2.
THE CONCEPT OF YOUTH-FRIENDLY HEALTH SERVICES AND WHAT MAKES SERVICES "YOUTH FRIENDLY" 25 MINUTES

Aim of the session

- To discuss and understand the concept of YFHS
- To describe health services that are "youth friendly"

Activity 2.1. Recap and brainstorming

Instructions

- YFHS was introduced and discussed during the first day of the training. However, now that we are concluding the training and planning to provide YFHS to young people, it is important for us to discuss the concepts and also to recap them before going deeper.
- Ask participants to recap by brainstorming the key concepts of YFHS and its definition. Allow 10 minutes for this discussion.

What do you understand by YFHS, and what makes health services youth friendly?

- Wrap up this session by referencing the Unit 1 introduction of YFHS. Present a summary of the characteristics of YFHS to the participants, using the list below.

- Technical competence
- Seeing the person, not the problem
- Making the service physically accessible
- Confidentiality and privacy
- Services that are acceptable to the local community
- Involving young people

- Explain this summary in detail, as highlighted in Unit 7, Box 57 of the *Participants Handbook*.

Activity 2.2. Group work

Instructions

- Divide the participants into groups.
- Ask the groups to go over this list and consider which of the characteristics they believe are relevant to their settings/context and which are not.
- Also ask them to reflect on their field visit to the youth-friendly facility and recall whether or not it had some of these characteristics.
- Allow 15 minutes for this activity.

Activity 2.3. Plenary feedback and discussion

Instructions

- After 20 minutes, bring the groups together in plenary.
- Taking one category of characteristics at a time, ask each group in turn to share their collective decision about that category's relevance and appropriateness.
- Ask the other groups not to repeat points in their contributions that other groups have already made.

Talking points

Inform participants that it is the strong wish of the Government of Malawi to ensure that all health services are youth friendly. Doing so will allow more young people to access services and also help reduce health problems that arise owing to poor relationships between health providers and facilities and young people.

According to the YFHS policy published by WHO, a provider capable of working with adolescents will have competencies in the following three domains:[16]

- Understanding of basic concepts in adolescent health and development, and effective communication
  - This is in line with what was covered in this manual.
- Understanding of law, policies, and quality standards
  - It is important that providers understand the legal and policy implications of certain services. This training package addresses them by highlighting in some key sections what the law or policy says about such issues as HIV testing and services for LGBT persons. Moreover, the training package discusses the YFHS standards in detail.
- Understanding clinical care of adolescents with specific conditions
  - This component targets all healthcare service providers who directly provide clinical care. In Malawi, all health service providers are trained to provide clinical services to young people.

[16] WHO. 2015. *Core Competencies in Adolescent Health and Development for Primary Care Providers.* Geneva, Switzerland: WHO.

Repositioning YFHS is a high priority for Malawi: for this reason, the Government of Malawi, through the MOH's RHD, developed the National Youth Friendly Health Services Strategy 2015–2020 (YFHS strategy). As a key to this goal, the strategy outlines priority areas to ensure that all of the characteristics of a youth-friendly facility can be realised.

These priority areas are as follows:

- Policy
  - This priority area is meant to facilitate an enabling environment in which policies are disseminated, with multisectoral linkages to support delivery of health services to young people.
- Service delivery
  - This priority area is meant to enhance the capacity of providers (health and non-health workers) to deliver YFHS. Thus, all providers of YFHS are to have good knowledge of the policies, standards, and strategies to strengthen YFHS provision.
  - It is intended to strengthen the coverage and use of YFHS.
  - It is also intended to spearhead the integration of YFHS into other outreach services in different communities. Multisectoral collaboration is clearly needed to do so.
- Coordination and collaboration
  - This priority area supports Malawi's multisectoral approach to YFHS. It is meant to strengthen the coordination, collaboration, and ownership of stakeholders, thus leading the implementation of YFHS. These stakeholders include the young people themselves, MOH (RHD), line ministries, parents, community leaders, and communities, among others.
- Mobilisation of young people and communities
  - This priority area will ensure mobilisation of parents, community leaders, and young people to actively advocate and support YFHS uptake.
- Resource mobilisation
  - This priority area will ensure adequate resources for implementation of the national YFHS programme. All players will need to be involved in advocacy to increase the resources available for YFHS.

SESSION 3.
WHAT HEALTH SERVICES DO YOUNG PEOPLE NEED? 20 MINUTES

Aim of the session

- To describe the ideal health services relevant to young people

Activity 3.1. Buzz groups

Instructions

- Organise the participants into groups of five and ask them to quickly write down their thoughts on the following question.

> **What kind of health services do you think are more appealing to young people?**

- If there are young people in the training session, encourage them to articulate freely what they would love to see when they visit a health facility. Let them share their experiences as honestly as possible. Wrap up the session by presenting the following talking points.

Talking points

Characteristics of YFHS

- A welcoming facility where young people can drop in and receive care quickly
- Privacy and confidentiality, without the requirement of parental permission to attend
- A conveniently located place, with convenient times, that is free, or at least affordable
- Staff who treat clients with respect and do not judge them
- A range of services broad enough so clients usually will not need to be asked to come back or be referred elsewhere
- Services that are appropriate, effective, affordable, and acceptable to the client community
- Counselling and support from experts: health workers, police, teachers, parents, and guardians

These characteristics are most likely to be found in facilities whose staff have been trained in YFHS and those with YFHS certification. Note, however, that not all YFHS facilities are currently accredited. YFHS are more likely to meet the needs of young people than any other services, but all institutions that serve young people should strive to be youth friendly. The next session will discuss in more detail the minimum requirements for an institution to be youth friendly.

SESSION 4. MINIMUM PACKAGE FOR DELIVERY OF YFHS 30 MINUTES

Aim of the session

- To describe the basic requirements a youth-friendly facility

Activity 4.1. Mini lecture

Instructions

- Present a lecture on the minimum package for YFHS, using the following slides.

The minimum YFHS package is a combination of clinical services and health promotion interventions provided to address the health needs of young people.

This package has three areas of emphasis:

- Health promotion
- Delivery of health services
- Referral and follow-up

Health services for young people are provided within the normal clinical standards and procedures approved by the MOH. The types of services to be provided are in line with the minimum package outlined in the Essential Health Package of Malawi. The mode of delivery of these services—stand-alone or integrated—depends on the institution's capacity.

TABLE 12. Clinical YFHS and their delivery modes

CLINICAL SERVICE	MODE OF DELIVERY
Community level	
• Contraceptive services, including condoms and HIV testing and counselling • Referral to health facility or other service delivery points • Youth outreach services • VMMC during outreach activities	• Stand-alone • Integrated • Outreach
Health centre level	
• Contraceptive services, including condoms • Prevention, diagnosis, and management of STIs • Antenatal, delivery, and postnatal care services • PMTCT • HIV testing and counselling • Treatment of sexual abuse victims • Referral to hospitals or other service delivery points • Postabortion care • Teen clubs for adolescents living with HIV • Cervical screening • VMMC • Provision of ART • Treatment for sexual abuse (including PEP)	• Stand-alone • Integrated • Outreach
Hospital level	
• Postabortion care • Contraceptive services, including condoms • Prevention, diagnosis, and management of STIs • Antenatal, delivery, and postnatal care services • PMTCT • HIV testing and counselling • Provision of ART • Treatment for sexual abuse (including PEP) • Referral to other service delivery points • Cervical screening • VMMC	• Stand-alone • Integrated
Health promotion and counselling during service delivery, and at all levels (cross-cutting)	
• STIs • Family planning • Psychosocial support • Nutrition • HIV and AIDS • Sexual abuse • Maternal healthcare • Adolescent growth and development	• Stand-alone • Integrated

Talking points

As the slides on clinical services show, the delivery of YFHS is not a wholesale concept, but rather takes into account the level of service delivery.

For instance, what services the district hospital can deliver, the health centre cannot. Thus, the minimum YFHS provided in a facility will depend on the capacity of that facility, as stipulated by the MOH. The goal is not to strain facilities but rather to support them in providing the services appropriate to their level in the health system.

All of the services listed on the slides can be delivered either integrated with others or on a stand-alone basis, depending on the capacity of the institution.

SESSION 5.
BARRIERS TO PROVISION AND USE OF HEALTH SERVICES BY YOUNG PEOPLE 30 MINUTES

Aim of the session

- To identify the important barriers to provision and use of health services by young people

Activity 5.1. Brainstorming

Instructions

- Post the following question on a flip chart page and read it aloud.

What barriers do young people encounter in accessing YFHS?

- Explain to the participants that you want them to identify what they believe are important factors that get in the way of young people's access to and utilisation of health services.
- Ask participants to write down their responses on VIPP cards—three ideas, one to a card.
- Give them five minutes for this exercise. Then collect the cards and post them.

Activity 5.2. Plenary discussion

Instructions

When the cards are up, present the following four categories of barriers:

- Personal/youth
- Interpersonal/service provider
- Institutional/service delivery point
- Other

Ask the participants to help you group the cards by deciding to which category each barrier belongs.

Bring up the following issues—if the participants have not raised them spontaneously—and encourage discussion about them:

- Do laws and policies restrict the provision of certain health services to individuals (based on considerations of age or marital status)?
- Do concerns about confidentiality hinder young people's use of health services?
- 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)?

Activity 5.3. Plenary session

Instructions

To wrap up this session, present the main barriers to access that the evaluation of YFHS in Malawi identified (E2A Project and University of Malawi, 2014). These are listed below.

Barriers to accessing youth-friendly health services

- Long distance to the nearest health facility
- Lack of knowledge on the part of the adolescent
- Cost of services
- Low self-confidence/shyness
- Poor attitudes of health workers
- Long waiting times and inconvenient hours
- Unavailability or denial of services
- Lack of privacy and confidentiality
- HIV testing as a condition for other services
- Religious and other beliefs
- Lack of financial resources/infrastructure
- Shortage of younger trained providers
- Inadequate health worker encouragement of youth to access YFHS
- Lack of youth participation
- Legal or cultural restrictions
- Cultural barriers
- Gender barriers
- Peer pressure

SESSION 6. THE MALAWI YFHS STANDARDS AND ACCREDITATION PROCESS 30 MINUTES

Aim of the session

- To provide the rationale and application of the Malawi YFHS standards and accreditation process

TIP FOR YOU
This session could be given by a guest presenter, if one is available.

Activity 6.1. Mini lecture

Instructions

- Explain that you will now briefly explain the rationale of the Malawi YFHS standards, focusing on the following areas:
  - Why the standards were developed
  - What the standards are
  - Who the standards are for
  - How the standards will be applied
- Read aloud the rationale for the YFHS standards. (Note: the facilitator should have the YFHS standards handy for all participants).

Rationale of the YFHS Standards

The guiding principles of the standards are based on the 2004 Young People's Health Strategy and Implementation Framework developed by the MOH. Key principles are

- Active participation of young people, according to their level of capacity, in the planning, implementation, and monitoring of health services
- Provision of services based on the development and health needs of young people
- Community participation in activities and services
- Provision of YFHS by trained health workers and community volunteers
- Certification/accreditation of all facilities providing YFHS

- Go over each of the standards in the next slide.

The Five YFHS Standards for Malawi

- Health services are provided to young people according to existing policies, procedures, and guidelines at all service delivery points.
- Young people are able to obtain health services that include preventive, promotive, curative, and rehabilitative health services appropriate to their needs.
- All young people are able to obtain health information (including on SRH and HIV) relevant to their needs, circumstances, and stage of development.
- Service providers in all delivery points have the required knowledge, skills, and positive attitudes to effectively provide YFHS.
- Health information related to young people is collected, analysed, and utilised in decision making at all levels.

- Divide the participants into five groups. Assign one standard from the YFHS standards booklet to each group. Ask each group to read and discuss their assigned standard, paying attention to the following questions.
  - What is the standard?
  - Why was the standard developed?
  - Who is the standard meant for?
  - How will the standard be applied?
- Inform them that they will come back and present in plenary. Explain that they could either give a mini lecture or conduct a plenary discussion.

Activity 6.2. Plenary feedback and discussion

Instructions

- After 15 minutes, bring the groups together in plenary. Taking one standard at a time, ask each group to share their discussions with everyone else.
- Ask the other participants to comment and ask questions. Repeat the process until all of the standards are covered.
- Once all of the standards have been discussed, remind the participants to read them in detail. Provide a copy of the YFHS standards to the participants.

Activity 6.3. Mini lecture

Instructions

- Inform participants that you will present a mini lecture on what health facilities need to do to be certified to provide YFHS. This process is called accreditation. Display the following slide:

Essential YFHS components are assessed in the accreditation process

- Ask participants to refer to Box 59 in Unit 7 in their handbooks (Table 13 below), and go over the assessment checklist with them.

TABLE 13. Essential YFHS components assessed in the accreditation process

STANDARD 1
• Availability of the Youth Policy, SRH Policy, Youth SRH Strategy, and HIV Policy and guidelines • Guidelines for provision of quality YFHS (check the availability of the YFHS standards) • Orientation on all of these policies, standards, and guidelines
STANDARD 2
• Minimum package for YFHS (according to level of facility) • Referrals to other service delivery points • Adequate infrastructure to provide YFHS (check for room/space) • A sign displayed that clearly shows the schedule and location of YFHS (check the sign) • Provision of outreach services • Availability of equipment, supplies, and medicines • Availability of recreational materials (check that they are being used by young people)
STANDARD 3
• Availability of take-away IEC materials for young people • Availability of posters being displayed that contain health information • Community participation through meetings (at least twice a year) • Youth participation at least twice a year
STANDARD 4
• Minimum of two service providers trained in YFHS • Orientation of support staff • Protection of young people's privacy during service delivery • Service providers managing youth with respect • Involvement of young people in service provision
STANDARD 5
• Availability of disaggregated data for youth ages 10–24, disaggregated by age, sex, and marital status, and collected using the YFHS forms • Analysis and data use by facility • Submission of quarterly reports to District Youth Officer/District Health Officer

Talking points

The accreditation process takes these standards into account. The process looks at the extent to which facilities are implementing health service delivery for young people in accordance with the standards. Each institution is assessed according to its level of health service delivery. In other words, what is assessed at a health centre and a district hospital are not the same.

A facility need not have every component; a grading tool allows the assessment team to determine whether to accredit the facility or not. This tool identifies the minimum components that should be available; if they are indeed available, the facility then is accredited (i.e., officially said to be providing YFHS). The availability of providers trained in YFHS is not sufficient for accreditation.

Activity 6.4. Group work

Instructions

- Now that participants have learned what components are needed to accredit a health facility, they will practice using the tool. Form 10 groups, with at least three people per group.
- Distribute copies of the accreditation tool to the groups. Ask each to create an imaginary facility in which one volunteer plays the role of a health provider and the other two play the role of assessors. Let each group member have a chance to assess the facility.
- Crucial to this group work is for participants to understand the key components they need to have in their facilities to ensure that they are providing YFHS. Allow 45 minutes to 1 hour for this activity.

Activity 6.5. Plenary discussion

Instructions

- Convene in plenary. Ask the participants the following questions:
  - In the provider role, how did they experience being asked the questions?
  - In the assessor role, how did they experience the process of assessing a facility?
  - Did the process help them to understand better how to make their own facilities youth friendly?
- Wrap up the session by emphasising the importance of the accreditation process in YFHS provision. Accreditation builds the capacity of providers and that of the service delivery points where they work.

TIP FOR YOU
Always make sure you have the accreditation tools handy, share them with the participants, and explain the process clearly to them. In this way, when they go back to their facilities, they can immediately start working on this process.

SESSION 7. HOW ARE SERVICES BEST DELIVERED TO YOUNG PEOPLE? 25 MINUTES

Aim of the session

- To describe YFHS delivery points
- To discuss advantages and disadvantages of each type of service delivery point

Activity 7.1. Brainstorming

Instructions

- Ask participants to brainstorm about the types of delivery points where young people can access and use health services. Do this by posing the question below.

Service Delivery Points for Youth-Friendly Health Services
What are the available service delivery points for YFHS in your area?
What are the advantages and disadvantages of each of the service delivery points?

- Ask the participants to write their responses on VIPP cards or on a flip chart page. Ask a volunteer to post the responses.

Activity 7.2. Plenary feedback and discussion

Instructions

- Go over each of the suggested service delivery points, discussing its advantages and disadvantages.
- Allow 15 minutes for the discussion. Then summarise by highlighting the key points from the discussion, as suggested in the following box. Then proceed to the next activity, which covers approaches that can make services more easily accessible.

Services at health centres or hospitals

- Hospital- or clinic-based services can become more adolescent friendly.

Services located at other kinds of centres

- Community settings include services provided at community or youth centres and in shopping centres.

Outreach services

- Outreach services are needed in cities to contact adolescents who do not attend clinics and those, like street children, who are marginalised.
- Outreach services in rural areas can be devised to reach young people living in isolated communities.

Health services linked to schools

- Schools are a critical entry point for bringing services to young people.

Health services linked to workplaces

- Young workers, including adolescents, can be reached with health education or screening services targeted to the workplace.

Community-level interventions: community-based distribution agents and health surveillance assistants

- These are an important resource, as they are available to young people in their communities. They are easily accessible, and most services offered are free.

Health services linked to religious institutions

- The legitimacy of religious institutions is indisputable. Linking SRHR to religious institutions can strengthen access to services by young people.

Services can be located anywhere young people go. No single setting should become the only model.

Activity 7.3. Buzz group

Instructions

- Ask participants to form buzz groups of three and have them brainstorm approaches to make health services widely available to and accessible by young people. The groups can write their responses on VIPP cards or a flip chart page.
- Have each group report their responses in a brief plenary discussion. Ask one participant to record all of the responses on a flip chart page.

Activity 7.4. Mini lecture

Instructions

- Display the slide below on service delivery approaches.

Approaches to making services accessible by young people

- Setting a special day
- Setting special times
- Designating a youth centre or a special room for young people
- Providing an outreach clinic

Talking points

1. SETTING A SPECIAL DAY

Facilities can set aside a special day for young people to come and access the particular services they require. Young people and the community at large should know about the day to ensure that they access the services. The day should be convenient for young people.

2. SETTING SPECIAL TIMES

The service delivery point can set aside a special time for young people to access services. Afternoon hours are recommended to allow those who go to school to access services.

3. A SPECIAL ROOM FOR YOUNG PEOPLE, OR A YOUTH CORNER

Where infrastructure allows, a youth centre or special room should be set aside for young people. The room can serve as an entry point to services for young people. Usually a peer who acts as a liaison between young people and the service providers manages the room. Some of the services that can be obtained are provision of condoms, other contraceptives, and IEC materials, and—whenever the service providers have time—some clinical services.

4. OUTREACH CLINIC

These clinics take services to young people. Most outreach clinics are conducted by outreach teams from government facilities or private institutions such as BLM, Family Planning Association of Malawi (FPAM), and Population Services International (PSI). Community-based distribution agents can also conduct these clinics. The settings can be youth clubs, youth gatherings, and locations within the community.

Activity 7.5. Group discussion

Instructions

- Divide participants into four groups. Ask them to discuss the advantages and disadvantages of each approach.
- Allow 10 minutes for this activity.

Activity 7.6. Plenary feedback and discussion

Instructions

- Bring participants to plenary and ask each group to present its responses. Discussions should follow each presentation.
- Conclude the session by emphasising that there is no one best approach to making services widely available to and accessible by young people. The approach depends on what young people in a particular location prefer, the availability of staff, and the infrastructure.

SESSION 8. EMPOWERING YOUNG PEOPLE TO DEMAND HEALTH SERVICES 25 MINUTES

Aim of the session

- To discuss how young people can be empowered to demand health services

Activity 8.1. Brainstorming

Instructions

- Ask participants to brainstorm how they can empower young people to demand health services. Write their responses on a flip chart page.

How can young people be empowered to demand YFHS?

Activity 8.2. Plenary feedback and discussion

Instructions

- Move around and encourage young people in the room to express their perspectives on the subject. Allow 20 minutes for this activity.
- Wrap up the session by presenting the following YFHS RHD requirements.

1. Choose one YFHS focal point person at a facility.
2. Post her/his contact details at the facility. Also post the contact details of the facility's manager.
3. Inform young people that they should channel their grievances to the focal point person. If that person is not being supportive, they should take their grievances to the manager.
4. Form a YFHS committee in the community. This should comprise community members, young people, and facility staff.
5. Among other things, the committee should plan YFHS activities, receive and handle complaints, and support implementation of YFHS at the facility.
6. Periodically (quarterly), the YFHS committee should provide a report to the young people in the community. Youth representatives from the YFHS committee can help to distribute it.

* Adapted from the national YFHS standards.

Talking points

Empowering young people is not meant to punish health facilities but rather to engage young people in collaboration and honest consultation. It should not be seen as witch hunting, but as motivating to the service providers to strengthen quality delivery of health services.

Young people should also be encouraged to support the service providers and the facility positively so they can work to improve service delivery as collaborators, not competitors.

SESSION 9. INITIATING CHANGES TO IMPROVE PROVISION OF YOUTH-FRIENDLY HEALTH SERVICES 25 MINUTES

Aim of the session

- To consider what changes participants propose to initiate in their work for and with young people

Activity 9.1. Individual work

Instructions

- Ask the participants to look at the activity sheets in Unit 8 of their handbooks.

Talking points

COLUMN 1

- Changes you personally plan to make in your everyday work with young people. Stress that each change could relate to something participants learned in any of the units. Each of the remaining columns raises particular questions about each change. Explain each remaining column in turn.

COLUMN 2

- Why do you believe this change is important: who or what will benefit, and in what way?

COLUMN 3

- What will be required to make the change?

COLUMN 4

- How will you know if a change is successful?

COLUMN 5

- Are there any personal or professional challenges and problems you anticipate in carrying out the changes?

COLUMN 6

- What help are you likely to need, and who could provide it?

Explain that the first task is to concentrate on the first four columns.

Ask the participants to identify at least five possible changes. Ask them to state why the proposed changes are important. Have them work individually, allowing them 10–15 minutes to fill in Columns 1 through 4.

Activity 9.2. Plenary discussion

Instructions

- Move around the room, encouraging the participants to be as precise as they can and answering any questions they might have.
- Ask the participants, in plenary, to share briefly any changes they propose to make that no one else has already mentioned.
- Ask a volunteer to write the changes on a flip chart page, adding some explanation to any points that are unclear.
- Cluster the suggested changes with the participants' help.
- Ask why each suggested change is important.
- Then ask participants how they will measure success. Ask a volunteer to record these measures on a flip chart. This should help those who are unsure about how to assess the changes they hope and expect to make in their work.
- To conclude the session, highlight some noteworthy issues raised by the participants in their feedback and in the discussion.

TIP FOR YOU
Allow participants from the same duty station to work together.

Activity 9.3. Individual work

Instructions

- Ask the participants to return to their activity sheets and lead them through Columns 5 and 6.
  - Column 5: Are there any personal or professional challenges and problems you anticipate in carrying out the changes?
  - Column 6: What help are you likely to need, and who could provide it?
- Ask the participants to complete these columns, addressing each change they entered in Column 1.
- Allow them 10 minutes to complete this task.

Activity 9.4. Plenary discussion

Instructions

- Encourage the participants to share the problems they anticipate and base the ensuing discussion on questions such as the ones below:

Addressing challenges

- Who else believes this is a problem or challenge?
- What can you do to solve this problem or meet this challenge?
- Who could support or help you?

- If anyone believes that the challenges facing them are difficult or impossible to overcome, suggest that they consider altering their proposed improvement to make it more "doable."
- Ask a volunteer to record on a flip chart page some useful ways to solve often-anticipated problems.

Activity 9.5. Individual plan

Instructions

- The purpose of this exercise is to help you prepare the outline of a personal plan to improve your work for and with adolescents. In this plan, you will identify the changes you intend to make in the way you work. The plan will have the following elements:
  - The changes you intend to make
  - The importance of the changes
  - What is required to make the change
  - How you will assess whether or not you are successful in making these changes
  - The personal and professional challenges and problems you may face in making these changes
  - The ways in which you are likely to address these challenges and problems, and the support you will need
- Review with participants the sample individual implementation plan in the *Participants Handbook* (see Table 20 in the handbook).
- Before the unit, create a blank table modelled on the sample plan and make enough copies for each participant to have five. Now distribute these to each participant. Give the participants the following instructions:
  - Please designate one sheet for each change you intend to make. That way, you will have enough writing space.
  - For each change you propose in Column 1, complete Columns 2, 3, 4, 5, and 6.
  - In monitoring your own changes and the application of this plan, it would be useful to set yourself target dates to review your progress and reassess your plans.

SESSION 10.
UNIT REVIEW 10 MINUTES

Activity 10.1. Review of spot checks

Instructions

- Ask participants to pull out the spot checks they completed in the first session of the unit. Ask them to review their answers to see whether they want to change any of them.
- Go over each answer with them, one at a time.

UNIT 7. SPOT CHECKS

1. What health services do young people need?

_____

_____

_____

2. Mention six barriers to accessing YFHS among people?

_____

_____

_____

3. Mention at least three things that are part of the elements for making a facility youth friendly.

_____

_____

_____

4. How can services best be delivered to young people?

_____

_____

_____

5. For Malawi YFHS accreditation, mention the five things you would look for in a facility.

_____

_____

_____

Activity 10.2. Review of objectives

Instructions

- Display the unit objectives below, invite participants to share any last questions or comments they might have, and address them.

Unit Objectives

1. Describe of the concept of YFHS in Malawi.
2. Describe the health services that young people need.
3. Detail the minimum package for the delivery of YFHS.
4. List at least six barriers to young people's access to YFHS.
5. Discuss the YFHS standards and accreditation process.
6. List the ways services can best be delivered to young people.
7. Discuss how to best empower young people to demand health services.
8. Brainstorm how to initiate changes to improve provision of YFHS.

Activity 10.3. Training programme personal diary

Instructions

- Ask the participants to get out their diaries and bring them up to date.

Activity 10.4. Reminders and closure

Instructions

- Ask participants to review the issues listed on the Matters Arising board and add any new ones.
- Say: "We wish you all success in your endeavours to improve your work with and for young people."

ANNEX 1.
FACILITATION TIPS AND GUIDLINES

PLEASE NOTE: These tips and guidelines will be used to train new YFHS facilitators, but experienced facilitators should also be familiar with them.

SECTION 1. TEACHING AND LEARNING METHODS

What experience do facilitators need?

The facilitator team using this manual should be familiar with youth SRH issues so they can answer participants' questions and provide insights. They should also have experience in carrying out group work and/or training workshops.

Criteria for selecting training programme facilitators

The following criteria are recommended for selecting the facilitators to run the training programme effectively:

1. Prior training in YFHS
2. Good experience in working with young people (because all issues in this manual are about young people, facilitators should have comprehensive knowledge of issues affecting young people and how to manage them)
3. A medical/nurse background (because much of the content of the units is clinical in nature, this background is critical)

Good facilitation skills: It is recommended that the people selected to facilitate the workshop should have experience in facilitating workshops, especially those using participatory methods, notably the Visualisation in Participatory Programme (VIPP) method.

If possible, it is a good idea to work with a multidisciplinary group that includes both male and female facilitators. This not only enriches the workshop but also can reinforce the facilitators' skills. If the facilitator team consists only of adults, it can be beneficial to ensure that the team always includes at least one younger adult. At least **two to three** facilitators are needed for this workshop so they can take turns leading exercises, guiding discussions, and taking notes (e.g., on points raised in group discussions that need to be highlighted in exercise summaries).

Ideally, the facilitators will have first completed all of the exercises themselves. They will then have a better idea of the issues that may arise during the activities. The exercises will also help them assess their own feelings, assumptions, and beliefs regarding sexual and reproductive issues, and thus be better able to support participants.

The role of facilitators

Facilitation is a helping or an enabling process. Such a process is appropriate for work with professionals, young people, or those already working in a field because they can bring a wealth of personal experience to any learning event. Indeed, facilitation is particularly relevant to this programme because many of the participants are likely to have extensive clinical or other experience in working with young people and young people's health issues.

Before actually running a workshop, the team should meet to discuss each exercise in detail and decide whether any adaptations to the local situation are needed (e.g., terminology used, examples to illustrate summary points, and role plays).

Sometimes participants may demand an authoritative or didactic approach, expecting the specialist or trainer to tell them what to know, think, or do. At the start of the programme, it may be wise to acknowledge this expectation so you do not lose credibility in the eyes of the participants. You can counter it by referring to this Chinese proverb:

> **"I hear and I forget. I see and I remember. I do and I understand."**
>
> **Confucius (551–479 BCE)**

Right from the start, it would be useful to stress to the participants that they must decide what is useful and important to them and their work. This applies to decisions and actions they need to make as they return to their places of work after the workshop. In this process, it is important to remember that as facilitators you are simply the people who provide the context in which the learning and decision-making process takes place. You are not supposed to tell anyone what to do; you can only advise them and give each person the support and the space to make up his or her own mind.

Workshop participants are diverse. Even if the participants are all service providers from the same district, the group will be diverse. They will differ in their background, age, religion, level of responsibility, and so forth. Such diversity is desirable, given the instructive and participatory nature of the training package. However, diverse backgrounds can also mean differences in accustomed and preferred ways of working and communication, and also in approaches in general, which are bound to arise during the workshop. The challenge facing facilitators is to put their own attitudes and preferences aside, and encourage all participants to appreciate and respect these differences and learn from one another.

The programme requires you to use a range of methods and approaches: direct input in the form of short mini lectures, conducting role plays, stimulating problem solving, and initiating exercises in small groups. Over the next few pages, we introduce the teaching and learning methods used throughout the training programme.

Group rules for participatory learning for facilitators

To help ensure tension- and friction-free interactions among the facilitators and the participants, establish some rules at the outset of the programme. Facilitators should ask participants for suggestions on ground rules. The following are ground rules that will serve facilitators in this training:

- Treat everyone with respect at all times, irrespective of training, culture, age, or sex differences.
- 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 fear of repercussions.
- Draw on the expertise of others, both co-facilitators and participants, in different situations.
- Ask for critical feedback on what you do, and treat that feedback with respect so that others see you are behaving fairly.
- Establish from the start when and how the facilitators and special contributors will work together, how to give positive and negative feedback, and how to keep one another on track.

Workshop leaders

Facilitators should ask participants to come up with a list of the key positions responsible for the welfare of fellow participants. Some of the positions could be the following:

- President/chairperson: responsible for participants' overall communication and welfare
- Timekeeper: responsible for keeping time
- Social welfare: responsible for issues arising from participants during the workshop, e.g., food, accommodation, and so forth

Content areas of the units on health issues

Below you will find information on the teaching methods used in the units. Each unit (independent of the number of formal sessions) has four main components:

- Introduction
- Input
- Participation
- Conclusion

Introductory component: unit introduction

This opening session sets the stage for the unit. It allows you to share with the participants the overall aim and objectives of the unit and any special remarks about it. Participants will also have an opportunity to complete the spot check for that unit.

Input component: mini lecture(s)

A mini lecture is an opportunity to give participants basic information they need. For each mini lecture, some of the following resources are available:

- Slides on regional and national aspects of the health issue
- Additional references—listed at the end of the Participants Handbook

In every unit, a few mini lectures are distributed across the sessions to provide input on aspects of the particular health issue covered. These sessions will be more effective if the participants contribute rather than just listen, so encourage active participation, primarily by using the question-and-answer technique.

In the unit's input component, the following choices are available to the facilitators:

- Invite a subject specialist to talk to the group (always vet the speaker first).
  - This can be very useful, particularly if the specialist has relevant local information on the health issues of young people. However, the presentation must be brief and address key issues about the specific health issues, with particular reference to the local situation.
- Present the mini lecture(s) on the health issues yourself.
  - This may seem to be the easiest option for a facilitator, in that you have control over the information being transmitted. However, bear in mind that some of the participants may have important knowledge and experience, so always be willing to involve them and allow time for presentation of local data on health issues. For instance, by day 3 consider assigning some sections to participants that they can present on the following day. This will help to identify the more capable presenters and potential facilitators.

TIP FOR YOU
"Talking points" have been created to give you more information to help you explain further the content of a slide.

Given these options, it becomes possible to present each unit's input session differently. The first options rely on specialist input of some sort, whereas the other gives participants more responsibility for developing their understanding of the issues.

Participatory component: Participatory methods to explore the topic in more depth

A number of different teaching and facilitation methods have been proposed for use in this programme. Each of the following methods has advantages and disadvantages. Therefore, the training programme has been designed with a balanced mix of methods to maximise the participants' interaction and resulting benefit. An experienced facilitator will be familiar with these methods. Even so, it may be helpful to go over the following points.

VISUALISATION IN PARTICIPATORY PROGRAMME (VIPP)

VIPP is a participatory process organised through the use of cards of different sizes, colours, and shapes, to show linkages between ideas and areas of consensus and disagreement. For VIPP to be successful, there are some rules for card-writing.

RULES FOR VIPP CARD-WRITING

- Write only one idea per card.
- Write a maximum of three lines on each card.
- Use key words.
- Write large letters in both upper and lower case.
- Write legibly.
- Use different sizes, shapes, and colours of cards to creatively structure the results of discussions.
- As the facilitator, you should establish a colour code for different categories of ideas.

VIPP cards can be used in plenary or small groups to get the participants to write their responses to a question. A question must be clear and unambiguous. The use of cards enables the responses to be organised in a logical manner, revealing areas of consensus and disagreement.

An advantage of this method is that it allows all participants the opportunity to express themselves so that the quieter members in the group are able to offer input.

The facilitators need to analyse the cards and assess what they represent. It is helpful to guide the discussion on any areas of disagreement to determine the underlying causes. VIPP methods are also used to evaluate how participants feel the programme is progressing; more information about this issue is provided in the section on evaluation methods.

The availability and cost of training materials and tools vary a great deal across districts. Here are some ways to deal with the problems you might experience:

- Card stock may not be readily available in some districts. If so, obtain long sheets of plain wrapping paper in advance. Cut them in the different sizes and shapes needed for VIPP exercises.
- Participants may be reluctant to apply some of the VIPP writing rules, such as writing only three lines per card in large letters. You can gently remind them of the importance of adhering to these rules because the aim is for their colleagues to be able to read the cards from a distance.
- If you do not have different coloured paper or cards, you could use different coloured crayons or marker pens.

BRAINSTORMING/BUZZ GROUPS

Brainstorming, or working in buzz groups, helps generate ideas quickly to serve as a basis for later discussion. It also helps participants to cooperate on a task and focus on an issue or problem.

This technique is often used at the beginning of a session. It involves posing a question and inviting participants to share any ideas that occur to them. During the brainstorming stage, neither the facilitator nor the participants should comment on any of the ideas that have been raised. The responses are usually written on a flip chart page or VIPP cards, which at a later stage can be organised to show the themes that emerged from the exercise. Once this has been done, the ideas can be examined and discussed.

It is important to decide in advance why you want the participants to brainstorm and what you will do after that. Make sure that your initial brainstorming question is clear and unambiguous. It is best to have the question written on a flip chart page for participants to see as you introduce it. Do not let the session go on for too long—5 to 10 minutes is about right—and make sure that everyone has the opportunity to contribute.

ROLE PLAY

Role play can be an exceptionally valuable device for teaching and learning. It provides the opportunity for the expression of emotions that cannot be achieved through discussion alone. In a short amount of time—only three to five minutes—role plays can illustrate both a problem and a way of dealing with it. For example

- The facilitator and/or participants can use a role play to demonstrate a "bad practice" or a "good practice."
- For the participants, a role play can be useful in the following ways:
    - As a problem identification tool, in which everyone in the role play is familiar with the scenario and role plays the difficulties it illustrates. Again, this would normally occur in plenary, although small groups could also use role playing as a means of developing their problem identification skills.
    - As a way to practice clinical or counselling skills or problem solving. For example, in this format, only the "patient" should know the complete scenario or history; the healthcare provider should have few details. After an initial practice run in plenary, role playing to practice skills is best undertaken in groups of three: the healthcare provider, the patient, and an observer. Working in groups of three enables each person to practice skills in turn.

Better still, ask the participants to volunteer "real" situations relevant to them, but be sure their issues are central to the health issue discussed in the unit. Facilitate a discussion to identify possible scenarios. Another approach is to ask participants to write a "difficult moment" on a card; the cards can then be displayed on the wall or read aloud by the facilitator, thus maintaining anonymity.

Then ask the group to think about what issues they as healthcare providers (not young clients) find most difficult in their work with youth: sexuality, abortion, contraceptives, sexual abuse, substance abuse, HIV and AIDS, mental health, and so forth. Ask them to focus on interaction with a young person, or a young person and the family, rather than on abstract issues. Let the group select one or two such situations to illustrate typical problems healthcare providers face when they deal with adolescents and ways to overcome such difficulties.

To ensure maximum naturalness, reduce initial discussion of the role play to a minimum. If in plenary, place two or more chairs at the front of the room: one for the healthcare provider, one for the adolescent and, if needed, one each for any others meant to be present, such as family members. Consider using props such as glasses, hats, scarves, doctors' coats, or anything else with which participants are comfortable.

Ask for volunteers for the role play and explain exactly what the healthcare provider's task is: to illustrate bad practices as part of the problem-solving exercise, or to work on good practices. In any case, explain that they will be expected to demonstrate a typical reaction, not an ideal one. Ask the volunteers to choose a name (not their own), age, and sex. Start the first role play with the arrival of the adolescent to see how she or he is greeted by the healthcare provider.

Let the role play run for three to five minutes. In particular, the facilitator should observe what the healthcare provider does or says that makes a difference in the way the adolescent reacts, what kind of body language the provider and adolescent use, what attitude the provider displays towards the adolescent and any family members, and any difficulties the provider experiences.

Afterwards, ask the role players to stay where they are until the discussion is over. Be sure to thank and praise the role players and then ask them to come out of their roles: that is, to say who they really are. Explain to the group that this is important to diminish the surprisingly powerful effect role plays can have on the players.

Next, ask for comments focused on what happened in the role play, not on general issues that can be taken up later. Begin by asking each of the role players how they felt in their roles (in addition to what they thought). When they have finished, ask the group for their reactions. If necessary, refer to any significant behaviour and ask people to comment on it. Demonstrate that you expect people to give helpful positive feedback. When the group has finished commenting, go back to the role players to give them the last word.

The box below shows an example of a role play. The second paragraph lists points that could be covered in the ensuing discussion.

Example of bad practices

A 15-year-old adolescent girl comes to see the doctor. She is embarrassed but manages to blurt out that something is happening at home that frightens her. The doctor asks how old she is, what class she is in at school, what subject she likes best, and how many sisters and brothers she has. The girl answers her, and then says that she is afraid to be at home when her mother is not there. The doctor tells her not to worry and to find things to do to take her mind off her worries. She then asks her if the girl has any other complaints. The girl says no. The doctor says she doesn't think there is anything wrong with her and that she should stop worrying.

Points to raise in discussion

The group is asked to consider what is wrong in this scenario. The doctor is sympathetic and friendly but she makes no reference to the girl's obvious anxiety and appears not to respond to the more important issues the girl is raising. She changes the subject twice and obtains information that may be irrelevant. She fails to ask what the girl fears, which might, for example, be sexual abuse or incest. The doctor may be a poor listener in general or may be too frightened to deal with the subject.

INTERVENING IF A ROLE PLAY BECOMES DIFFICULT

Occasionally, someone involved in a role play may become deeply emotional. Please do all you can to reassure the participants that they must go no further than they feel comfortable; they are free to stop and come out of their roles at any time.

It is sometimes possible to reduce the risk of this happening by intervening. Through careful observation of the role play, the facilitator will notice if a participant playing the role of a patient or client, or even a healthcare provider, is becoming unduly upset. The facilitator can then gently intervene to review what has caused the person to feel so strongly. If the cause is something that the healthcare provider has done, it might help if the role players replay that part of the intervention and attempt to alter what happened. However, it is also possible to freeze the role play and ask another participant to take that role to finish it, or use a different approach altogether. To be able to do this, the facilitator must employ tact, empathy, and keen observation.

CASE STUDIES

The purpose of case studies is to illustrate good and bad practices in dealing with a young person who has a particular health problem. Within the time available, it is possible to lead the case studies in a number of ways, which we discuss below.

Always remember to allow the participants sufficient time for reading. Because some can read faster than others, it helps to keep the faster readers occupied while waiting for the others to finish. At the same time, avoid putting pressure on the slow readers. Facilitators could also consider having a volunteer read the whole case study and ask everyone if they understand. In this way, nobody is left behind.

Facilitators can vary methods in the following ways:

- Sometimes use the case studies in plenary and at other times in small groups.
- Modify the task—for example, by getting the participants to do the following:
  - Answer questions, either posed directly to the participants or provided to them on a task sheet
  - Devise a list of good and bad healthcare practices based on the case studies
- Vary the method of feedback after small group work by asking the groups to do the following:
  - Write their agreed-upon points on a flip chart page and report their findings in plenary
  - Offer points as feedback and write each on a flip chart page, repeating the process until none of the groups has anything more to add

GUIDED DISCUSSION

The purpose of including this activity in a health issue unit is to elicit changes that the participants would want and be able to carry out so as to modify applicable aspects of their clinical practice, thus making their services related to a specific health issue more youth friendly. This will also be reinforced when the participants use the training programme personal diary.

Following the group work, it is likely that most participants will have in mind a range of ideas for change when they return to their work situation.

Depending on the amount of small group work that the participants have already done, you might initially ask them to work alone, in pairs, in small groups, or even (if there is little time remaining) in plenary.

If they begin by working alone or in pairs, the participants might then move on to a larger group to pull together ideas before finally sharing them in plenary.

It is also possible to suggest separate tasks for each pair or small group. Doing so means that participants avoid listening to many different versions of the same lists; it also provides an opportunity for each group to challenge, alter, or affirm the solution of another one.

Your role is to facilitate a proper discussion by the whole group. This requires a careful balance between intervening and taking a back seat. If the group works well together, your main role is likely to be to guide the discussion if it wanders off course or dries up. You may sometimes need to intervene by noting on a flip chart page or cards the main points as they are raised, asking open-ended questions, and directing the discussion.

Remember to draw out contributions from quiet participants and restrain other members from dominating the group. As a facilitator, you can say, "Let's hear from someone who hasn't spoken yet." If people are making comments to their neighbours, you can ask them to share with the rest of the group.

When discussing controversial issues, create an environment in which everyone can state their views, experiences, and worries honestly, without fear of disapproval.

At the end of the discussion, ask the group to summarise the main points that have arisen or do it yourself. You can also assign a participant ahead of time to help summarise the main points of the discussion.

Concluding components: unit review

At the end of each unit, summarise the key points brought out in the plenary discussion and group work. It is also necessary to go back to the unit's objectives and ask the participants to say whether or not they feel these have been fully met. This will provide you with feedback on areas you may need to strengthen in future workshops or those you need to revisit, if time allows, during the current one. The section on evaluation methods gives some examples of how you can obtain feedback.

SECTION 2.
INVITING PARTICIPANTS AND OTHER CONTRIBUTORS

Selection of participants

The training package is modelled to complement the 2015–2020 YFHS strategy's multisectoral approach. Thus, participants will be joining different cadres across the sectors. In the health sector, participants will be trained and registered health service providers at all levels who are involved in curative, preventive, and promotive health services, and who interact with young people. Across sectors, participants are likely to be professionals and volunteers working with adolescents on SRH issues, such as psychologists, social workers, victim support officers, teachers, faith leaders, youth development workers, youth leaders, young people, community-based distribution agents, and youth peer educators.

Qualifications

Ideally, the service providers to be trained will need a minimum of a Junior Certificate (JCE) and experience in community work. Ability to communicate in English (spoken and written) is also key. Training will extend to peer educators (male and female) ages 15–24 who have already received intensive training on SRH, HIV and AIDS, or gender. Anyone lacking the above minimal criteria should be oriented. Orientation should cover effective communication with young people, issues affecting young people, laws and policies affecting young people in health service delivery, and the YFHS standards (Unit 7).

It would be useful to invite service providers from different specialties to enhance the opportunity for information sharing and networking during the workshop, and for post-workshop collaboration. It is suggested that the mix of professional service providers to other technical experts should be a ratio of 2 to 1, depending on the relevance of the topic. It is advisable to limit the total number of participants for each training workshop to 20.

The workshop planning team should work with a cross-section of organisations for help in selecting appropriate candidates to be invited to the workshop. This should enhance the multisectoral approach and ensure that all sectors of service provision will become accomplished in YFHS. The skills mix also provides a platform for networking during the workshop, as well as post-workshop communication, collaboration, and exchange of experiences in serving youth. If a follow-up workshop is to be held, establishing some formal channel for inter-organisational collaboration might be discussed.

Involving young people

Understanding young people and their distinct SRH needs, as well as the barriers they may face in accessing the information and services they need, is vital for a thriving YFHS programme. It is essential for those working with and serving young people not to have a biased or judgmental attitude towards them, irrespective of any differences in perspective. Whereas most adults retain clear memories of their own adolescence, the speed of change (including growing urbanisation and globalisation) means that

young people today face some challenges that did not exist even 10 years ago. Thus, adults' personal experiences of adolescence may not be fully relevant to today's young people; likewise, adults may find it difficult to understand and empathise with today's adolescents. For these reasons, the training should involve young people who can share their experiences and guide facilitators through some of the sessions.

A useful way to deal with generational differences in the training programme is to invite a small group of young people, including adolescents, to participate throughout the workshop. We strongly suggest inviting an appropriate group of local young people—perhaps from a middle or secondary school, or a community youth club or group. Both male and female young people should be represented. Once they are selected, you need to meet with them before the workshop and introduce them to their roles. Some points that may arise are given in the next two sections.

BEFORE THE WORKSHOP

Explain the themes and purpose of the training programme, and how they could contribute. (Examples are a short drama or reading letters published in a magazine aimed at young people.)

Reinforce the important contribution of these young people as equal participants in the workshop, regardless of their age, sex, or background.

DURING THE WORKSHOP

Facilitators should encourage these young people to participate actively in the small group discussions and activities to provide the perspective of an adolescent on key issues.

Drawing on the expertise of specialists

The facilitation team should decide which resource individuals, if any, they would like to invite. We advise you to spend some time reading the rest of these preparation notes and the health units so you can be clear about the role that guest specialists could play. For example, when discussing mental health issues, you may want a mental health expert to be present; for the unit on HIV, you may want the services of an HIV specialist.

SECTION 3.
PLANNING THE WORKSHOP

Before the workshop, organisers and facilitators should address the items proposed in the following workshop preparation and planning checklist. We recommend that a small group of two to three people form a planning group, review the checklist, and distribute responsibilities six to eight weeks in advance.

Workshop preparation and planning checklist

8–10 weeks before the workshop

- Orientation programme structure and agenda
  - Develop the programme structure and content, working with the key organisations involved.
  - Make contact with other facilitators to agree on the programme and who will be responsible for each unit and session.
- Selection of participants
  - Initiate this process in collaboration with the relevant organisations.
  - Decide on a deadline for completing the process and notifying the participants.
- Accommodation, meals, and coffee breaks
  - Book hotel rooms.
  - Make arrangements for meals and coffee breaks.
  - If the workshop is for local participants, we recommend that you hold it in a place some distance from their places of work to minimise interruptions.
- Workshop facility
  - Select the workshop facility/training room.
  - The room for plenary should be large enough for the participants to spread out and work in small groups comfortably without disturbing one another.
  - At least one end of one plenary room should be capable of being darkened for overhead projection or to show PowerPoint slides.
  - Ensure the availability of two or three small tables for the facilitators to use.
  - Ensure that you will have the flexibility to rearrange the tables for breaks and small group sessions.
- Photocopying and computers
  - Ensure the availability of photocopying facilities on the premises or nearby.
  - Ensure the availability of a computer and printer.

- Workshop equipment and tools
  - Three or four flip chart stands
  - Six to eight pads of flip chart paper
  - Coloured markers for flip charts
  - An overhead projector or a computer with PowerPoint projection equipment
  - Blank transparencies and pens for the overhead projector
  - A screen or free wall for slide projection
  - VIPP cards or the equivalent
  - Masking tape or pushpins to mount charts on walls and boards
  - A pair of scissors
- Participants' tools
  - Notepads, one for each participant
  - Pens, one for each participant
  - Name tags for participants and facilitators
- Notification of participants about the course objectives, dates, and venue
- Start of gathering local data on adolescent health and development that are relevant to the sessions

Two weeks before the workshop

- Make photocopies of the following documents:
  - Workshop agenda
  - Local data on adolescent health and development
  - Support materials (case studies, role plays, and so forth)
- If possible, make additional copies of the whole package in case you have unexpected visitors or extra participants. This will save you from having to do it during the workshop.
- Make transparencies of the slides or have them ready for PowerPoint projection.
- Prepare the VIPP cards or alternatives (as discussed in Section 1). Check that the needed pieces of equipment are available.
  - Flip charts and stands
  - Markers
  - Overhead projector and blank transparencies and pens, or a laptop and PowerPoint projection equipment
- Confirm that you will have sufficient seating.
- Make sure that all reference materials, such as other capacity-building materials and training manuals, will be available at the workshop for reference.

One week before the workshop

- Confirm that those invited to the formal opening ceremony can attend.
- Confirm that the participants can all attend.
- Confirm venue and accommodation arrangements.
- Confirm catering arrangements.

One day before the workshop

- Check the workshop meeting room and the facility.
- Arrange the seating in a U-shape to ensure that the participants face each other and can also comfortably see the speaker and the projection screen.
- Confirm that all required pieces of equipment are in place and in working order.
- Greet the participants who arrive early.

SECTION 4.
EVALUATION METHODS FOR THE WORKSHOP

People usually enjoy coming to workshops, particularly when they are active participants, as they will be in this training programme. However, measuring what they have learned from the workshop can be difficult. In this programme, we offer a pre-test and post-test to examine the degree to which participants benefit from the training. The pre-test and post-test questions are the same. A facilitator will mark them and give feedback to participants following the training but before participants go home. The pre-test and post-test are not included in the *Facilitators Guide* or *Participants Handbook*; instead, they are provided separately.

An evaluation at the end of each day is recommended. Examples of these evaluations include (but are not limited to) the following:

- Ask participants to write down one thing they liked most and one thing they liked least that day.
- Mood metre: Participants can tick a smiley, sad, or neutral face.

This daily evaluation could facilitate day-to-day improvements and also help with the overall workshop evaluation. Using these methods will provide you with the following:

- Evidence of how the workshop has affected the participants
- Indications of where the workshop has been less effective, so facilitators can try to address the reasons in the future
- A way to gain support for offering the workshop to others because you can show that you can evaluate the results or, even better, because you can show the positive effects of the current workshop

People often use questionnaires in such settings. However, analysing them takes time; because facilitators are always busy during the workshop, the results are usually not available until sometime later.

The methods we have suggested here are immediate! They free you from time-consuming analysis. Moreover, they act as a kind of needs assessment because they can reveal which topics and issues require special attention during the various units.

Evaluations can be conducted at different levels to measure different things. In this training package, we offer methods to measure change at three levels:

- Participants' knowledge
- Changes in the participants' attitudes
- Changes in participants' skills and practice

The next sections outline these methods and how to use them. You will find the methods built into the units of the training package.

Evaluation method to measure participants' reactions to the workshop: discussion groups

If you are interested in getting more in-depth feedback from the participants after a particular unit, you could ask five participants if they are willing to talk about the session and give them a small number of questions to discuss. You can use the questions given below to guide your discussion or develop your own.

- How do you feel about this unit?
- Which sessions worked best?
- Which sessions did not work well?
- What could we have done differently?
- What did you get out of the unit?

Please remember that the point of such a discussion is for you to hear participants' opinions. Try not to talk much yourself; listen to criticism without being defensive. There is no need to respond directly to any criticism. However, facilitators should discuss among themselves all of the points raised in the debriefing to recognize what techniques are working and where improvements should be made.

Evaluation method to measure changes in participants' knowledge: spot checks

You will find a series of spot checks for each of the units. The spot checks will enable you to see how the participants feel about certain issues and what they know about the topic before you begin the unit. Reviewing the same spot checks at the end of each unit will reveal any change in participants' attitudes and knowledge. Each spot check poses a question or questions and asks participants to answer. If multiple responses are needed, ask participants to respond to all of them. Some questions have blank spaces for participants to write down their answers. Options are given below:

Option 1

Individual work

- Ensure that every participant has the relevant spot checks.
- Ask the participants to work individually on their spot checks (this is explained in detail in each unit of the *Facilitators Guide*). Inform them that you will review the spot checks together during the unit review session.
- Ask the participants to get the spot checks out again during the unit review and go over each one to see if participants would change any of the answers they gave at the beginning of the unit.
- Ask volunteers to share examples of the changes they make. This will give everyone an opportunity to share the immediate impact of participating in the unit.

Advantages of option 1

- It obliges each individual to write down what she or he believes is the right response to each question posed.
- It minimises the concern that some participants might have about responding with an incorrect answer in plenary and then feeling embarrassed.
- It allows participants to reflect on the changes in their own attitudes, knowledge, and understanding as a result of their participation in the unit.
- It is less time-consuming.

Disadvantages of option 1

- It does not allow facilitators to observe the overall change.

Option 2

Group work

- Make two photocopies of each spot check—on large sheets of paper if possible. Divide them into two sets—"before" and "after"—and mark them accordingly.
- Drawing from the "before" set, put one copy of each spot check in the room, with a thick marker by each one.
- Before the unit begins, ask the participants to tour the room and work on each spot check. Encourage them to do this quickly and without any discussion. If they do not have an opinion or do not agree with any of the statements, they could mark their spot checks with a dot in a corner of the page. Tell them that they can add more than one dot next to the same answer.
- You should watch out for results that suggest negative attitudes towards working with adolescents and gaps in knowledge and understanding. Do not talk about them at this stage, but consider paying special attention to them during the unit.
- Repeat the process with the "after" set of spot checks at the end of the workshop.
- Present the findings to the participants by comparing the "before" and "after" sets. (You could do this by pinning the pairs of spot checks on the wall.) There is no need to count the dots; the patterns should be visible. If the workshop has had the desired effect, you will see more dots on the "correct" answer for factual questions as well as a shift in the kind of attitudes needed for effective work with adolescents.

Advantages of option 2

- It allows facilitators to get a good sense of the knowledge, understanding, and attitudes of all participants and see any changes that occur during the workshop.
- The responses of the participants may contribute to the learning and attitude development process.

Disadvantages of option 2

- It is more time-consuming.
- It will give participants a chance to look at the responses of others, which may influence their own responses.

If, in the "after" spot check, the participants have shifted to more desirable options for improving YFHS, the programme has probably had a positive impact on the participants' ideas of what they can do.

Note the kinds of options clustered together on the left- and right-hand sides of the page to determine whether the general distribution of spots has shifted.

Evaluation methods to measure changes in the participants' practice

After participants undertake this workshop, we hope what they learn will influence how they work with adolescents in the future. One way to support this is to help the participants distil what they have learned into changes they intend to make. This should improve the chances that they will put what they have learned into practice. Three methods can be used to track these changes:

- **Training programme personal diary:** diary questions for personal reflection at the end of each unit
- **Personal plan** to improve working with and for adolescents: developing a personal plan in the concluding unit
- **Follow-up questionnaire** for use where a follow-up workshop is not possible

Training programme personal diary

The diary is a notebook for daily input in the "unit review" session at the end of each unit. You will post a flip chart page with the following two statements for participants' input at the end of each unit:

- List three important lessons that you learned through participation in this unit.
- List three things that you plan to do in your work for and with adolescents.

Encourage the participants to take a few moments to jot down their answers. This will help them tap into—and remember—what they found in each unit that was most relevant to their own attitudes and practices. It will also help them when they develop their personal plan in the workshop's concluding unit. During that unit, the participants will get a chance to share examples of their reflections and answers to the statements above.

Please remember that you will not be collecting the diaries. These are for the participants to keep and apply to implement changes in their work with and for adolescents. The things that they might write down will obviously vary from person to person. For Unit 7, "Providing Young People with the Health Services They Need," we might expect answers such as the following in response to that unit's questions:

- Name three lessons or other things you learned as a result of participating in the unit:
  - It is up to us to make the health centre attractive to young people!
  - I had forgotten how much I used to hate going to the clinic when I was young.
  - It is possible for the clinic to be made youth friendly without spending too much money.
  - Our procedures take too long; no wonder young people get fed up waiting.
- List three things that you want to apply when you go back to your workplace (actions or changes you want to make):
  - I'm going to talk to my colleagues about this. We could go through this unit together and come up with ideas to improve things.
  - I think I can cut out some of the bureaucracy and speed things up.
  - I'm going to lobby for another counsellor; we just don't have the capacity we need at the moment.

  - I'm going to rearrange the furniture and put up some partitions to provide more privacy.

- What do policies and guidelines on the following topics say about provision of services to young people?
  - HIV testing: Any person age 13 and above should be considered mature enough to give full and informed consent for HIV testing and counselling. However, this service for adolescents under age 13 should be done with the knowledge of their parents or guardians, unless this is not possible and the testing is for provision of treatment and care services.
  - Contraceptive provision: There is no minimum age for accessing contraceptives. Adolescents and youth can access any contraceptive of their choice at any time.
  - VMMC: Adolescents ages 10–17 need parental or guardian consent to undergo VMMC. Any person age 17 and above can make a voluntary choice.
  - Abortion: Abortion is illegal unless it is performed to save the life of the mother.
  - LGBT: In Malawi, many LGBT persons are discriminated against and sometimes charged under various laws. It is not legal to treat those who are LGBT with violence; all LGBT persons have the right to provision of services.

Personal plan

The concluding session of the unit "Providing Young People with the Health Services They Need" focuses on change. It leads participants through the process of making a plan to change the way they work with and for young people. The process is important for two reasons. First, it helps the participants apply what they have learned in practical ways by enabling them to think of realistic changes that they can make or new things they can do while in the company of and with the support of the facilitators and other participants, rather than on their own when they will be back at work and busy. Second, by making these plans, the participants are stating goals against which they can measure the success of the changes they make.

Follow-up

Participants who have finished YFHS training will need supportive mentoring to kick-start and strengthen their delivery of such services. Because most of the participants will keep their personal diaries, recommend that they share what they have learned with their supervisors. The MOH 2015 YFHS strategy strongly recommends the following strategy for follow-up:

1. Participants share their personal plans with their workplace supervisors.
2. Trainers follow up with mentoring visits.
3. Where possible, check in with participants via the internet. (Perhaps create a listserv group to share new policies, information, dates of mentors' visits, and so forth.)
4. Take advantage of smartphone technology by establishing a Skype or WhatsApp group.

For follow-up visits, develop and use a questionnaire based on plans of the participants. You can use the following example to guide your conversation. Before the visit, remind participants of the changes they intended to make by sending them a copy of their plan.

Example

Follow-up questionnaire

In your personal plan, you identified a number of areas in which you planned to make changes.

- Please describe the areas in which you have been successful in making the changes you planned.
- What helped you to be successful in these areas?
- Please list the areas in which you have been least successful.
- What prevented you from making the changes you planned?
- Please describe any other areas in which you have made changes or improvements that are not listed in your personal plan.
- Overall, what are your thoughts and feelings about your work with and for adolescents following the workshop?

Evaluation methods to measure attitudes of providers

Barometer of values

Choose statements regarding issues that affect adolescents and young people, and ask the group to state their opinions individually using the following barometer of values:

-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 son or daughter who is 17.
- I will tell my neighbour if I know her daughter came in to get a family planning method.
- There is no need to offer privacy when dealing with young people.

Ask participants to form groups with those who have similar opinions: agree, disagree, or neutral. Discuss with each group why they have chosen their answer.

This exercise is meant to analyse and challenge negative attitudes. To facilitate positive attitude change, ensure that input from all participants is heard.

Cross the line

As with the barometer of values, prepare statements that can be used to assess participants' attitudes. Here are two examples:

- I cannot allow my daughter to marry a young man who is HIV positive.
- It is evil to give an adolescent long-term contraceptives.

Now read the first statement and instruct participants who agree with it to "cross the line" and those who do not agree to stay put. Ask those who are neutral to form their own group. Allow for discussions to expand on people's attitudes and work to critically analyse and resolve negative ones (if possible).

Conduct the same exercise with the second statement.

SECTION 5.
PREPARATION AND CHECKLISTS

Unit checklist

The unit checklist covers reminders, tips, materials, and equipment needed to run each unit. We recommend that you review the following checklists before the training.

- Unit preparation
- Materials and audio-visual equipment

Unit preparation

- Prepare name tags for the participants and facilitators.
- Ensure that the flip charts are ready for the group-work tasks.
- Ensure that the facilitators are clear about their respective roles during their designated session(s).

Materials and audio-visual equipment

The training package has been designed to require a minimum of workshop supplies. Ideally, the facilitators will be able to use the PowerPoint slide decks, videos, and handouts included in the toolkit at different points in the workshop. If a laptop and projector are not available, the key points can be written on large sheets of paper (flip charts) and displayed during the workshop. If you cannot afford to use flip chart paper, a blackboard may be used in some exercises. Where VIPP cards are not available, flip chart paper can be cut into small rectangles.

MATERIALS/EQUIPMENT

- Handouts
- Slides
- Flip charts and flip chart paper
- VIPP cards
- Matters Arising board
- Video or slide projector
- Masking tape, pushpins, or glue
- Name tags
- Coloured markers
- Notepads
- Markers
- Pens
- Chalk

ANNEX 2.

MORE SEXUALITY FACILITATION TALKING POINTS

CIRCLES OF SEXUALITY EXPLANATION

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.

Circle 1:

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 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.

- 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.

Circle 4:

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 behavior.

- *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.

Circle 5:

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.