National Adolescent Sexual & Reproductive Health (ASRH)

Training Manual For Health Workers

Ministry of Health

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UNFPA

United Nations Population Fund - Swaziland

Acknowledgement

The Ministry of Health and The United Nations Population Fund (UNFPA) are proud to present this Training of Trainers Manual for Sexual and Reproductive Health that aims to build the capacity of health providers of youth friendly services in Swaziland. This document is a fully collaborative effort between the Ministry of Health and UNFPA in their efforts to enhance Sexual and Reproductive Health services at the youth-friendly centres.

Thanks are due to the SRH unit and the core team for their support in the development of this manual. Special gratitude is due to all the facilitators and participants (Nurses, Career guidance officers, teachers, program officers and directors) who took part in the pre-testing of the original version of the Training Manual. We hope that this simplified version of the manual will be a useful resource in training ASRH service providers as a means to bring about immediate and long-lasting impact on the reproductive health and well-being of youth in Swaziland.

ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
ALHIV	Adolescents Living with HIV
ART	Antiretroviral Therapy
ARV	Antiretroviral
AYFS	Adolescent Youth Friendly Services
CSE	Comprehensive Sexuality Education
ICPD	International Conference on Population and Development
ECPs	Emergency Contraceptive Pills
FP	Family Planning
GBV	Gender Based Violence
GSM	Gender and Sexual minority
HIV	Human Immunodeficiency Virus
HTC	HIV Testing and Counselling
HTS	HIV Testing Services
PMTCT	Prevention of Mother to Child Transmission
LGBT	Lesbian, Gay, Bisexual, Transsexual
MICS	Multi-Indicator Cluster Survey
MSM	Men who have Sex with Men
MOH	Ministry of Health
NGO	Non-Governmental Organization
IUD	Intra Uterine Device
PEP	Post-exposure prophylaxis
PHC	Primary Health Care
POPs	Progestin Only Pills
SHIMS	Swaziland HIV Incidence Measurement Survey
SRH	Sexual and Reproductive Health
SRHU	Sexual and Reproductive Health Unit
STIs	Sexually Transmitted Infections
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Emergency Fund

UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFS	Youth Friendly Services
YFCs	Youth Friendly Centres
YSRH	Youth Sexual and Reproductive Services

FOREWORD

The Sexual and Reproductive Health Unit under the Ministry of Health has over the years embarked on building the capacity of service providers on the provision of quality adolescent Sexual Reproductive Health services, in order to attract the youth to access healthcare services and so that all the healthcare facilities are made youth friendly. However, the SRHU did not have standardised ASRH materials to support the YFS training.

The planned capacity building will enable the Ministry of Health to carry out its commitment which according to the National SRH Policy 2013 is the provision of comprehensive sexuality education, information and integrated SRH services to all children, adolescents and young people at all levels of health care delivery systems and other relevant settings according to their age and needs. It is in this regard that a national ASRH training manual was needed for the country to enhance the standard of care for the youth in general.

The main objective of this standardized ASRH training manual is to strengthen the capacity of health care providers and improve the quality of youth friendly sexual and reproductive health (SRH) services provision in Swaziland.

TABLE OF CONTENT

TRAINING MANUAL AGENDA

DAY	7.30-8.30am	8.30-1030am		11.00-12noon	12.00-1.00pm		2.00-3.00pm	3.00-5.00pm
MONDAY	Registration, Introductions and Welcoming Remarks	M1: Objectives Overview Pre Test Why ASRH	**T**	M2: Physical Development and Healthy Adolescents	M3: Values Clarification about Adolescent Sexuality	**L**	M4: Teenage Pregnancy	M5: Adolescent Sexual Reproductive health and Rights (ASRHR)
TUESDAY	Morning devotion M6: Comprehensive Sexuality Education (CSE	M7: STI's (HIV) and HTS	**E**	M8: Psychosocial Support for ALHIV	M9: Gender and ASRH	**U** **N**	M10: Gender Based Violence and Adolescents	M11: Ten year plan Challenges faced by youth
WEDNESDAY	Morning devotion M12: Key Population Highlight	M13: Substance Abuse	**A**	M14: Characteristics of a Youth Friendly services	M15: Framework for working with Youth Life skills	**C** **H**	M16: Interpersonal Communication skills	M17: Counselling Process
THURSDAY	Morning devotion Recap M18: Nutrition & adolescent	M19:Adolescents and Contraception		M20: Cancers of the Reproductive Health System	M21: How to establish a teen club and linked with the community		M22: SRH for Adolescents in difficult circumstances	M23: M & E and Sustaining ASRH Programmes
FRIDAY	Morning devotion Post Test	M24: Drug Adherence		M25: Disclosure and Transition to adult care	M 26: Action planning for Youth friendly services		Closure and departure	Closure and departure

GUIDING PRINCIPLES FOR ASRH SERVICE DELIVERY

Respect for Persons

"To respect autonomy is to give weight to the autonomous person's considered opinions and choices while refraining from obstructing his or her actions..."

– Belmont Report

Beneficence

"Persons are treated in an ethical manner not only by respecting their decisions and protecting them from harm, but also by making efforts to secure their well-being. Such treatment falls under the principle of beneficence. The term beneficence is often understood to cover acts of kindness or charity that go beyond strict obligation. In this document, beneficence is understood in a stronger sense, as an obligation."

– Belmont Report

Justice

"Just as the principle of respect for persons finds expression in the requirements for consent, and the principle of beneficence in risk/benefit assessment, the principle of justice gives rise to moral requirements that there be fair procedures and outcomes in the selection of research subjects."

– Belmont Report

1.0INTRODUCTION

The mission of the Swaziland's Reproductive Health (SRH) Program in the Ministry of Health is to attain the highest possible level of health for all the people in Swaziland through the implementation of appropriate SRH policies, objectives, and strategies (MOH, 2013). This is in line with recommendation made in Cairo through the International Conference on Population and Development (ICPD) in 1994 and 2004. Such recommendations mainly involved the recognition of SRH needs and rights of individuals and universal access to comprehensive sexual and reproductive health services by 2015. Sexual and reproductive health is a state of complete physical, mental and social well-being in all matters related to reproductive health system, its functions and processesSafe Motherhood. It involves the following components: Family Planning; Adolescent Sexual Reproductive Health (ASRH); Gender Based Violence and SRH; Male Involvement and Community Midwifery (MOH, 2013).

ASRH on the other hand is a component of SRH and is defined as the physical, mental, and emotional well-being of adolescents. It includes freedom from: unwanted pregnancy, unsafe abortion, maternal death and disability (MOH, 2013); sexually transmitted infections (STIs), including HIV/AIDS and all forms of sexual violence and coercion. ASRH encompasses the following components: Youth–friendly health services (screen for cancers, NCDs, etc.); Information, education and communication; Peer education; Teen Clubs; Family Planning; Life skills; ALHIV- adolescents; Gender Based Violence (GBV) and Social Behaviour Change Communication (Swaziland SRH report, 2013).

Training health workers and ASRH service providers (e.g. nurses, teachers, doctors, community health workers, and police) on issues related to adolescents is therefore paramount in scaling up and maintaining adolescent and youth-friendly services in Swaziland. It is wise to train ever worker in a health-facility, from the security guard to the clinic manager so that everyone has improved attitudes towards young people. Training should include values clarification and also assist all service providers to provide improved psycho-social support to young people and adolescents.

The Sexual and Reproductive Health Unit under the Ministry of Health has over the years embarked on building the capacity of service providers on the provision of quality adolescent Sexual Reproductive Health services. In order to enhance and standardise training of service providers on ASRH issues; this training manual was developed. We believe this initiative will make ASRH service delivery youth friendly and therefore attract more youth to access healthcare services.

1.1CONCEPTUAL FRAMEWORK OF THE MANUAL

After reviewing different models that fit the issue at hand, one may be convinced that the Supply and Demand Model is more appropriate in addressing ASRH issues. This model has been used across different settings and works effectively especially in developing SRH programs(UNFPA, 2007)

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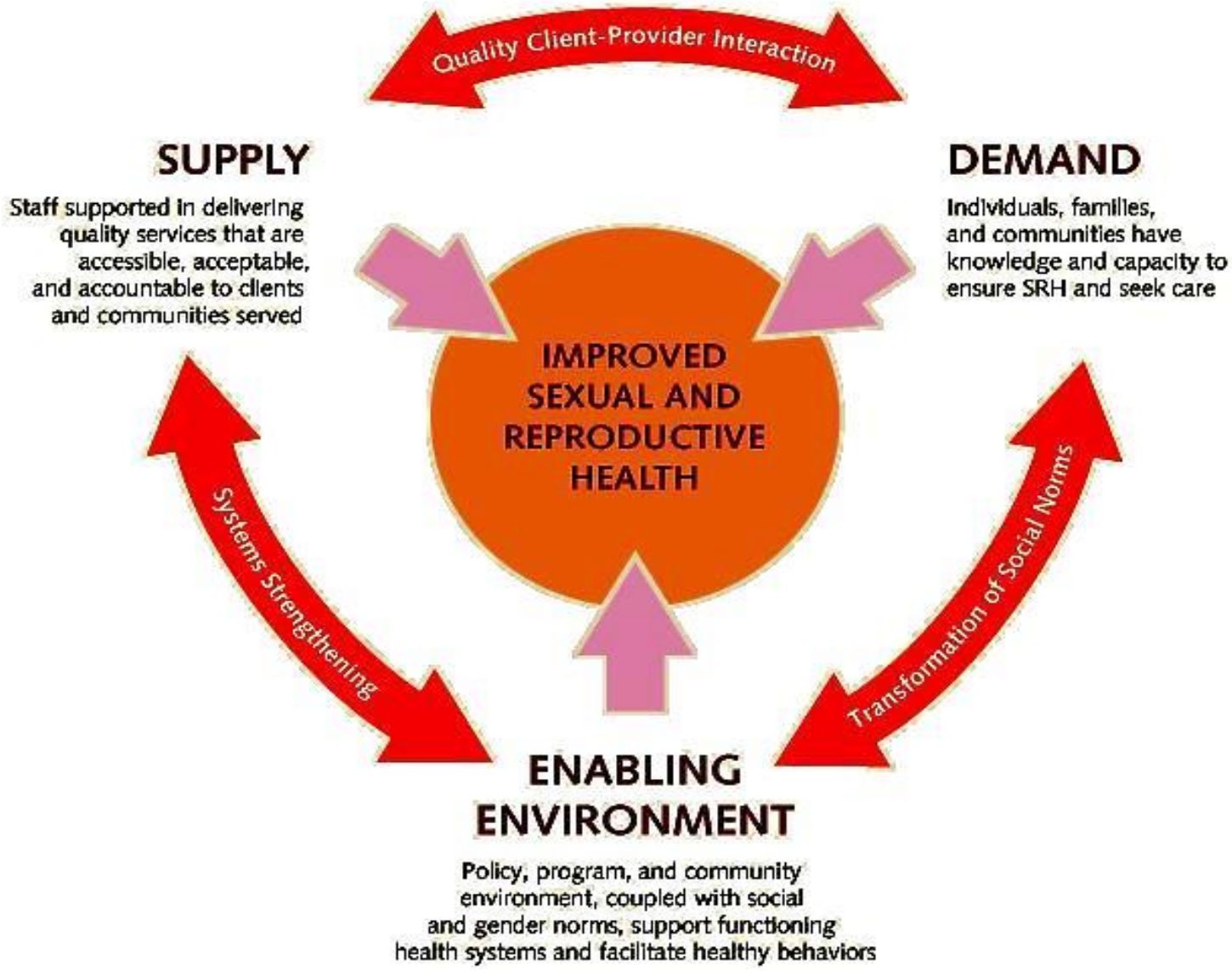
The Supply–Enabling Environment–Demand (SEED) Programming Model is a holistic programming framework based on the principle that Sexual and Reproductive Health (SRH) programs will be more successful and sustainable if they include synergistic interventions that:

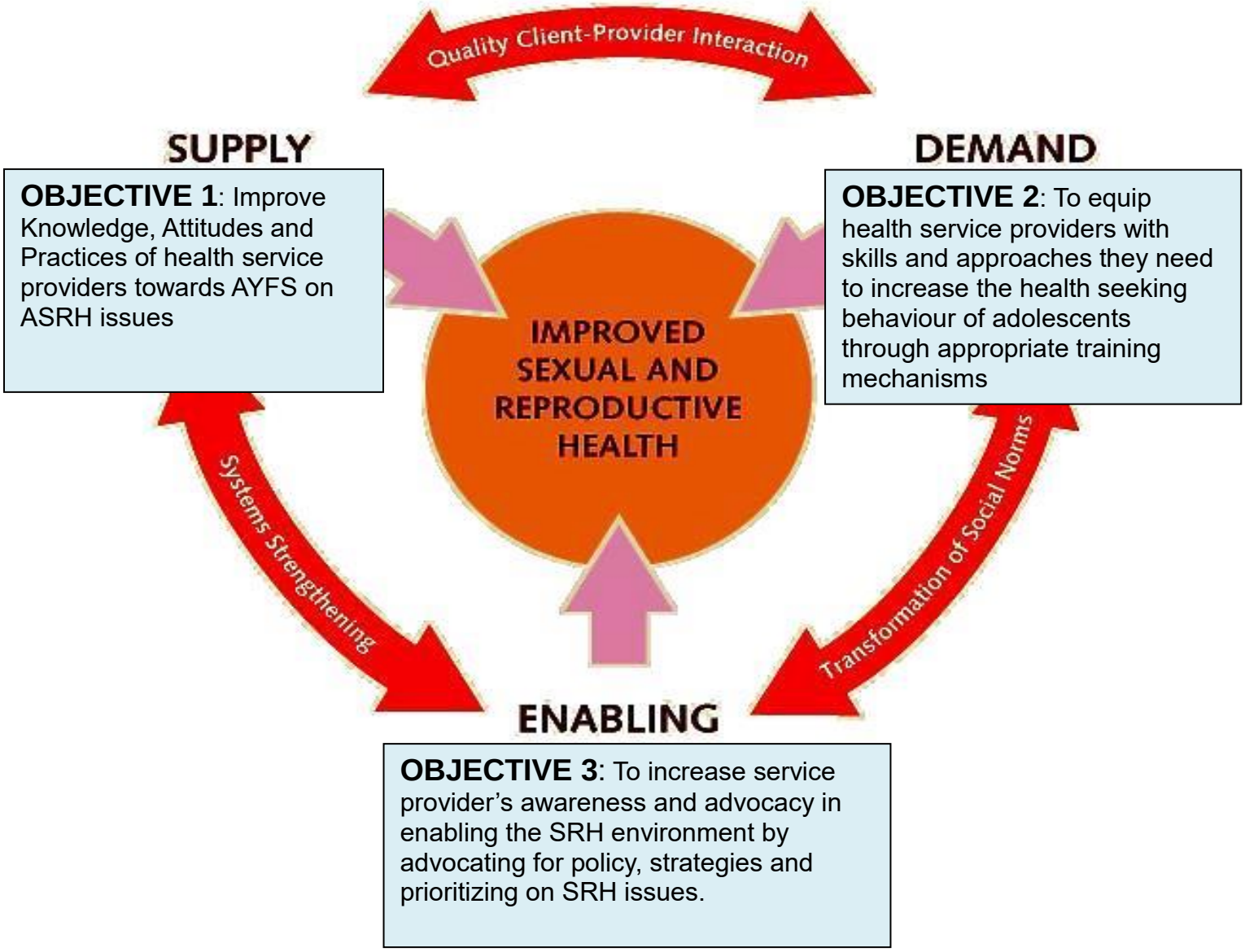
- Strive to improve the knowledge, attitudes and practices of ASRH service providers in order to ensure consistent availability of quality ASRH services.
- Seek to increase and cultivate demand for ASRH services among youth
- Strengthen health systems and foster an enabling environment for ASRH-seeking behaviour

Figure 1: The Supply–Enabling Environment–Demand (SEED) Programming Model



(The ACQUIRE Project, 2007)

1.2OBJECTIVES OF THE MANUAL



1.3 NOTES FOR THE FACILLITATOR

The Modules utilize the following Interactive Training Methods

A variety of training methodologies are presented and the facilitator should choose a methodology that best suits the nature of participants, their skill and level of knowledge. Interactive learning methods read a wider range and help in keeping participants engaged. The proposed training methods are as follows:

1. **Mini lectures:** these are mainly power point presentations to present information on ASRH for discussion initiation
2. **Discussion triggers:** The will include brainstorming, case studies, questions or statements, problem posing, short videos and readings that are used to prompt spoken or written responses from the participants.
3. **Creative play:** Creative play keeps participants motivated as they stimulate new thought processes and ideas. These include games, role plays and creative writing.
4. **Group discussions:** These give participants an opportunity to express themselves, to be heard and to hear others. This helps participants to develop both verbal and listening skills. It fosters democratic values and culture. Group discussions will include informal dialogue, panel discussions and debates.
5. **Participatory reflection and analysis**: This involves the division of participants into groups to solve problems and foster group unity and critical thinking. Examples include community mapping, problem trees, research projects and the analysis of media messages.
6. **Personal reflection:** It helps participants gain insight of their own experiences and fosters maturity and judgement. Personal reflection may also open the door to new attitudes and behaviours; examples include guided memories, clarification of values and creative art projects.
7. **Other tools for the participatory approach:** The facilitator should involve the participants in goal setting, assigning roles to help manage the learning environment (time keeper, reporter of the day, leader of the day and others). This will help in the review of lessons learned on a daily basis.
8. **Energizers:** These are fun group activities designed to provide participants an opportunity to be physically active, to promote team building and positive feelings about the group. These may include ice breakers, songs, games and physical exercises.

The facilitator should always remember that:

Service providers who are our target groups are adults and have their strong points and challenges. Hence, applying the following approach improves the training process.

Adults learn better when:

- They realise that what their learning is valuable
- They have clear goals
- Their experience is valued and useful
- New knowledge and skills are connected to what participants already know
- They receive direct and frequent feedback
- They engage in discussions/debates so that they learn from each other
- They feel respected and listened to.

- They need to have a say in how the teaching and learning should happen.
- Differences in identity and experience are acknowledged and accepted.

Facilitator's Guidelines

This training manual will contain guidance for the facilitators to conduct each session in the form of session plans including: session title, objectives, allocated time, training methodology, materials, power point presentations and selected hand-outs. It is recommended that the facilitators will use interactive techniques to stimulate group thinking and active participation through a variety of training methods including brain storming, asking questions, group work and role-plays, which are included in this training manual. A set of power point slides are included for each session and will be given to the participants for self-learning.

The Role of the Facilitator is:

- To guide and encourage the participants to share ideas, information and experience
- To encourage participation so that they all benefit from discussions.
- To bring discussions to a meaningful conclusion

The Participant's Manual contains: This manual contains "Participant Handouts" for group exercises, case studies, and pre- and post-tests, as well as a participant evaluation form. Any handouts that are to be used in class are found in this section. "Content" drawn from the Trainer's manual that can be used as reference material by the participant. The material should be photocopied and available by the time training begins. The materials may be given out at the end of each specific learning objective or all together at the end of the course. Handouts are numbered using module number followed by the objective number.

1.4STRUCTURE OF THE MANUAL

This manual contains 26 modules.

The structure and content organization of this manual was informed by recommendations from a Training of Trainers (TOT) Workshop involving nurses, SRH program officers, career guidance officers and teachers.

The initial version of the manual was pretested in this TOT workshop.

Module Summary:

- Each session includes a module number and topic, target objectives, approximate length of time for the session, materials that the trainer will need to have on hand to present the session

- Handouts are named by first referring to the module number followed by objective number then lastly the number indicating whether the handout is the first, second, etc. under that specific objective. For an example: **HAND-OUT (HO): 3.1.2;** refers to a handout in module 3, objective 1 and is the second handout (2) under this objective.
- Evaluation forms should be given to participants during training; they will then be analysed in order to distil useful information that will lead to improvement of the training manual over time.

DAY 1: MODULE 1

TIME: 8.30 to 10.30 am

INTRODUCTION TO ASRH

Time: 2 hours

In this module, participants will learn about the meaning of adolescence and the need to focus on young people. They will also learn the importance of raising awareness and advocating for Youth Friendly Adolescent Sexual and Reproductive Health services.

Objectives:

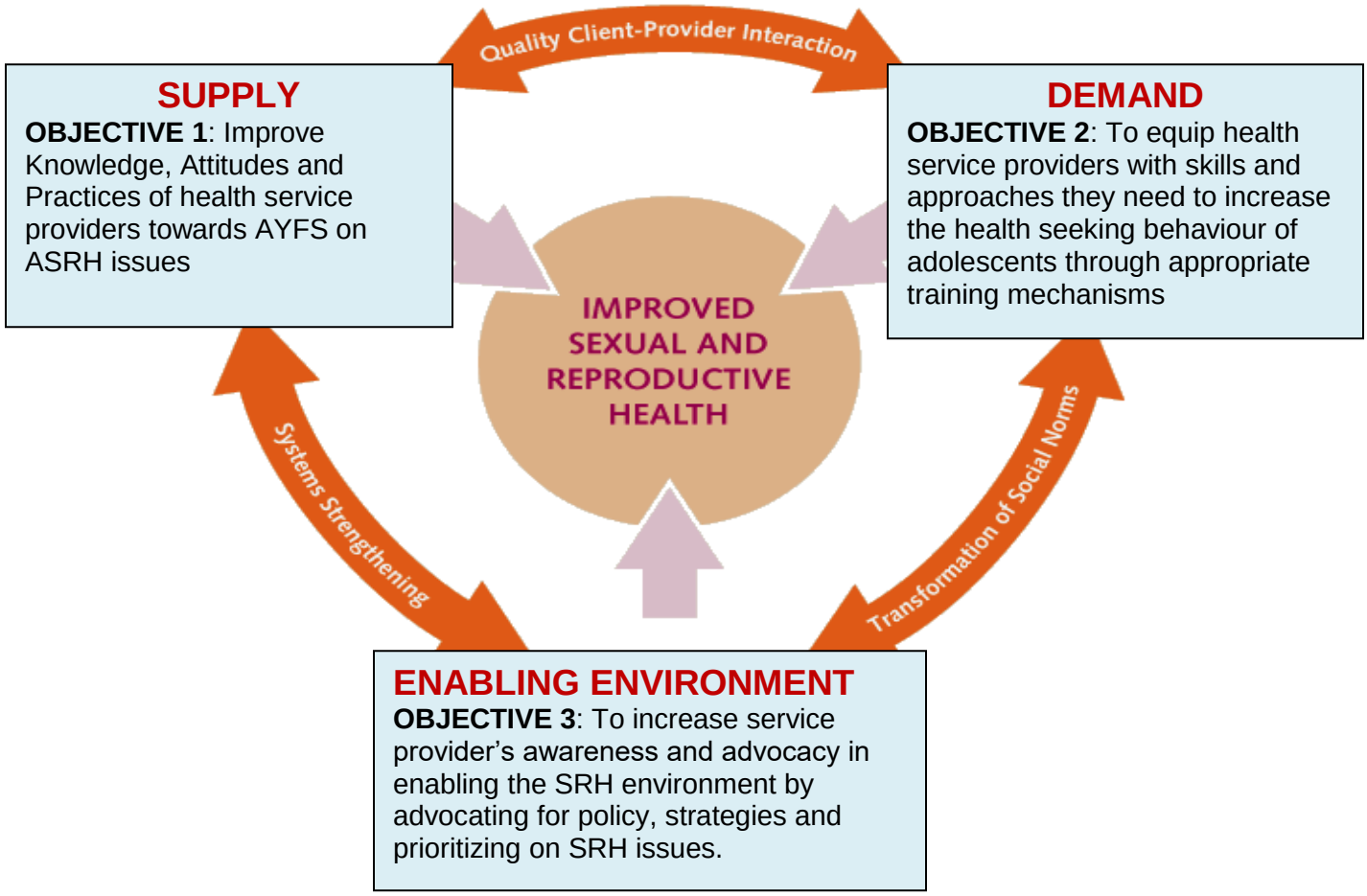
By the end of the session, participants will be able to describe:

1. Training Objectives (Overview)
2. The Meaning of Adolescence
3. The ASRH Situational analysis
4. Why ASRH is important
5. Youth Friendly SRH Services Package
6. ASRH rights, policies and laws

CONTENT	METHODOLOGY	RESOURCES
○ Training Objectives (Overview) ○ The Meaning of Adolescence ○ The ASRH Situational analysis ○ Why ASRH is important ○ Brief overview of the Youth Friendly SRH Services Package	✓ Presentation ✓ Presentation and Discussion ✓ Presentation ✓ Brainstorming and Presentation ✓ Handout and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 1.5.1 ○ Flip chart and Markers

OBJECTIVE 1: INTRODUCTION TO ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH

PowerPoint Presentation of the Training Objectives



NB: THE FACILITATOR SHOULD EXPLAIN THE ABOVE OBJECTIVES CLEARLY TO PARTICIPANTS AND THE REASON FOR FOCUSING ON A HOLISTIC APPROACH.

OBJECTIVE 2: THE MEANING OF ADOLESCENCE

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

Adolescence, derived from the Latin word "adolescere" meaning "to grow up" is a critical developmental period. During adolescence, major biological as well as psychological developments take place. The World Health Organization (WHO) has defined adolescence as the progression from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity, the development of mental processes and adult identity, and the transitions from total socio-economic dependence to relative independence.

The most important organizing event of adolescence is puberty, and because puberty occurs and progresses across a wide range of chronologic ages and differs between the sexes, attempts at chronologic categorization are troubled with boundary problems. Accordingly, it is reasonable to define early, middle, and late adolescence in terms of stages of pubertal development, since these follow a consistent pattern for individuals regardless of chronologic age.

(Adapted from Behrman & Vaughan, 2002

The "Ages" of Adolescents

Adolescence Adolescence (10 – 19 years of age) is not one developmental stage, but three developmental stages: Adolescence can be broadly divided into three stages: Early (10–13 years), middle (14–16 years), and late (17–19 years).

- Adolescence (10-19 years of age)
- Early Adolescence (10 – 13 years of age)
- Middle adolescence (14 – 16 years of age)
- Late adolescence (17 – 19 years of age)
- Youth (15 – 24 years of age)
- Young people (10 - 24 years of age)

(UNFPA, WHO, UNICEF)

Youth 15 -35 years according to the Swaziland National Youth Policy.

NB: For the purpose of this training manual, the term "Adolescents" will be used interchangeably with the term "Young people"; referring to individuals 10-24 years old according to (UNFPA, WHO, UNICEF)

OBJECTIVE 3:

NB: ALWAYS REFER TO THE LATEST STATISTICS AND NEW INFORMATION

OVERVEIW OF SITUATIONAL ANALYSIS

The MICS (2010) found that about 3.8% of young girls started sex before their 15th birthday compared to boys at 2.6%. With regard to teenage pregnancy, about 22% of women 20-24 years of age reported to have had their first live birth before their eighteenth birthday (MICS 2014). Data indicates that although more than 98% of adolescents aged 15 – 24 knew of a modern contraception method, few actually use them (approximately 43%). More than half of the HIV infected people are below 25 years. Approximately 14% of girls aged 15 – 24 years had HIV with females more infected than men (22.9% vs 5.9% respectively). Swaziland HIV Measurement Survey (SHIMS, 2012) reveals that HIV incidence among 20-24 was 4.17 % among women and 1.6% among men. The high HIV incidence among adolescents is attributed to low comprehensive knowledge on HIV prevention, low condom use, cross-generational and transactional sexual relationships, and inadequate testing and treatment of sexually transmitted infections (STIs) including HIV.

The mission of the Swaziland's Reproductive Health (SRH) Program in the Ministry of Health is to attain the highest possible level of health for all the people in Swaziland through the implementation of appropriate SRH policies, objectives, and strategies**.** This is a state of complete physical, mental and social well-being in all matters related to reproductive health system, its functions and processes. The National SRH unit encompasses the following programs:

- Safe Motherhood
- Family Planning
- **Adolescent Sexual Reproductive Health (ASRH)**
- Gender Based Violence and SRH
- Male Involvement
- Community Midwifery

ASRH refers to: The physical, mental, and emotional well-being of adolescents. It includes freedom from: unwanted pregnancy, unsafe abortion, maternal death and disability; sexually transmitted infections (STIs), including HIV/AIDS and all forms of sexual violence and coercion

ASRH Services (Elements)

- Youth–friendly health services (screen for cancers, NCDs, etc.)
- Information, education and communication
- Peer education
- Teen Clubs
- Family Planning
- Life skills
- ALHIV- Adolescents Living with HIV
- Gender Based Violence (GBV)
- Social Behaviour Change Communication

OBJCTIVE 4: WHY ASRH?

Why should there be special training for adolescent reproductive health care provision?

1. **Adolescents are different from adults.**

- They have different needs because of their physical and psychological stages.
- They have different cognitive abilities and skills, requiring different counselling approaches and more time.
- They tend to be less well-informed and require more information.
- Conflicts between cultural/parental expectations and adolescents' emerging values present serious challenges for young people.

2. **Adolescence is a critical age for risk-taking.**including

- Adolescents are moving toward independence, and tend to experiment and test limits, practicing risky behaviours.
- Using substances or drugs for the first time typically occurs during adolescence.
- Sexual experiences (not always voluntary) usually begin during adolescence.
- Consequences of risky behaviours can have serious and long-term effects.

3. **Adolescence is an opportune time for professional interventions**

- Adolescents are undergoing educational and guidance experiences in school, at home, and through religious institutions; health education can be part of these efforts.
- Life-long health habits are established in adolescence.
- Interventions can help adolescents make good decisions and take responsibility for their actions, often preventing serious negative consequences for their future.
- There are many effective channels for reaching adolescents: through schools, religious institutions, youth organizations, community and recreational activities, parental communication, peer education, the media, and health service facilities.

4. **Special training allows providers to be more responsive to the needs of adolescents.**

Well-trained providers are able to better serve adolescents and deliver services in a more efficient and effective manner.

OBJECTIVE 5: YOUTH FRIENDLY SERVICES PACKAGE

Brainstorming Session: What services should be provided to young people?

Services that should be provided for young people

- Information and counselling on sexual and reproductive health issues
- Promotion of healthy sexual behaviours
- Family planning information, counselling and methods of contraception (including emergency contraceptive methods)

- Condom promotion and provision
- Testing and counselling services for pregnancy, HIV and other STIs
- Management of STIs
- Antenatal care (ANC), delivery services, postnatal care (PNC) and pregnant mother-to-child transmission (PMTCT)
- Abortion and post-abortion care
- Appropriate referral linkage between health facilities at different levels.

NB: Facilitators notes:

- *Make a presentation on characteristics of Youth Friendly SRH Services.*
- *Discuss the characteristics and ask participants to share information on ASRH services provided at their institutions.*

HANDOUT 1.5.1: CHARACTERISTICS OF YOUTH FRIENDLY SRH SERVICES

Programmatic characteristics

- Adolescents are involved in programme design, boys and girls, married and unmarried are welcomed and served.
- Parental involvement is encouraged
- Wide range of services offered or necessary referrals are available.
- Adequate supply of commodities available
- Short waiting times
- lEC available on sight
- Services are well promoted in areas where youth gather
- Linkages are made with schools, youth clubs and other youth friendly institutions.
- Alternative ways to access information, counseling and services are provided.

Service provider characteristics

- Staff are trained in adolescent issues
- Respect is shown to young people
- Privacy and confidentiality are maintained
- Adequate time is given for client provider interaction
- Peer educators'/counselors are available

Health facility characteristics

- Convenient hours
- Convenient location
- Adequate space
- Sufficient privacy
- Comfortable surroundings

Youth perceptions of the programme

- Privacy is maintained at the facility
- Confidentiality is honored
- Youth are welcome regardless of marital status
- Service providers are attentive to adolescent needs

DAY 1: MODULE 2

TIME: 11.00 to 12.00 noon

Physical Development and Healthy Adolescents

Time: 1 hour

This module focuses on thephysical development and reproductive health system of young people. It describes the stages of physical development according to specific age groups of adolescents and why it is necessary for health workers to understand the developmental stages of adolescents. The intention is to make health workers aware of the desirable health status of adolescents and to appreciate the importance of using age-specific messages, interventions and approaches when addressing young people.

Objectives:

By the end of the session, participants will be able to describe:

1. The physical development and the body
2. The desirable health status of an adolescent

CONTENT	METHODOLOGY	RESOURCES
○ Physical development and the body	✓ Activity: Participants draw and label of male and female reproductive organs. ✓ Handout Discussion	○ Flip chart and Markers ○ HO 2.1.1 ○ HO 2.1.2 ○ HO 2.1.3 ○ HO 2.2.1
○ The desirable health status of an adolescent	✓ Brainstorming and Presentation ✓ Handout Discussion	○ Flip chart and Markers

1. OBJECTIVE 1: PHYSICAL DEVELOPMENT AND THE BODY

BRAINSTORMING SESSION

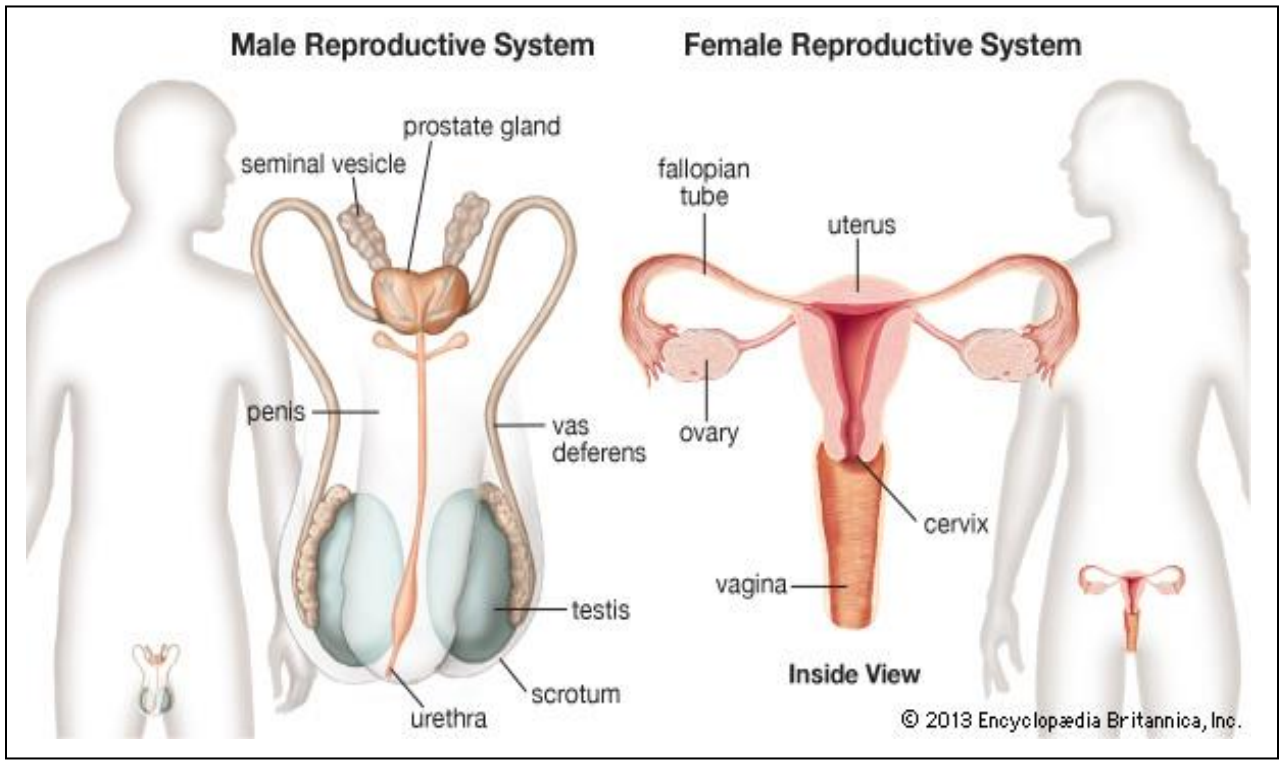
(I) Ask participants:

- Why is it important that a health worker to understand the physical development and reproductive health system?

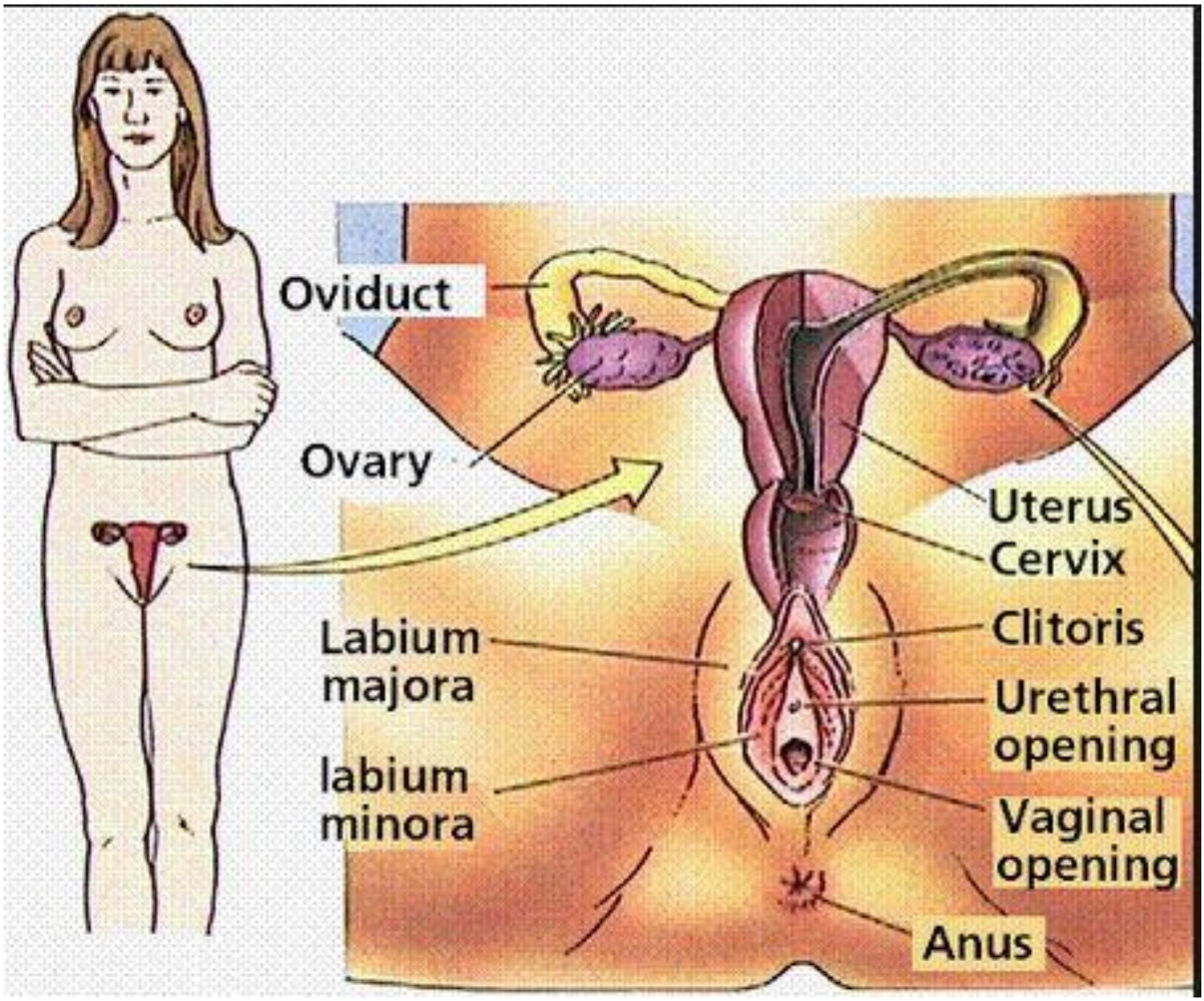
(II) Present session Objectives

- Divide participants into manageable groups
- Ask participants to draw and name corresponding organs of the male and female reproduction system and their functions: Use a flip chart for this activity.

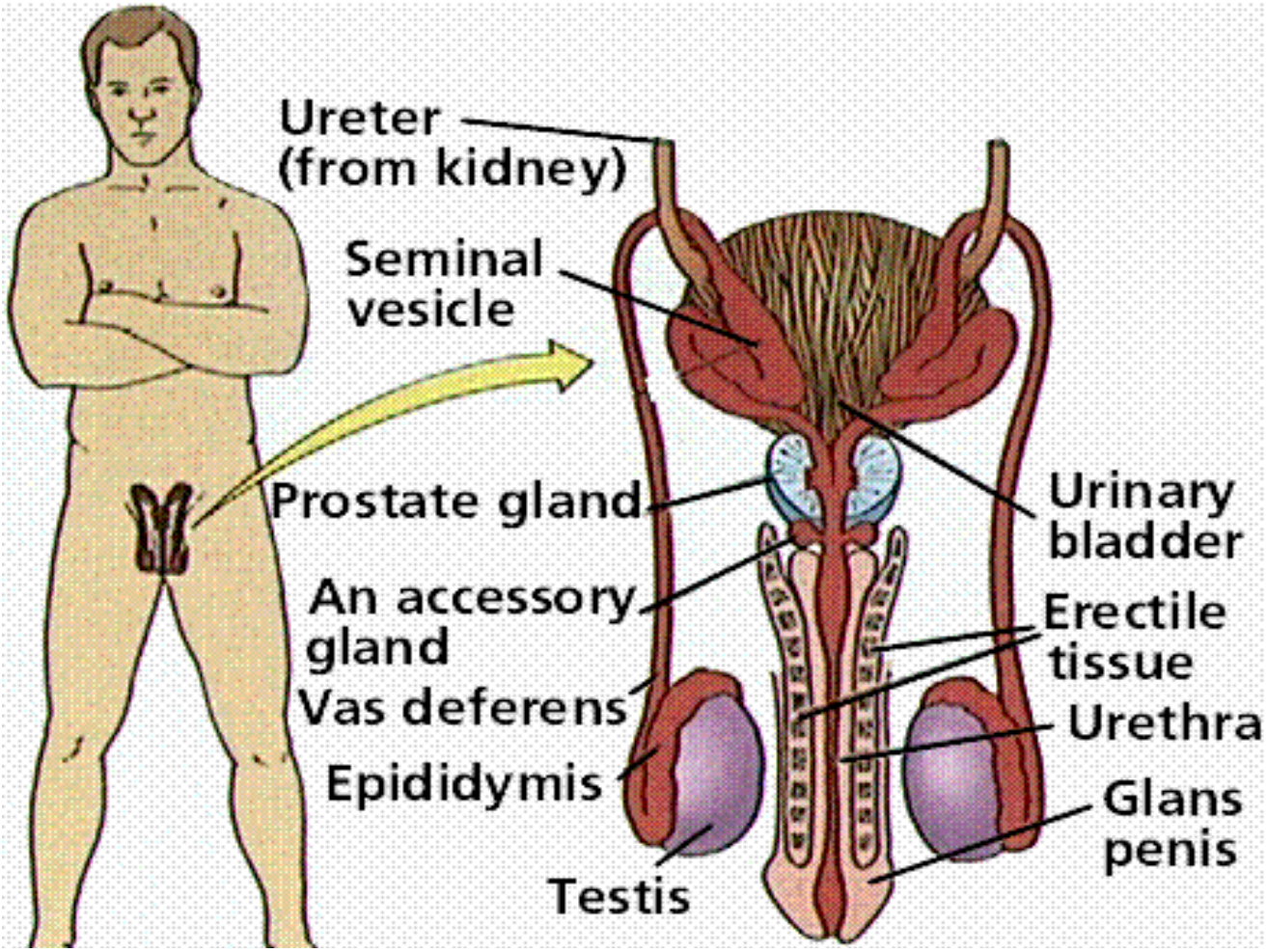
FIGURE 2.1.1: CORRESPONDING ORGANS OF THE MALE AND FEMALE REPRODUCTIVE SYSTEM



HANDOUT 2.1.2 FEMALE REPRODUCTIVE SYSTEM



HANDOUT 2.1.3: MALE REPRODUCTIVE SYSTEM



OBJECTIVE 2: DISCUSS DESIRABLE HEALTH STATUS OF ADOLESCENTS:

Ask participants to list some of the desirable health outcomes of Adolescents:

Others are as follows:

- ✓ Adequate height and weight for age.
- ✓ Good nutrition.
- ✓ Free of disease and illness.
- ✓ Emotional support from family/friends.
- ✓ Ability to avoid substance abuse.
- ✓ Ability to make an informed decision on sexual activity (whether to engage in sexual activity, with whom, when, what type, and how to protect oneself from pregnancy and STI/HIV) that is free of coercion.
- ✓ Good self-image both in terms of physical appearance and **personalcharacter.**

The facilitator should now lead a discussion on the characteristics of a positive and healthy adolescent. Health professionals should assess the achievements of the adolescent and provide guidance to the family on anticipated tasks. The effects are demonstrated by health supervision outcomes.

HANDOUT 2.2.1: ADOLESCENT DEVELOPMENTAL CHART

CATEGORY OF CHANGE	EARLY (10–15 years)	MIDDLE (14–17 years)	LATE (16–19 years)
GROWTH OF BODY	Secondary sexual characteristics appear Rapid growth reaches a peak	Has advanced secondary sexual characteristics Growth slows down; reaches approximately 95% of adult size	Physically mature
COGNITION (ability to get knowledge through different ways of thinking)	Thinks in concrete terms (i.e. the "here and now") Does not understand how actions affect future	Thinking can be more abstract (theoretical) but goes back to concrete thinking when under stress Better understands long-term results of own actions	Abstract thinking now established Plans for the future Understands how current choices and decisions have an effect on the future
PSYCHOLOGICAL AND SOCIAL	Worries about rapid physical growth and body image Has frequent mood changes	Has established body image Thinks about fantasies or impossible dreams Feels very powerful May experiment with sex, drugs, friends, risks	Plans and follows long-term goals Has established sense of identity (who he or she is)
FAMILY	Still defining comfort with independence/ dependence	Has conflicts with authority Figures	Is moving from a child-parent/child-Guardian relationship to more adult-adult relationships

PEERS	Peers very important for development Has intense friendships with same sex Has contact with opposite sex in groups	Has strong peer friendships that help affirm self-image Peer groups define right and Wrong	Decisions/values less influenced by peers and more influenced by individual friendships Selection of partner based on individual choice rather than on what others think
SEXUALITY	Focus is on self-exploration and evaluation	Has preoccupation with romantic fantasy Tests how he or she can attract others Sexual drives emerging	Forms stable relationships Has mutual and balanced sexual relations Is more able to manage close and long-term sexual relationships Plans for the future

DAY 1: MODULE 3

TIME: 12.00noon to 1.00 pm

Values Clarification about Adolescent Sexuality

Time: 1 hour

This module intends to equip participants with the necessary knowledge and skills required for realization of their own values; differentiating between personal and professional values andfurther establishing a therapeutic relationship with adolescents by not imposing their personal values. This will inturn enforce a trust relationship between health workers and adolescents.

Objectives:

By the end of the session, participants will be able to:

1. Define and differentiate the meaning of values, attitudes and perceptions
2. Recognize the foundations and sources of moral values
3. Describe their own values

CONTENT	METHODOLOGY	RESOURCES
○ Define and differentiate the meaning of values, attitudes and perceptions ○ Recognize the foundations and sources of moral values ○ Clarification of one's own values	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Exercise ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 3.3.1 ○ HO 3.3.2

INTRODUCTION VALUES CLARIFICATION

OBJECTIVE 1: DEFINITION OF TERMS – Presentation and Discussion

- **Ask participants what they understand about these three words: values, attitudes and perceptions.**
- **Record responses on a flip chart and give correct definitions.**

Values: Is a principle, standard or quality regarded as worthwhile or desirable. We inherit many of our values from our family, and religion, friends, education; cultural factors and personal experience influence our values. Values are beliefs, principles and standards to which we assign importance. They are things we prize and give a degree of significance to.

Attitudes: Is a state of mind or feeling. It is the mental stance we take in relation to the world.

Attitudes are largely based on our personal values and perceptions. Attitudes are mental views, opinions, dispositions, or postures.

Perception: This is a state of awareness achieved directly through the sense, to achieve understanding. Thus, perception leads to insight, intuition, or knowledge.

Sources of Values, Attitudes and Perceptions – Discussion

- **Lead discussions on what shapes our values and attitudes.**
- **Ask participants how values, attitudes and perceptions are related to one another.**
- **Display the drawing of a Hippo and explain that values, attitudes and perceptions can be imagines as a Hippopotamus in the water.**

Where do we get our values and attitudes?

- From parents, society, culture, traditions, religion, peer groups, media (Television, music, videos, magazines, advertisements), school, cinemas, climate, environment, information communication technology, politics, friends, personal needs, economics, family, and personal experiences.

- Values Clarification means sorting out one's own "real" (intrinsic) values from the (extrinsic) values of the outside world – separating one's personal beliefs from the beliefs of others. It means saying what we really mean.

- Although one may only see the small ears and eyes sticking out of the water, beneath the water lies a very large Hippo on which the eyes and ears are based.

- The same is true of values, attitudes and perceptions. We present our attitudes to the world, and they may appear to stand on their own. Yet they are based on a large set of often unspoken underlying values and perceptions.

- If those underlying values and perceptions were different, it is most likely that our attitudes, our stance towards the world, would be different. Just as if the Hippo's body was, in fact a Giraffe, the eyes and ears shown to the world would be different and perhaps, less frightening! Therefore, in order to change our attitudes, it is important to become aware of the perceptions and values the lie beneath the surface.

- Each person is a unique mix of values, attitudes and perceptions that makes up a personal cultural identity.

- Most of us only see the obvious "attitudes" but these are based on values and perceptions that are below awareness – often even our own awareness.

OBJECTIVE 2: DESCRIPTION OF KEY MORAL VALUES – Exercise, Discussion

Which values should be upheld for effective ASRH service delivery?

Key Moral Values

- **Love:** commitment to treat others well.
- **Honesty:** commitment not to lie, cheat, steal or deceive
- **Justice:** to be without prejudice, discrimination or dishonesty.
- **Faithfulness:** undeviating allegiance to a person, contract or oath.
- **Dignity:** according appropriate worth to self and to others.
- **Responsibility:** thinking rationally and being accountable for one's behavior.
- **Compassion:** caring for those smaller and weaker than ourselves and not abusing or taking advantage of anyone.
- **Integrity:** consistency in what one says and does and the commitment to be honest and conscientious in what one does or say.

PERCEPTION – Show the picture of woman on PowerPoint Slide

Exercise: Seeing the Woman
Display image of Old/Young Woman to the group. Ask them to silently and individually, without talking or sharing, write down how old they think the woman is. Ask the participants to each say out loud the age they wrote down.

- Ask the group "How is it that some people think she was old and others young?
- What led to such a variety of answers?

Young/Old Woman

Exploring Perceptions: what influences perceptions?

- Our age, gender, social class, tribal background and other personal factors affect our perceptions.
- We may think that we see somebody clearly but these influences color our vision as though we were wearing colored eyeglasses.
- As a result, no two people perceive something or someone exactly the same.

Exploring perception is known as direct perceiving, unencumbered by values and judgments. To spend a few minutes a day sitting quietly and paying attention to our direct perceptions can be very useful to us in experiencing the world more clearly. In many cultures, this practice is known as meditation.

OBJECIVE 3: VALUE CLARIFICATION – Exercise

Exercise:

- Are there any values contrary to the delivery of ASRH services in Swaziland?
- How can we best deliver our care to young people in the presence of these values?

If we allow our own attitudes and values to impose themselves on the counseling and communicating relationship, it is unlikely that we will attain our primary goal of helping adolescents.

We cannot "get rid of" our own values and attitudes or act like we think they are wrong. The point is to become as aware as possible of the underlying assumptions we have and to learn skills that will help us to perceive the young client in as objective a light as possible.

APPLICATION AND CONCLUSION

- ***Ask participants what are some attitudes that the counselor could hold which would hinder the counselor – adolescent relationship?***
- ***Exercise: Ask participants to complete the handout "Personal values, attitudes and perceptions," individually.***
- ***After a few minutes ask volunteers to share their hindrances and strategies.***
- ***Ask for additional suggestions from the participants.***

- NB: It takes a life time to form values, attitudes and perceptions and it is not an easy or quick process to change them. It is, however, important to examine them in order to make conscious decisions about which values and attitudes we want to keep and which we think may no longer be useful to hold.
- People are a complex mix of unique characteristics, which includes physical characteristics but also various values, attitudes and perceptions.
- This session focused on how one's internal world can help or hinder one's ability to help young people.

HANDOUT 3.3.1: Values Clarification

1. The age of majority should be reduced from 18 years to 16 years.
2. All teenagers should have access to contraception if they want it.
3. Girls should be virgins when they marry.
4. Most of the youth today are promiscuous.
5. Sex and sexuality should be taught in primary school level.
6. It is the girl's responsibility not to be raped.
7. An unmarried pregnant school girl should be expelled from school.
8. Abortion is murder.
9. An unmarried pregnant girl of 14 should be able to have an abortion.
10. Men can enjoy sex without love.
11. Any teenager caught abusing drugs should be locked away in prison
12. Women can enjoy sex without love.
13. Information on contraception should be introduced at primary schools.
14. Love is not necessary for marriage.

15. Polygamy is a family planning method.
16. Family planning increases women's promiscuity.
17. Boys cannot control their sexual behavior when aroused.
18. Disabled persons should not have children.
19. Girls who swear, go around half naked, are promiscuous.
20. It is a girl's fault if she gets pregnant.

HANDOUT 3.3.2: Personal Worksheet

Personal Values, Attitudes and Perceptions

1. Perceptions, values and attitudes that I hold that help when I counsel youth:

---

2. Perceptions , values and attitudes that I hold that may hinder when I counsel youth:

---

3. Ways I can balance the perceptions, values, attitudes that hinder my effectiveness:

DAY 1: MODULE 4

TIME: 2.00 to 3.00 pm

Teenage Pregnancy

Time: 1 hour

This module focuses on equipping participants with knowledge and skills necessary for them to educate and empoweradolescents to void pregnancy.When adolescents are empowered, they become healthy, can avoid child marriage, unintended pregnancy and HIV; they also become able to contribute fully in fighting the battle against poverty

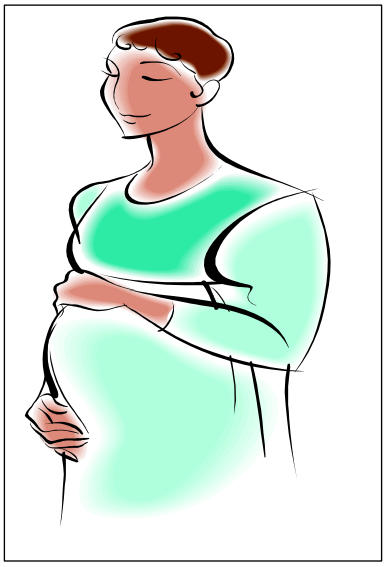
By the end of the session, participants will be able to:

1. Define teenage pregnancy
2. To state the causes of teenage pregnancy
3. State and discuss the impact of teenage pregnancy, on the mother and on the child

CONTENT	METHODOLOGY	RESOURCES
○ Define teenage pregnancy ○ To state the causes of teenage pregnancy ○ State and discuss the impact of teenage pregnancy, on the mother and on the child	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Exercise ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 4.4.1 ○ HO 4.4.2

OBJECTIVE 1: DEFINING TEEN PREGNANCY
Brainstorming: what is teenage pregnancy?

- When an under aged girl becomes pregnant, we call it teenage pregnancy.
- It is specifically pregnancy among girls within the age of 13 to 19 years.



- The global incidence of teenage pregnancy rates range from 143/1000 in sub-Sahara Africa to 2.9 per 1000 in South Korea.
- There have been no record in Swaziland for such rates, but deliveries from teenage mothers are up to 30% according to studies.
- Globally about 30 million of children are born to woman before the age of 20years, with 90 % of these occurring in developing countries.

Risks of Adolescent pregnancy and childbirth

- Carries a greater risks for both the mother and her baby
- Maternal and perinatal mortality among adolescents;
  - ✓ maternal mortality is two – five times among girls 15-25 years
  - ✓ perinatal mortality is two-three times greater in the offspring of adolescents than adult

Causes of teenage pregnancy

- Poverty has been found to contribute to high incidences of pregnancy.
- Peer pressure –girls are more pressurized according to local studies.
- Lack of knowledge of or access to conventional methods of preventing pregnancy.
- Traditional gender roles – the general expectation that a maturing woman has to bear children.
- Sexual abuse of statutory rape.
- In some societies early marriage contributes to teenage pregnancy.
- Early age at first inter-course (sexual debut).
- Use of inhibition-reducing drugs and alcohol also contribute to teenage pregnancy.
- Incorrect use of contraceptive by teens. Will also contribute to pregnancy.
- Lack of contraceptive use.
- Domestic violence and family strife in childhood.
- Poor parental relationship is likely to contribute to teenage pregnancy.

Factors contributing to adolescent pregnancy

- Biological factors
  - ✓ The declining age of menarche
  - ✓ Early initiation of sex

- Socio – cultural factors
  - ✓ Norms and traditions; early marriage and pressure to have children upon marriage
  - ✓ Changing circumstances of young people; premarital sexual activity and use of alcohol and other substances
  - ✓ Vulnerability of young people;Sexual coercion (including rape) and Socio economic factors

- Service - delivery factors
  - ✓ Lack of access to sexual and reproductive health information and education
  - ✓ Lack of access to contraceptive information and services

- Other factors
  - ✓ Children who grow up in foster care are also likely.
  - ✓ Low educational expectation
  - ✓ Mass media – because of the displays of fantasized images of sex.
  - ✓ For children who do not grow up in environments that show love them desire for unconditional love; that can be another cause of teenage pregnancy.

The consequences of teen motherhood are:

- Less likely to complete high school or college
- More likely to be a single mother
- More likely to have more children sooner on a limited income
- More likely to abuse or neglect the child
- Drop out of school.
- Lack of skills in the teen mother may result having difficulties in finding and keeping a job.
- These teen mothers are more likely to live in poverty.
- Depression is very common.
- Because they have not developed parenting skills, this negatively affects the proper socialization of their children.

Consequences of Teenage Pregnancy on the children

- Malnutrition
- Improper health care. E.g. lack of immunization
- Little cognitive and social stimulation for the child, resulting in under developed intellect.
- Risk for child neglect and abuse.

- Risk for long-term problems in major areas of life such as school failure, poverty, physical and mental illness.
- Boys born of teenage mothers are 13% more likely to be incarcerated/jailed.
- Girls born of teenage mothers are more likely to become teenage mothers themselves
- The child born of teenage mothers have developmental and conduct/behavioral disorders.
- The children run the risk of being abandoned/dumped.
- The risk of infanticide from teen mothers
- The risk of the pregnant teen mom developing medical problems, such as PIH, Genital infections , premature labour, CPD, HIV.
- Many of the teenagers may not have social support systems (e.g. chased away from home) to help them deal the stress of raising the child.
- Many of the teenage mothers wish to have babies because they do not recognize the stress of raising a child.
- Substance (drugs and alcohol abuse.
- Exposure domestic violence (beaten by partner)
- Limited job opportunities.
- Social isolation

Common Antenatal Complications among Adolescents

- Pregnancy induced hypertension (PIH)
- Anemia
- STIs / HIV
- Higher severity of malaria

Complications during labour and delivery

- Preterm Birth
- Obstructed labour – pelvic bones of the birth canal are not fully formed hence cephalo-pelvic disproportion occurs more often

Post-partum problems that can affect both the adolescent mother and her baby

- Anemia
- Pre-eclampsia
- Post-partum depression
- Too early repeat pregnancies – unmarried adolescents face considerable barriers to obtaining contraceptive methods hence unprotected intercourse and repeat pregnancies can occur in these circumstances

NB: Realizing that many of the milestones occur during adolescence helps us to understand the challenges that young people face during their physical, emotional, and social development. It is important to note that because of many factors; individuals may reach particular milestones at different ages.

DAY 1: MODULE 5

TIME: 3.00 to 5.00 pm

Adolescent Sexual Reproductive health and Rights (ASRHR)

Time: 2 hours

Sexual and reproductive health and rights (SRHR) are based on the right and the ability of all individuals to decide over their own bodies, and to live healthy and productive lives. Addressing SRHR is thus key to ensuring Sustainable Adolescent Health and development.

Objectives:

By the end of this session, participants will be able to:

1. Define all important terms related to the subject
2. Mention and describe sexual and reproductive health rights.
3. Describe national and international laws, policies or/and strategies that promote adolescent sexual and reproductive health and rights.
4. Identify gaps within existing policies and strategies and come up with strategies of addressing them.

CONTENT	METHODOLOGY	RESOURCES
○ Define all important terms related to the subject ○ Mention and describe sexual and reproductive health rights. ○ Describe national and international laws, policies or/and strategies that promote adolescent sexual and reproductive health and rights. ○ Identify gaps within existing policies and strategies and come up with strategies of addressing them.	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Exercise ✓ Handouts and Discussions ✓ Presentation ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 5.1.1 ○ HO 5.2.1 ○ HO5.3.1

OBJECTIVE 1: DEFINITION OF TERMS

Mini Lecture, Discussion

- *Ask participants to define human rights and SRH rights.*

PowerPoint Presentation:

- SRH is not just about health care or information about disease - it is also about rights and choices. SRH is a human right and is fundamental to human survival and development.

- Human Rights are basic rights and freedoms that all people are entitled to regardless of nationality, sex age, national or ethnic origin, race, language or other status. They are conceived as universal and egalitarian with all people having equal right by virtue of being human beings. These rights may exist as natural rights or as legal rights in both national and international contexts.

Sexual Rights include the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality.

Reproductive Rights are integral parts of human rights. They are the basic rights of women and men to decide freely and responsibly on issues of sexuality and family planning, to have access to information to make these decisions and the means to carry them out. Reproductive rights include the right to attain the highest standard of sexual and reproductive health and the right to decide on issues of reproduction free of discrimination, coercion and violence.

Note: Sexual and Reproductive health rights are human rights.

RIGHTS, RESPONSIBILITIESAND BARRIERS

- *Participants will be requested to list rights in one column and identify responsibilities that adolescents should observe.*
- *Facilitator will also add other rights that might not have been identified by the participants*
- *Discuss rights and responsibilities for adolescents*
- *Ask participants to identify barriers that hinder adolescents from enjoying sexual and reproductive health rights.*

HANDOUT 5.1.1: REPRODUCTIVE RIGHTS OF THE ADOLESCENT CLIENT

The right to good reproductive health
The right to decide freely and responsibly on all aspects of one's sexuality
The right to information and education about sexual and reproductive health so that good decisions can be made about relationships and having children
The rights to own, control, and protect one's own body
The right to be free of discrimination, coercion, and violence in one's sexual decisions and sexual life
The right to expect and demand equality, full consent, and mutual respect in sexual relationships
The right to quality and affordable reproductive health care regardless of sex, color, marital status, or location
The right to privacy and confidentiality when dealing with health workers and doctors
The right to be treated with dignity, courtesy, attentiveness, and respect
The right to express views on the services offered
The right to gender equality and equity
The right to receive reproductive health services for as long as needed
The right to feel comfortable when receiving services
The right to choose freely one's life/sexual partners
The right to celibacy
The right to refuse marriage
The right to say no to sex within marriage

(Source: IPPF. 1991. Rights of the Client. London: IPPF).

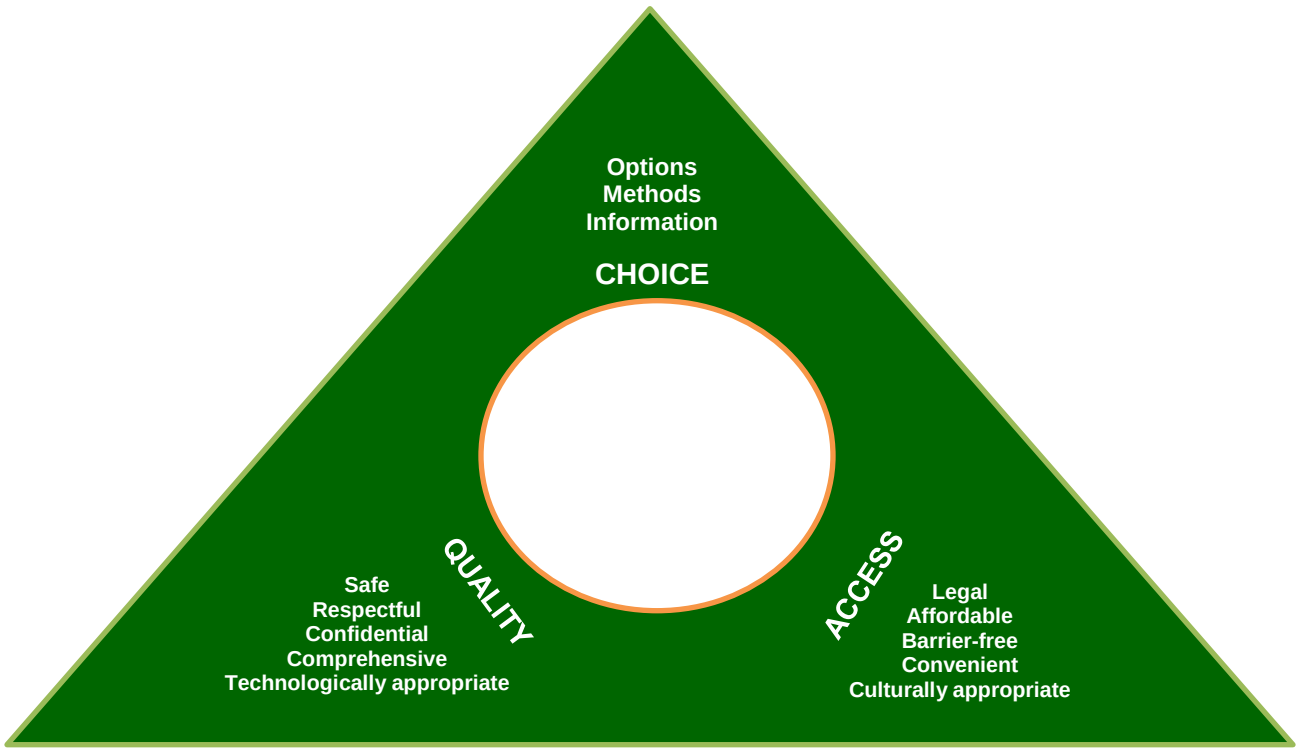
Adolescent Responsibilities VS their Rights

- Participation in issues that affect their sexual and reproductive rights
- Advocacy for better services
- Taking responsibility for consequences of one's actions

Barriers to Rights:

- Cultural barriers
- Economic barriers
- Legal barriers: Example: although young people have a right to decide when to have a child but abortion is not an option that they can simply choose except in cases of rape, incest or when the pregnancy threatens the health of the mother or the child
- Social barriers
- Lack of harmonization between some laws and policies

OBJECTIVE 2: WHAT REPRODUCTIVE RIGHTS IS ALL ABOUT?



HANDOUT 5.2.1: DEFINITION OF TERMS

Human Rights:
Are basic rights and freedoms that all people are entitled to regardless of nationality, sex age, national or ethnic origin, race, language or other status. They are conceived as universal and egalitarian with all people having equal right by virtue of being human beings. These rights may exist as natural rights or as legal rights both national and international.

Reproductive rights:
Are the basic rights of women and men to decide freely and responsibly on issues of sexuality and family planning, to have access to information to make these decisions and the means to carry them out. Reproductive rights include the right to attain the highest standard of sexual and reproductive health and the right to decide on issues of reproduction free of discrimination, coercion and violence.

(1) "people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so" and (2) "the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and

provide couples with the best chance of having a healthy infant". (International Conference on Population and Development Programme of Action, 1994).

The ICPD definition of Reproductive Health (ICPD)
"Reproductive health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore 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 if, when and how often to do so.

Sexual rights:
Include the human rights of women and men to have control over and decide freely and responsibly on matters related to their sexuality.

HANDOUT 5.2.1: INTERNATIONAL AND REGIONAL CONVENTIONS

- Participants should list the international and regional conventions that they know and discuss on what they are about
- The facilitator will discuss these with the participants and identify their key contributions to sexual and reproductive health for young people.
- Pick two Conventions and highlight their provisions that are in line with adolescent's sexual and reproductive health.

There are a number of international and regional conventions, commitments and agreements that contribute to sexual and reproductive health provision and total well-being of adolescents.

Examples include:

International Conventions and Commitments
- Convention on the Elimination of all forms of Discrimination Against Women (CEDAW),
- United Nations Convention on the Rights and Welfare of Children
- Programme of Action adopted at the International Conference on Population and
- Development (ICPD) in Cairo in 1994
- Universal access to treatment
- Millennium Development Goals

Regional
- Sexual and Reproductive Health Strategy for the SADC Region: 2006-2015,
- Maputo Plan of Action on Reproductive Health and Rights
- African Charter on the Rights of Children,
- African Youth Charter.

OBJECTIVE 3: NATIONAL LAWS, POLICIES AND STRATEGIES
Activity:
- *Brainstorm on 3 laws, national policies and strategies that address sexual and reproductive health and rights, including their provisions.*
- *After presenting the laws, national policies and strategies the facilitator should request participants to discuss the challenges of these*

- *How do service providers address some of the identified challenges to ensure access and service provision to the adolescent?*
- *Share practical experiences from your work place and community.*

A number of laws, policies and strategies have been put in place for the protection of all the citizens of Swaziland.

NOTE: THESE LAWS, POLICIES AND STRATEGIES ARE REVIEWED FROM TIME TO TIME. AS THE FACILITATOR, YOU NEED TO ENSURE THAT YOU ARE REFERRING TO THE MOST RECENT VERSION IN YOUR PRESENTATIONS.

HANDOUT 5.3.1: INTERNATIONAL AND REGIONAL CONVENTIONS AND COMMITMENTS

Provisions from Selected International and Regional Conventions and Commitments

1. The United Nations Convention on the Rights of the Child (1989)
State parties should strive to ensure that no child is deprived of his or her right of access to such health care services required and, in particular, to reduce infant and child mortality, develop preventive health care, provide guidance for parents and family planning education and services as well as taking all effective and appropriate measures with a view to abolishing traditional practices detrimental to the health of children.

2. The international Conference on Population and Development (September 1994,Cairo)

The Programme of Action also stresses the following need to:

- Eliminate all forms of discrimination against the girl child
- Eliminate the root causes of son preference; to increase public awareness of the value of the girl child and to strengthen her self-esteem
- Eliminate female genital mutilation, trafficking of girl children and use of girls in prostitution
- Promote gender equality and to encourage and enable men to take responsibility for their sexual and reproductive behavior and their social and family roles.

3. Millennium Development Goals: 2000

Young People and MDGs: Achievement of the MDGs depends heavily on the extent to which the health, education, and socio economic wellbeing of young people is improved	
MDG	Adolescent related action required to achieve MDG
Goal l: Eradicate extreme hunger and poverty	Reduce the adolescent proportion of population living on less than $ 1.25 per day
Goal 2. Achieve universal primary education	Increase literacy among adolescents
Goal 3. Promote gender equality and empower women	Equalize the enrolment of girls and boys In primary, secondary and tertiary education and with regards to employment opportunities
Goal 4. Reduce child mortality	Increase age at first birth among adolescents

Goal 5. Improve maternal health	Reduce adolescent fertility and unmet need for contraception and increase skilled attendance at delivery
Goal 6. Control HIV/AIDS, malaria and other diseases	Reduce HIV prevalence among adolescents. Increase consistent and correct condom use
Goal 7. Ensure environmental sustainability	Improve the lives of adolescents who live in slums. Increase access to safe drinking water and sanitation
Goal B. Develop a global partnership for development	Reduce unemployment among adolescents
Adapted from the Population Reference Bureau (PRB):2010	

4. African Youth Charter: July 2006; Gambia

The African Youth Charter (AYC) is guided by the vision of the African Union; to promote and emphasize the importance of the youth ages 15 to 35 to the development of Africa.

It recognizes the following four major issues that are affecting African youth: education, employment and youth development; women and girl's rights; quality sexual reproductive health services and youth participation, involvement and empowerment.

State Parties shall, "secure the full involvement of youth in identifying their reproductive and health needs and designing programs that respond to these needs with special attention to vulnerable and disadvantaged youth..." and that State Parties shall, "provide access to youth friendly reproductive health services including contraceptives, antenatal and post-natal services

5. African Union (AU) Campaign on Accelerated Reduction of Maternal Mortality in Africa (CARMMA): May 2009; Ethiopia

- Launched in 2009, in Addis Ababa, Ethiopia, by the African Union (AU) Ministers of Health, under the theme Africa Cares: No Woman Should Die While Giving Life!
- It is enshrined in the 2005 AU Policy Framework for the promotion of sexual and reproductive health and rights in Africa, and in the Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006), which underscores the need for maternal mortality reduction.
- CARMMA recognizes that early sexual encounters and marriages have negative implications on women's health and increase chances of maternal morbidity and mortality.
- It therefore, recommends the need to ensure availability of appropriate contraceptive services and access to information on sexuality amongst men and women, including adolescents.

OBJECTIVE 4: GAP ANALYSIS

BRAINSTORMING AND ACTIVITY SESSION

- *Ask participants to discuss on the gaps that exist within the laws, policies and strategies on sexual and reproductive health and rights at international, regional and national level.*
- *Identify areas of contradiction in some of the instruments, (if any).*
- *Where possible, give practical examples.*

DAY 2: MODULE 6

TIME: 7.45 to 8.30 am

Comprehensive Sexuality Education (CSE)

Time: 45 minutes

CSE is a broad range of issues that cannot be prescribed to any context but adjusted to the culture, norms, values and behaviors of that country – there is no blue print but an age appropriate and culturally sensitive curriculum. This module serves to make participants aware of the CSE package.

Objectives:

By the end of this session, participants will be able to:

1. Define all important terms related to the subject
2. Outline the Key Elements of Effective CSE
3. Describe the CSE Policy Framework

CONTENT	METHODOLOGY	RESOURCES
○ Define all important terms related to the subject ○ Outline the Key Elements of Effective CSE ○ Describe the CSE Policy Framework	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Presentationand Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: DEFINITION OF COMPREHENSIVE SEXUALITY EDUCATION (CSE)

- Comprehensive sexuality education (CSE) has been defined as "rights-based and gender-focused approach to sexuality
- Education, whether in school or out of school". By embracing a holistic vision of sexuality and sexual behaviour, not only
- Focusing on prevention of pregnancy and sexually transmitted infections (STIs), UNFPA notes that CSE can enable children and young people to:
- Acquire accurate information about sexuality, sexual and reproductive health and human rights.
- Explore and nurture positive values and attitudes towards their sexual and reproductive health, and develop self-esteem, respect for human rights and gender equality.
- Develop life skills that encourage critical thinking, communication and negotiation, decision-making and assertiveness.

WHAT IS COMPREHENSIVE SEXUALITY EDUCATION ALL ABOUT?

Conventional sexuality education focuses on physiology and sexual and reproductive health, but does not address issues of gender and power. By contrast, comprehensive sexuality education (CSE) focuses on gender norms, power in relationships, and participatory teaching methods. Properly conceived and implemented, CSE seeks to empower young people, and therefore:

1. has as its core value the human rights of all persons;
2. provides thorough and scientifically accurate information about a range of interrelated topics, namely: human rights, gender norms, and power in relationships (including consent and decision-making, sexual coercion, intimate-partner and gender-based violence, and sexual diversity); the body and puberty; communication and relationships; and sexual and reproductive health (including STIs/HIV and AIDS, unintended pregnancy, condoms and contraception, and how to access health and other support services);
3. has an explicit gender focus, and addresses gender norms and gender equality as stand-alone topics and across other CSE topics;
4. is provided in a safe learning environment, free of harassment and violence;
5. uses participatory and interactive teaching approaches that help learners personalize information and strengthen their skills in communication, decision-making, and critical thinking;
6. relies on youth advocacy and civic engagement in program design, but also in empowering learners beyond the curriculum, as agents in their own lives and leaders in their communities; and
7. is age appropriate and culturally appropriate, and is tailored as needed for distinct sub-populations..

OBJECTIVE 2: KEY ELEMENTS OF EFFECTIVE CSE

In many cases, young people lack knowledge and information about how to engage in safe and respectful sexual behaviour, menstrual hygiene management, how to protect themselves from pregnancy and infection etc. CSE is needed to ensure that individuals and in particular adolescents gain a better knowledge about their rights and to be able to make informed choices about sex and relationships. CSE can also counteract myths and false perceptions about sexuality. Ideally, CSE comprises a rights-based approach that includes prevention of sexual harassment, gender-based violence and discrimination

Analysis of effective CSE programs has found, apart from the focus on gender norms and power in relationships, the following commonalities:

- Do not teach abstinence only (young people who have only received abstinence-only education are less likely to use any kind of protection on first intercourse).
- Include modules on personal empowerment.
- Train teachers adequately and on an ongoing basis in using interactive and participatory methods and discussing gender equality, sexuality, and human rights topics.
- Offer linkages to protective factors in the environment (e.g., school safety programs, latrines in schools, cash transfers linked to school retention for girls, girls' financial literacy and savings programs, campaigns against violence including male-on-male violence, etc.).
- Refer participants to health and other services.
- Tailor delivery models and key concepts on gender and relationships for younger children, before gender and sexual norms become solidified.

OBJECTIVE 3: POLICY FRAMEWORK OF CSE

GOVERNMENTS AT THE UNITED NATIONS HAVE MADE A SERIES OF COMMITMENTS TO RESPOND TO YOUNG PEOPLE'S NEEDS FOR INFORMATION AND SKILLS TO PROTECT THEIR SEXUAL AND REPRODUCTIVE HEALTH:

ICPD (1994) PARA 7.47: Governments, in collaboration with non-governmental organizations, are urged to meet the special needs of adolescents and to establish appropriate programmes to respond to those needs. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family-planning practice, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention. Programmes for the prevention and treatment of sexual abuse and incest and other reproductive health services should be provided. Such programmes should provide information to adolescents and make a conscious effort to strengthen positive social and cultural values. Sexually active adolescents will require special family-planning information, counselling and services, and those who become pregnant will require special support from their families and community during pregnancy and early child care. Adolescents must be fully involved in the planning, implementation and evaluation of such information and services with proper regard for parental guidance and responsibilities.

ICPD+5 (1999) PARA 35(B): Include at all levels, as appropriate, of formal and non-formal schooling, education about population and health issues, including sexual and reproductive health issues, in order to further implement the Programme of Action in terms of promoting the well-being of adolescents, enhancing gender equality and equity as well as responsible sexual behaviour, protecting them from early and unwanted pregnancy, sexually transmitted diseases including HIV/AIDS, and sexual abuse, incest and violence. Ensure the active involvement and participation of parents, youth, community leaders and organizations for the sustainability, increased coverage and effectiveness of such programmes.

ICPD+5 (1999) PARA 73(C): Develop at national and other levels, as appropriate, action plans for adolescents and youth, based on gender equity and equality, that cover education, professional and vocational training and income-generating opportunities. Such programmes should include support mechanisms for the education and counselling of adolescents in the areas of gender relations and equality, violence against adolescents, responsible sexual behaviour, responsible family planning practices, family life, reproductive health, sexually transmitted diseases, HIV infection and AIDS prevention (Programme of Action, para. 7.47). Adolescents and youth themselves should be fully involved in the design and implementation of such information and services, with proper regard for parental guidance and responsibilities. Special attention should be devoted to vulnerable and disadvantaged youth.

BEIJING+5 (2000) PARA 79(F): Design and implement programmes with the full involvement of adolescents, as appropriate, to provide them with education, information and appropriate, specific, user-friendly and accessible services, without discrimination, to address effectively their reproductive and sexual health needs, taking into account their right to privacy, confidentiality, respect and informed consent, and the responsibilities, rights and duties of parents and legal guardians to provide in a manner consistent with the evolving capacities of the child appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention on the Rights of the Child, 15 in conformity with the Convention on the Elimination of Discrimination against Women and ensuring that in all actions concerning children, the best interests of the child are a primary consideration.

DAY 2: MODULE 7

TIME: 8.30 to 10.30 am

STI's (HIV) and HTS

Time: 2 hours

From this module content, health workers will have a better understanding of why young people are at risk of developing sexually transmitted infections (STIs), and the long-term health consequences of acquiring these infections.

Objectives:

By the end of the session, participants will have a detailed understanding of the following:

1. Risk Factors for Sexually Transmitted Infections
2. Impact of STI/HIV on adolescents
3. Management of STI/HIV among Adolescents
4. HTS and Adolescents

CONTENT	METHODOLOGY	RESOURCES
○ Syndromic and clinical management of STIs ○ Impact of STI/HIV on adolescents ○ Management of HIV among Adolescents ○ HTS and Adolescents	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Presentation,Exercise and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: WHY ARE YOUNG PEOPLE AT RISK FROM SEXUALLY TRANSMITTED INFECTIONS?

Answer

There are many biological, psychological and social reasons that put young people at a high risk of acquiring STIs. The major ones are listed below.

Biological Factors:

- Young women are biologically more susceptible to STIs than older women. This is because their vaginal mucosa and cervical tissue are immature, and this makes these tissues more vulnerable to STIs.
- Boys and girls may have immune systems that have not previously been challenged and have not mobilized defenses against STIs and HIV.
- Young people may also be more prone to infection because of anemia or malnutrition.

Psychological Factors

- Adolescents often lack basic information concerning their sexual health, or the symptoms, transmission and treatment of STIs.
- Often there is poor communication between young people and their elders, and there are few learning materials (books, magazines) designed for young people.
- Sexual intercourse is often unplanned and spontaneous among young people.

Social Factors

- They often have multiple, short-term sexual relationships and do not consistently use condoms.
- Young people may feel peer pressure to have sex before they are emotionally ready to be sexually active and they often confuse sex with love and engage in sex before they are ready in the name of 'love'.
- Young men sometimes have a need to prove their sexual powers. Young men may have their first sexual experiences with **prostitutes** (commercial sex workers), while young women may have their first sexual experiences with older men, both of which increase the chance of getting STIs including HIV.
- Sexual violence and exploitation, lack of formal education (including sex education), inability to negotiate with partners about sexual decisions (in some cultures, girls are not empowered to say 'No') and lack of access to reproductive health services together put young women at especially high risk.
- Some adolescents are subject to early marriage, forced sex, trafficking and poverty, and may engage in sex work for money or favors.
- Substance abuse or experimentation with drugs and alcohol is common among young people, which often leads to their making irresponsible decisions such as having unprotected sex.
- Even when young people realise that they are infected they may be afraid to seek treatment for STIs and so go on to infect others unnecessarily.

OBJECTIVE 2: IMPACT OF STIS (INCLUDING HIV) ON YOUNG PEOPLE

Sexually transmitted infections are of public health concern because of their potential to cause serious and permanent complications in infected people who are not treated in a timely and effective way. These can include cervical cancer, pelvic inflammatory disease, chronic pelvic pain, fetal death, **ectopic pregnancy** (pregnancy outside the uterus) and related maternal mortality.

Generally, the long-term health consequences of STIs are more serious among women.

Question: Why is this so?

Answer: This is because, women and girls are less likely to experience symptoms, and so many STIs go undiagnosed until a serious health problem develops.

People who become ill from STIs may face loss of community credibility and even health workers sometimes treat them badly, being judgmental and refusing to provide services. It is important that you provide a good role model and become known for being sympathetic and non-judgmental.

STI Prevention Strategies for Young People

As a Health Extension Practitioner, you should advise and encourage young people to adopt the following healthy behaviors:

- Delay onset of sexual activity. Abstain from sexual intercourse until married or in a stable relationship.
- Learn how to use condoms. If young people are already sexually active, it is important to make sure they know how to use condoms correctly. You should demonstrate the proper use of condoms in your education sessions related to sexually transmitted infections either individually or in group meetings (in schools, at the health post or in the community).
- Condoms should always be used except when pregnancy is desired or when partners in a stable relationship know for certain they are both disease-free.
- Avoid any kind of risky behavior; try to stick with one partner. Boys should avoid having contact with prostitutes.
- Discuss sexual issues. Young men and women must feel comfortable communicating with their partners and family about sex and their sexual histories. A communicative relationship is essential to emotional and physical health.

OBJETIVE 3: SUMMARY OF APPROACHES TO THE MANAGEMENT OF STIS

- **Etiologic:** A diagnosis is based on the results of laboratory tests that can identify the specific organism causing the infection. Thus, it is possible to treat only for one infection. Results of laboratory tests should be returned quickly for effective treatment.
- **Clinical:** Provider makes a diagnosis (or educated guess) about which organism is causing infection based on the patient's history, signs, and symptoms.

- **Syndromic:** The patient is diagnosed and treated based on groups of symptoms or syndromes, rather than for specific STIs. All possible STIs that can cause those symptoms are treated at the same time.

Ask Participants:
What is needed for the etiologic approach?
Response: Patient must have symptoms, provider must be able to do a good physical examination and take laboratory samples, there must be skilled laboratory technicians, the lab must have working equipment and reagents, and the patient must return for results later. The client must be informed that it takes time for results to return from the lab.

What is needed for the clinical approach?
Response: The patient must have symptoms and a trained provider must be able to take a history and do a complete physical examination in a private space.

What is needed for the syndromic approach?
Response: The patient must have symptoms, and the provider must have knowledge of the prevalence of various STIs in the country, training in the use of flowcharts or a guide to what signs and symptoms make upeach syndrome, and the ability andprivate space to do a physicalexamination.

ACTIVITY: SMALL GROUP WORK CASE STUDY
The trainer should:
Describe the following case to Participants: *A 20 year-old single man complains of burning on urination, discharge from his penis, and says he had a new sexual partner three days ago. On examination of the urethra, a thick, yellowish discharge can be seen.*
Divide Participants into 3 groups and giveeach group markers and a piece ofthe flipchart.
Ask each group to do the following:
Choose one person to write on a piece of flipchart and another to present to the large group.
Discuss and describe the diagnosis and treatment of the patient in the case study using:

- Etiologic management (group 1)
- Clinical management (group 2)
- Syndromic management (group 3)

Using Etiologic Management:
The provider takes a history, does a physical exam, and notes a thick discharge from the penis. With a drop of the discharge, s/he makes a slide so a gram stain can be conducted immediately. The provider takes another sample of discharge to be tested later for chlamydia, the results of which will be ready in one week. The patient waits for two hours for the results of the gram stain, which is positive for gonorrhoea. The provider gives treatment for gonorrhoea and asks the patient to return in one week for results of the chlamydia test. The patient is asked to bring his partner for treatment and is counselled and given condoms.

Using Clinical Management

The provider takes a history and does a physical exam. If s/he sees a urethral discharge, s/he may diagnose gonorrhoea because the discharge is thick and yellow in colour. S/he treats the patient for gonorrhoea and asks the patient to bring his partner(s) in for treatment. The provider counsels the patient and gives him condoms.

Using Syndromic Management

The provider takes a history and does a visual inspection of genitals. There is a thick yellow urethral discharge. S/he treats the patient for the urethritis syndrome that, according to the national guidelines, includes treatment for gonorrhoea and chlamydia. She/he asks the patient to bring his partner for treatment, counsels him, and gives him condoms.

Syndromic Management of Vaginal Discharge Management of vaginal discharge has the following problems:

- Vaginal discharge most often indicates vaginitis. A number of studies have shown that the most common causes of vaginal discharge are bacterial vaginosis (BV), Trichomonas vaginalis (TV), and candidiasis. Of these, only TV can be sexually transmitted.
- Most women with cervicitis do not have any symptoms.
- Often vaginal discharge is either normal or related to vaginal infections. This can lead to massive overtreatment of STIs. Studies of the validity of syndromic management have shown that vaginal discharge should not be used as a routine screening tool.
- There is some evidence that syndromic management of vaginal discharge can be improved by examining the cervix to determine whether there is a cervical discharge or inflammation, but this requires training, tools, time, and supplies.

OBJETIVE 4: HIV TESTING SERVICES (HTS)

The overarching HTS goal is to identify people living with HIV timeously through the provision of quality testing services for all including adults, children, couples and families and effectively link them to appropriate prevention, care treatment and support services.

The main objectives of this document are to provide guidance to the health-care worker that will ensure:

- consistent provision of high quality HTS;
- appropriate use of HTS modalities to reach different populations;
- strengthened linkages to prevention, care and treatment services; and
- strengthened quality assurance and the delivery of accurate results.

- HIV testing services (HTS) include the full range of services that should be provided together with HIV testing.
- All HIV testing services should continue to be provided within WHO's essential 5**C**s: **C**onsent, **C**onfidentiality, **C**ounselling, **C**orrect test results and **C**onnection (linkage to prevention, care and treatment).
- This includes pre-test information, post-test counselling, linkage to appropriate HIV prevention, care and treatment services and other clinical and support services, quality HIV testing, accurate test results and diagnosis, and coordination with laboratory services to support quality assurance.

DAY 2: MODULE 8

TIME: 11.00 to 12.00 Noon

Psychosocial Support for ALHIV

Time: 1 hour

This module aims to equip participants with the information and skills they need to understand and appropriately support Adolescents Living with HIV.

Objectives:

At the end of this unit you will be able to:

1. Explain psychosocial support in ALWHIV.
2. Explain impact of HIV /AIDS on Adolescents
3. Describe psycho social assessments and interventions.
4. Demonstrate psychosocial skills when working with Adolescents.

CONTENT	METHODOLOGY	RESOURCES
○ Explain psychosocial support in ALWHIV. ○ Explain impact of HIV /AIDS on Adolescents ○ Describe psycho social assessments and interventions. ○ Demonstrate psychosocial skills when working with Adolescents	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Exerciseand Discussions ✓ Presentation, Exercisesand Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: DEFINING PSYCHOSOCIAL SUPPORT

Psychosocial: Made up of two words psycho and social

- Psycho refers to the mind (unique feelings, emotions, behavior, thoughts, beliefs, attitudes, perceptions and feelings)
- Social refers to interpersonal relationships and what goes on in the natural environment and how these contribute to the emotional well-being of an individual

Psychosocial can therefore be defined as the dynamic relationship between social and psychological experiences where the effects of one continually influence the other

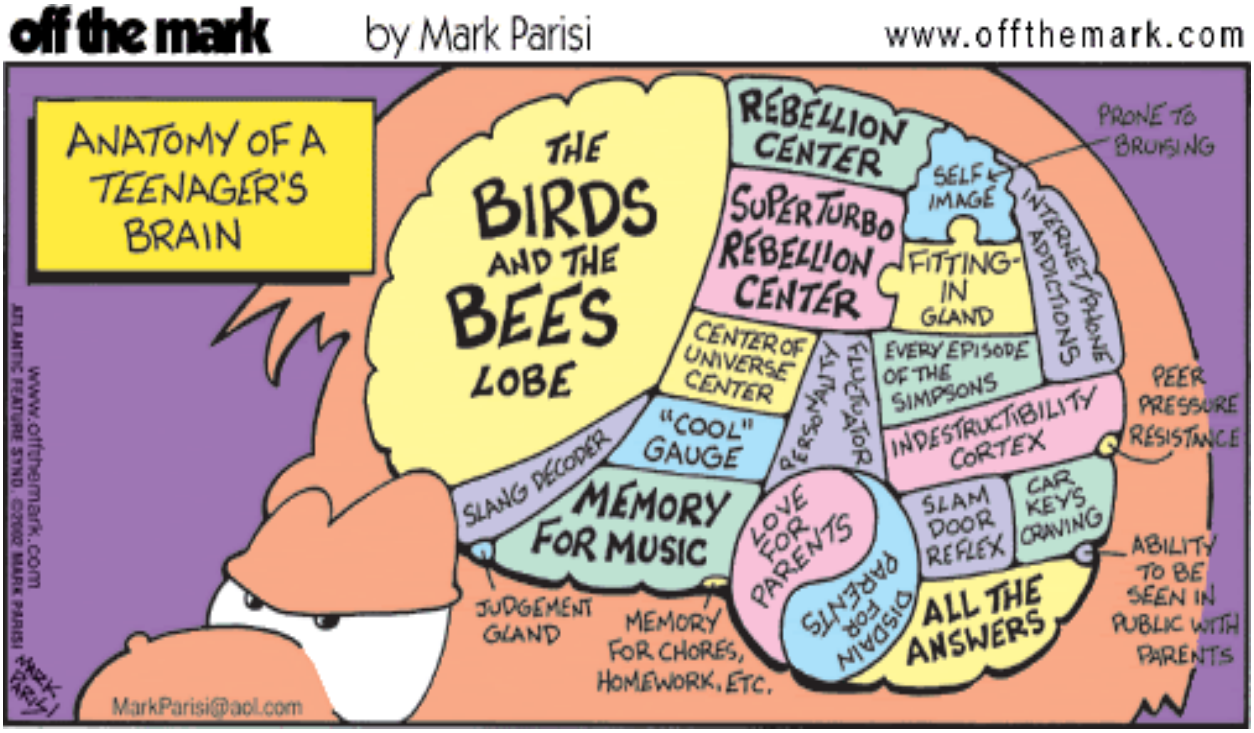
Psychosocial problem: A problem having a psychological or social cause where the effects of each are continually influencing the other.

Psychosocial support: Interventions geared towards improving on the emotional and social wellbeing of an individual.

PSYCHO SOCIAL PROBLEMS

Psycho	Social
o **Anger** o **Helplessness** o **Suicidal thoughts** o **Low self-perception** o **Anxiety** o **Frustration** o **Guilt**	o **Sickness of self and family members** o **Loss of loved ones** o **Child estrangement** o **Family separation** o **Lack of basic needs**

ANATOMY OF AN ADOLESCENT BRAIN

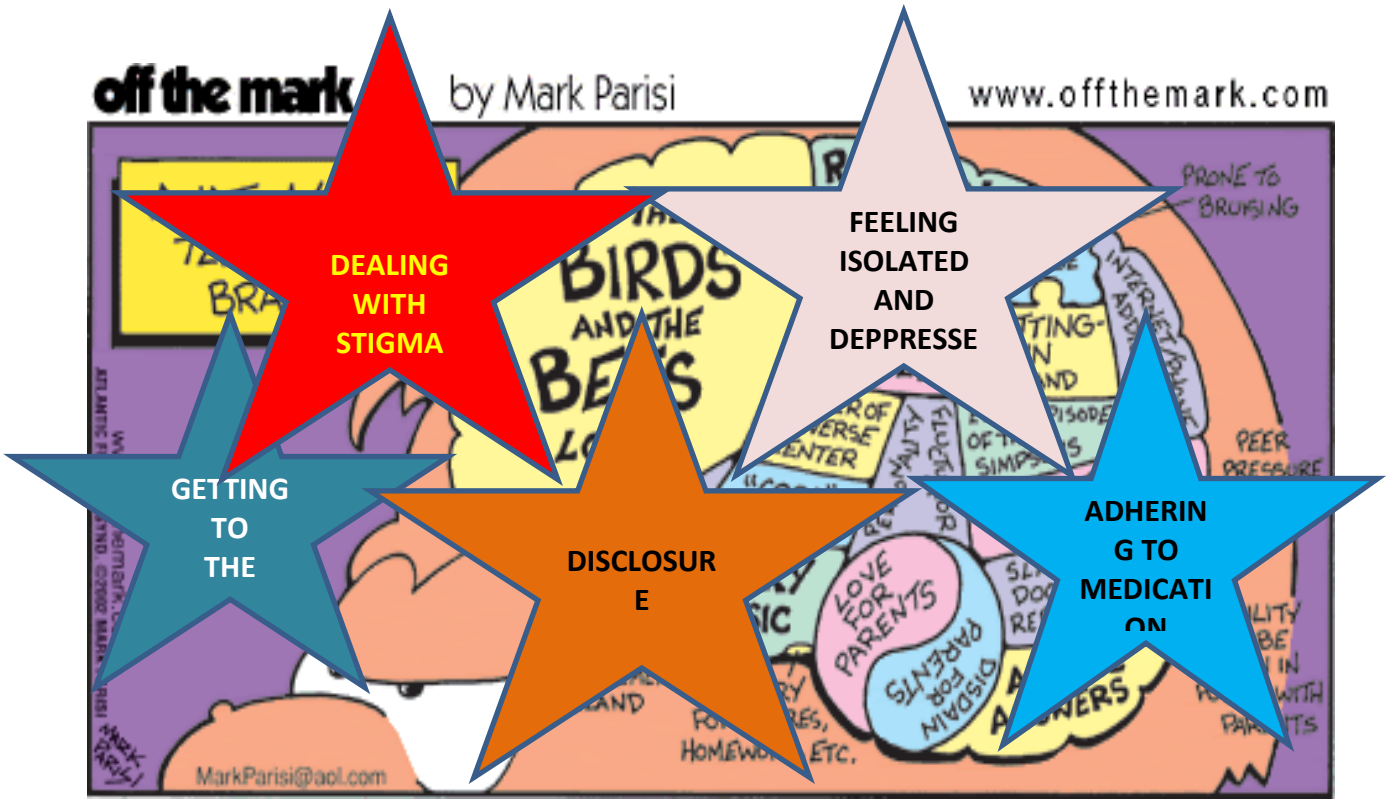


Explanation:A lot goes on in the adolescent mind; their minds are immature and unstable. They need our close guidance and support. They tend to view things from a totally different perspective and thus need our unfading support.

From the above diagram; it is evident that most of the adolescent's brain is occupied with unimportant things and very little of the important and necessary traits.

They tend to focus on being popular, music, fashion, rebellion. They have a very poor sense of judgement and memory. This explains the reason why adolescents are unpredictable; find it easy to take risks, forget easily, are always preoccupied and more.

ANATOMY OF AN ADOLESCENT BRAIN LIVING WITH HIV



Explanation: Over and above experiencing challenges associated with the adolescent; ALHIV experience further difficulties as they deal with all the issues associated with HIV. It is much more difficult for them to cope because of their immature mind and unstable emotions.

Causes of psycho social problems in HIV infected adolescents

- Stigma and discrimination
- Death of parents and siblings
- Loss of a home
- Separation from brothers and sisters after death of parents
- Chronic illness
- Non-disclosure of HIV test results

Principles of psychosocial support for HIV infected adolescents

- Best interest of adolescents.
- Empowerment
- Child's participation
- Family involvement.
- Individualization

Importance of psychosocial support

- It is therapeutic in that it brings about healing to the affected individual
- Addresses the fears, worries and anxiety that come with learning the test results.
- Instills hope to live and facilitates positive living
- Through counseling and disclosure adolescents and families understand their situation and adopt appropriate ways to deal with it.
- Psychosocial care interventions facilitate resilience and coping thus enabling HIV infected adolescents to live meaningful lives

ACTIVITY: What is the impact of HIV on children?

GROUP WORK – 10 MIN PER GROUP

- Group 1: Physical impact
- Group 2: Behavioral impact
- Group 3: Emotional impact
- Group 4: Cognitive impact

PROBLEMS ASSOCIATED WITH ALHIV

PHYSICAL –PSYCHOSOMATIC

- Multiple pains
- Abdominal pain
- Headache
- Chest pain
- General malaise
- Fatigue

BEHAVIOURAL

- Restlessness
- Hyperactivity
- Withdrawal and self-neglect
- Aggressiveness

- Sleep disturbance
- Acting out
- Stealing
- Drug abuse and sexual promiscuity

EMOTIONAL

- Emotional neglect in infants from sick depressed mother
- Irritability
- Lack of interest in surroundings
- Depression, sadness and mood changes
- Suicidal tendencies
- Anxiety, fear and anger
- Temper tantrums

COGNITIVE SYMPTOMS

- Inability to concentrate
- Regression of milestones
- Forgetfulness or poor memory
- Confusion
- Poor academic performance

SOCIAL

- Avoidance and rejection by peers (due to effects of wasting, skin lesions etc)
- Social withdrawal and isolation
- Complications of treatment
- Antisocial behavior

DAY 2: MODULE 9

TIME: 12.00 to 1.00 pm

Gender and ASRH

Time: 1 hour

In this module, health workers will be equipped with pertinent information on gender, gender diversity, gender and norms Gender and Sexual minority (GSM) needs. This will enable health workers to be cognizant of such issues when rendering ASRH services.

Objectives:

This module will give participants an understanding of the following:

1. Gender and Sex
2. Sexual orientation and diversity
3. Gender norms and health
4. Gender Person and Reaching GSM adolescents

CONTENT	METHODOLOGY	RESOURCES
○ Gender and Sex ○ Sexual orientation and diversity ○ Gender norms and health ○ Gender Person and Reaching GSM adolescents	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Exercise ✓ Handouts and Discussions ✓ Presentation ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 9.1.1 ○ HO 9.2.1 ○ HO 9.3.1

OBJECTIVE 1: GENDER AND SEX

Participant's activity 4.1
Ask participants to distinguish between sex and gender on a flipchart and discuss.

4.2 Definition of Gender and Sex
Gender - This describes certain attitudes, roles and responsibilities assigned through a social process to males and females, and can often result in different opportunities and behavior for both men and women. Gender role is determined by society and influenced by cultural, economic, political and environmental factors. It also varies within and between societies.
Sex – This describes the biological characteristics of being a boy or girl, male or female. This is a crucial element in everyone's sexuality.

OBJECTIVE 2: SEXUAL ORIENTATION AND DIVERSITY

Participants Activity 4.2
Ask participants to divide into 2 groups, group one should discuss what they understand by Sexuality and group two should discuss their understanding on diversity in sexuality. Groups should come together and brainstorm on their thoughts.

Sexuality is an expression of who one is as a human being. Sexuality involves your feelings, thoughts, and behaviours of being a male or female, being attractive, being in love, and being in a relationship that include intimacy and physical sexual activity. This explains ones sexual behaviour and intimate relationships.

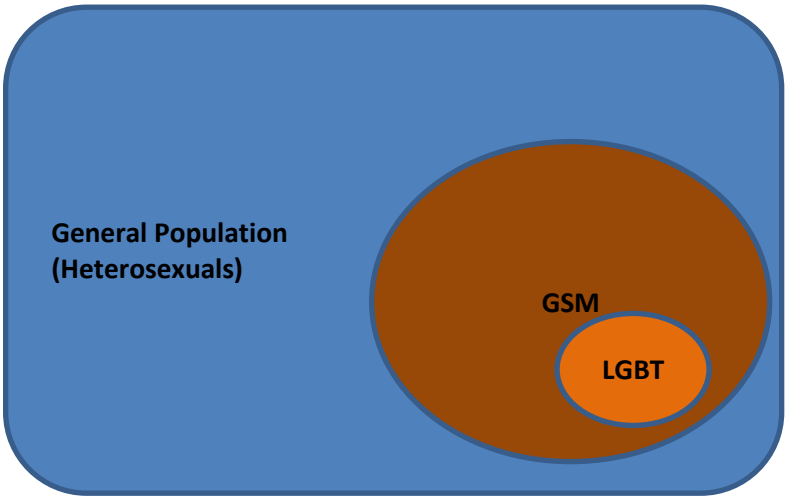
As earlier stated that **gender roles** are defined by cultural, religious, environmental, political and society, likewise a person's sexuality is influenced by these same factors. It is formed from the early stage to the end of an individual's life, and informed by personal social values such as attitudes, behaviours, physical appearance, beliefs, emotions, personality, likes and dislikes, spirituality.

How Sexuality differs from sex:

- It combines the person's biological characteristics (sex) - how one feels about his/her body as a male, female or intersex.
- Gender identity – expression of ones' sexuality as a male, female or transgender.
- sexual orientation
- Sexual behaviour
- Social value – attitudes, behaviours, and sexual relationship.

Sexual orientation
A person's sexual orientation is its identity in relations to the sex/gender (concept) to which they are attracted, the fact of being heterosexual, homosexual and bisexual. This is a person sexual expression between man-woman, man-man, woman-woman or both sexes.

The illustration below indicates sexuality disparities across the population;



- **Heterosexual** are persons that are sexually attracted to male – female sexual relationships; Individuals who prefer partners of opposite sex.
- **Gender and Sexual minority (GSM)-**People whose gender, sexual orientation, or biological sex characteristics differ from what is typically expected by a culture or society.
- **Lesbian, Gay, Bisexual and Transgender (LGBT), Lesbian-** are female persons who are sexually attracted to only females, **Gay –** are male persons who are sexually attracted to only males, **Bisexual –** are either male or female persons that are sexually attracted to both sex (male and female), **Transgender-** are persons who have a gender identity, or gender expression, that differs from their assigned sex. They are referred to as **Transsexual** if they desire medical assistance to transition from one sex to another.

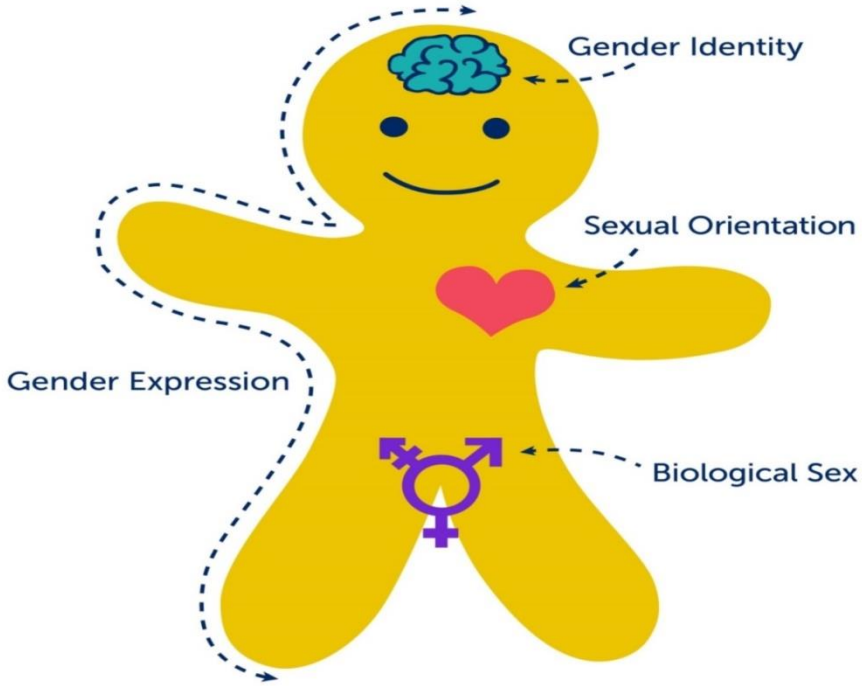
OBJECTIVE 3: THE GENDER PERSON AND REACHING GSM ADOLESCENTS

All health personnel are expected to be a gender person – that understand the different dimension of gender and sexuality and advocate for good health delivey and accessibility for the GSMs especially adolecsents, who have multiple health and psychological needs. However, in countries where the culture and circumstances doesn't accept and promote gender diversity, it is better to understand how to render health services to these groups especially in the area of HIV prevention and care.

Adolescents Struggling with Sexual Identity:

An adolescent client who is struggling with her/his sexual identity often experiences deep emotional turmoil that sometimes can lead to suicide. While health personnel may hold their own personal opinions regarding sexual orientation, it is their responsibility to provide accurate and unbiased information and services to all adolescent clients. Many gay and lesbian youth avoid health services for fear that they will be judged or that their sexual orientation will be disclosed to others. Providers and counselors can help clients overcome this fear by maintaining strict practices of confidentiality and serving clients in a non-judgmental manner.

BRAINSTORMING: Ask participants what they understand from the figure below; tease out all reasons for arrows pointing at different body parts.



Adapted from Killermann (2013)

OBJECTIVE 4: GENDER NORMS AND HEALTH OUTCOME

Gender norms are set of gender roles that has been assigned to a specific sex - male or female, the norms dictates what type of behaviours are generally considered appropriate and acceptable or desirable for a person based on their actual or perceived sex and sexuality.

Activity: The facilitator should ask participants these questions:

- **What are specific gender norms in their communities around gender diversity and sexual orientation?**
- **Discuss the impact of the norms on health outcome using human right focus?**

Reflection: Among men who have sex with men (MSM) in Swaziland, stigma and discrimination impacts seeking healthcare and disclosing same-sex sexual practices to healthcare providers (Risher et al., 2013). The impact of gender norms on the health seeking behaviour of GSM community affects their health outcome and this can only be improved through service providers. However, major gender norms cannot be stopped based on the legal, cultural, religious beliefs but service providers can assist to improve the quality of life of this community. Rather than allowing an underlining operation and poor health and increased prevalence of HIV infection, which could be common among adolescents as they are more secretive.

Reaching GSM adolescents: Key roles of service provider

- **Non Judgemental -** The provider does not have to be an expert on sexual orientation. Providing an understanding ear, not being judgmental despite your personal belief and referring the adolescent to resources is often enough.
- **Confidentiality - Adolescence** is a period when sexual identity starts to be defined. An adolescent who realizes s/he may be gay, bisexual, or transgendered may feel isolated and depressed, which can sometimes lead to suicide. It is the provider's responsibility to help the adolescent cope with her/his sexual orientation and accept her/himself and keep the adolescent safe from communal gender norm.
- **Doing No harm-** It is ethical to do no harm and protect the interest of the service user, hence If possible the adolescent could be referred to a support group or human right community for safety and psychosocial support.
- **Delivering best practice care-**Service provider's need to stress that homosexual, bisexual, and transexual/transgendered behavior is normal regardless of the provider's personal views and give the right information on HIV Prevention and care or any other required information by the client.

DAY 2: MODULE 10

TIME: 2.00 to 3.00 pm

Gender Based Violence (GBV) and Adolescents

Time: 1 hour

Objectives:

By the end of this session, participants will be able to:

1. Defining the Concept GBV
2. Types and Effects of GBV
3. Barriers towards reporting of GBV

CONTENT	METHODOLOGY	RESOURCES
1. Defining the Concept GBV 2. Types and Effects of GBV 3. Barriers towards reporting of GBV	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Presentationand Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

GENDER-BASED VIOLENCE

OBJECTIVE 1: DEFINING THE CONCEPT GBV

Gender-based violence (GBV) is any form of deliberate physical, psychological or sexual harm, or threat of harm, directed against a person on the basis of their gender.

Adolescents, Sexual violence and HIV- Adolescents experience many different types of violence, both physical and sexual. Issues facing the adolescent include domestic violence, sexual abuse, sexual assault, sexual harassment, and gang-related violence. Although all forms of violence have a significant impact on adolescents, we will be focusing on sexual violence and rape given their direct effect on young people's reproductive health. Most adolescents experiences sexual violence from peers, close relatives, acquaintances as a result of situation they find themselves.

Sexual Abuse- Sexual abuse includes all forms of sexual coercion (emotional, physical, and economic) against an individual. It may or may not include rape. Any type of unwanted sexual contact is considered sexual abuse. For example, an older person of same sex or opposite sex forcefully having a sexual intercourse without the other persons' consent is referred to as sexual abuse or sexual violence.

Rape- is defined as the use of physical and/or emotional coercion, or threats to use coercion, in order to penetrate a child, adolescent, or adult either vaginally, orally, or anally against her/his will. Rape is not a form of sexual passion; it is a form of violence and control.

Acquaintance rape- When the person who is attacked knows the attacker.
Marital rape-When one spouse forces the other to have sexual intercourse.
Stranger rape-When the person who is attacked does not know the attacker.
Gang rape-When two or more people sexually assault another person.

The HIV/AIDS epidemic remains a serious health concern for young people, and unprotected sexual activity is responsible for a substantial majority of these infections in youth. Several groups of young people are at an elevated risk for HIV infection, including young men who have sex with men (MSM), bisexuals, transgendered persons, homeless youth, runaways, injection drug users (IDUs), victims of sexual abuse, mentally ill youth, and young people in the penal or foster care systems. Among young people more than any other age group, HIV is spread sexually, and sex between men remains a significant risk factor. As a result of this evidence based result, Oral pre-exposure HIV prophylaxis (PrEP) should be introduced to adolescents should in case issues of sexual violence.

Although gender-based violence is not exclusively directed against females, they do suffer from it the most, which is why the focus of this study session is on women and girls. GBV is a violation of fundamental human rights. Violence against girls and women prevents them from enjoying their rights, such as those shown below.

Fundamental human rights to which everyone is entitled without distinction based on race, sex, language, religion, political or other opinions

- Everyone has the right to life, liberty and security of person.
- No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

- Everyone has the right to a standard of living adequate for health and wellbeing.
- Everyone has the right to social security and personal development.
- Everyone has the right to education.
- Everyone has the right to freedom of opinion and expression.

There are various factors that make girls and women vulnerable to acts of violence, such as:

- They lack power
- They have low status
- They are often less educated
- They are often poor and economically dependent on men and this inequality places them in a situation where they are easily abused
- Cultural beliefs and values reinforce rigid gender roles and the low status of women. Most of the violence against girls and women is perpetrated under the cover of culture
- Limited awareness (among both females and males) about the rights of girls and women
- Boys and men commonly drink alcohol and use other mind-altering substances which impair judgement and/or make them violent.

Trainer: Stop reading for a moment and think about this from your own experience. What sort of violence against girls and women happens in your community?

OBJECTIVE 2: TYPES AND EFFECTS OF GBV

Types of gender-based violence

Physical	Psychological	Sexual
Beating	Insulting	**Harassment** (any type of unwanted sexual attention)
Biting	Yelling	Touching sexual parts of the girl's/woman's body
Kicking	Recalling past mistakes	Touching in a sexual manner against the will of the girl/woman (e.g. kissing, grabbing, fondling)
Restraining	Constant criticism	**Rape** (forced sexual intercourse)
Pulling hair	Expressing negative expectations	Use of a weapon to force into a sexual act
Choking	Humiliation	Forced prostitution
Throwing objects	Denying opportunities	Sexual trafficking
Using weapons	Discriminating	

Effects of gender-based violence

Physical	Psychosocial/mental	Sexual and reproductive
Partial or permanent	Anger, anxiety, fear	Sexual disorders and risky behaviours

Physical	Psychosocial/mental	Sexual and reproductive
disability		
Poor nutrition	Shame, self-hate, self-blame	Early sexual experiences (for those who are victims of childhood sexual abuse)
Exacerbation of chronic illness	Post-traumatic stress disorder (nightmares, recurrent distressing thoughts)	Unprotected sex
Chronic pain	Depression	Abortions
Gastrointestinal problems	Sleep disorders	Bad pregnancy outcomes, low birth weight, neonatal death
Organ damage	Suicidal thoughts	Maternal death
	Substance abuse	Suicide
Social stigma	STIs including HIV	
Social rejection and isolation	AIDS	
	Infertility	
Chronic pain		

OBJECTIVE 3: BARRIERS TO REPORTING SEXUAL VIOLENCE

BRAINSTORMING SESSION: What inhibits victims from reporting rape?

Reasons for not reporting GBV include:

- ✓ *Fear of stigma and discrimination*. Someone who has been raped may be seen by others as unclean. She will be blamed for what has happened to her and may experience discrimination.

- ✓ *Blame*. Society expects girls and women to be able to avoid sexual violence including rape. If any form of sexual violence occurs, society often blames the woman for the way she behaves and dresses, saying that the rape is her fault because she has provoked sexual desires in boys and men.

- ✓ *Fear of disbelief*. Many girls do not think anyone will believe them, particularly if they have been abused by someone they know. For this reason, many people who have experienced sexual violence, including children, remain silent.

- ✓ *Fear of revenge*. Many girls and women who are raped are intimidated by their attacker, who threatens that he and his family and friends will cause her further harm if she makes a police report. They may even make death threats.

- ✓ *Ineffective policing*. Even when young women who have been raped do report the case to the police they may not achieve much. They are not often protected by the police and if the wrong doer is not imprisoned they may be in greater danger than before.

- ✓ *Health workers' attitudes*. People who have experienced sexual violence can recover from the trauma if they find someone who will acknowledge their experience and provide support. One way they could heal is through hearing encouraging words from healthcare providers. However, health workers are not usually understanding and supportive when someone who has been raped seeks care from health facilities. They often tend to be judgmental. This is why many girls who experience GBV will seek practical help for health issues but will not talk about the violence that has caused them to attend at the health facility.

Question: What is our role as health workers in preventing gender-based violence?

Look at the list of factors that make GBV likely. How can you help to make girls and women in your community less vulnerable?

Answer

Educating women and involving community members, particularly men, are good ways to prevent GBV in your community. Educated women are less likely to have undesired life outcomes. Providing girls with educational opportunities improves their status in the community. You can help by encouraging parents to send their daughters to school and by encouraging girls to go to school and to continue with their schooling. Girls and women often lack information on reproductive health issues, but education gives them necessary knowledge. You could also involve women as members and leaders of community-based health committees.

DAY 2: MODULE 11

TIME: 3.00 to 5.00 pm

Ten year plan Challenges faced by youth

Time: 2 hours

Objectives:

By the end of this session, participants will be able to:

1. Define the concept "Ten Year plan Challenges"
2. Understand the importance of the subject matter "Why Ten Year plan Challenges faced by Youth"
3. Outline the challenges faced by adolescents and youth
4. State and outline ways to address the challenges faced by the youth in the facilities

CONTENT	METHODOLOGY	RESOURCES
○ Define the concept "Ten Year plan Challenges"	✓ Presentation and discussion	○ PowerPoint Presentation ○ Flip chart and Markers
○ Understand the importance of the subject matter "Why Ten Year plan Challenges faced by Youth"	✓ Group work and Discussions	
○ Outline the challenges faced by adolescents and youth	✓ Presentation and discussion	
○ State and outline ways to address the challenges faced by the youth in the facilities	✓ Presentation and discussion	

OBJECTIVE 1: TEN YEAR PLAN CHALLENGES FACED BY YOUTH

What exactly is a challenge?

Is a task or situation that tests someone's abilities

A challenge is a new or difficult task that tests somebody's ability and skill (oxford dictionary 2010)

Why teenagers?

- Future of the nation
- To decrease the rate of poverty and improve health

Definition of important terms related to subject

Teen pregnancy

- Teenaged/under aged girl becoming pregnant before the age of 20.

Poverty

- The state of being extremely poor, inferior in quality or insufficient in amount.
- Not having enough money to meet basic needs
- It is something that robs people of their dreams for tomorrow.

Drug abuse

- The intentional use of drugs for reasons other than improving health, including the taking of illegal drugs, which leads to significant problems or distress
- It can lead to addiction.

OBJECTIVE 2: CHALLENGES FACED BY ADOLESCENTS

- Unemployment
- Peer pressure
- Drug abuse
- Parental expectations
- Early sexual debut
- Poverty
- Abuse(sexual, physical, psychological)
- Materialism
- Erosion of national pride/identity
- Obesity/ body image
- Education disparity
- Shifting economy (low paying jobs)
- Growing up too fast
- Single parent
- Inability to access quality health care services
- Parental neglect

KEY ELEMENTS OF EFFECTIVE CSE

EARLY SEXUAL DEBUT			
Causes	**Prevention**	**Effects**	**Key issues**
○ Ignorance ○ Peer pressure ○ Exposure ○ Poverty	○ Sex Education ○ Puberty ○ Abstain ○ Delay ○ FP	○ STIs which may lead to infertility ○ HIV ○ Unintended pregnancies ○ Increase school dropouts ○ Increase single parent	○ Lack of correct information ○ Lack of access to quality health care services

Effects of Poverty	**Drug Abuse: Prevention (Empowerment)**
○ Impedes learning ○ Social and behavioral problems ○ Inferiority at school	○ Good parenting skills ○ Teach good morals ○ Control misbehavior ○ Coach, model and reinforce good behavior ○ Stay away from drug users ○ Create non-aggressive environment (family, community & at cultural level)
Effects of Drug Abuse ○ Increase crime rate ○ Impends learning ○ Increase school dropouts ○ Increase violence ○ Interferes with sanity	

OBJECTIVE 2: WAYS TO ADDRESS KEY CHALLENGES FACED BY YOUTH

Homelessness - create awareness at the family and community level through:

- Early family meeting/ ten year plan
- Parents/ guardian should display caring attitudes , pay school fees, and limit pocket money and educate the child on how to spend money
- Partners to utilize: SOS and Mdutjane

Suicide‑create awareness at community and family level through:

- Early family meetings/ ten year plan, encourage openness in the meeting and educate on life and coping skills
- Refer to psychologist
- Encourage to join support group(peer group)
- Observe behaviour changes
- Avoid family secrets

Homicide

- Improve safety measures, make sure all that can be of danger and be used as a weapon be placed in safe place.
- Observe behavioral changes
- Equal/fair treatment amongst the children
- Early family meetings

Accidents

- Create awareness to the family
- Improve safety measures e.g. for knives and car keys
- Early family meetings to discuss hazard things, ten year plan and educate on life skills

Drug Abuse

- Create awareness to parents about things that can be abused at home e.g. ARVs, coffee etc.
- At a clinic level provide continuous education and control of drugs
- Partners Rehabilitation centre e.g Mafini, Malkerns industrial school, psychiatric centre and drug abuse unit (RSP)

Unwanted Pregnancy

- Family empowerment and promotion of sex education in the families
- Church and community empowerment
- Educate the schools on SRH issues
- Clinic - provide counselling, education and FP
- Partners include FLAS, SWAGGA, SRHU and all Health Facilities

Eating Disorders

- Educate on healthy eating
- Importance of regular exercise
- The effects of anorexia nervosa
- Be aware that some eat libovu and do not utilize zondle at school yet they don't have enough food at home.
- Partners: nutrition council, Rural Health Motivators and health facilities

HIV/STI/TB

- Education on the mode of entry
- Prevention measures
- Disclosure
- Taking anti- retro viral therapy
- Behavior change
- Abstinence, condom use
- Resistance

DAY 3: MODULE 12

TIME: 7.45 to 8.30 am

Key Population Highlight

Time: 45 minutes

Objectives:

By the end of this session, participants will be able to:

1. Key Populations: Definition and Guidelines
2. HIV Prevention among Key Populations
3. Key Populations and Adolescents

CONTENT	METHODOLOGY	RESOURCES
○ Key Populations: Definition and Guidelines ○ HIV Prevention among Key Populations ○ Key Populations and Adolescents	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Presentation and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: KEY POPULATION DEFINITION AND GUIDELINES

Presentation

- Throughout the world, including sub-Saharan Africa, HIV prevalence is substantially higher among key populations. As many as half of all new HIV infections occur in people from key populations, yet they often have the least access to prevention, treatment and care.

- Discriminatory laws and policies, such as the criminalization of sex work, drug use, sexual orientation or gender identity, contribute to and reinforce low levels of access to health services.

- In 2014, WHO produced the first consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations.

- The Guidelines focus on five key populations: men who have sex with men; people who inject drugs; people in prisons and other closed settings; sex workers; and transgender people.

- WHO defines key populations in the Guidelines as "groups who, due to specific higher-risk behaviors, are at increased risk of HIV irrespective of the epidemic type or local context.
- Also, they often have legal and social issues related to their behaviors that increase their vulnerability to HIV.
- The key populations are important to the dynamics of HIV transmission. They also are essential partners in an effective response to the epidemic."

The Guidelines are based on the following principles:

- The human rights of members of key populations must be protected.
- Everyone has the right to access quality healthcare, free from discrimination.
- Access to justice is particularly important for people from key populations.
- Interventions to reduce the burden of HIV among key populations must be respectful and acceptable to recipients as well as appropriate and affordable for them.
- People from key populations require accurate health and treatment information to enable their decision-making.
- Integrated service provision is needed to meet the multiple co-morbidities and poor social situations experienced by many people from key populations.

www.who.int/hiv/pub/guidelines/keypopulations/en/

OBJECTIVE 2 HIV PREVENTION AMONG KEY POPULATIONS

- The correct and consistent use of condoms with condom-compatible lubricants is recommended for all key populations to prevent sexual transmission of HIV and sexually transmitted infections (STIs).
- Among men who have sex with men, pre-exposure prophylaxis (PrEP) is recommended as an additional HIV prevention choice within a comprehensive HIV prevention package.
- Where serodiscordant couples can be identified and where additional HIV prevention choices for them are needed, daily oral PrEP (specifically tenofovir or the combination of tenofovir and emtricitabine) may be considered as a possible additional intervention for the uninfected partner.

- Post-exposure prophylaxis (PEP) should be available to all eligible people from key populations on a voluntary basis after possible exposure to HIV.
- Voluntary medical male circumcision is recommended as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men, particularly in settings with hyperendemic and generalised HIV epidemics and low prevalence of male circumcision.
- Harm reduction for people who use drugs
- All people from key populations who inject drugs should have access to sterile injecting equipment through needle and syringe programmes.
- All people from key populations who are dependent on opioids should be offered and have access to opioid substitution therapy.
- All people from key populations with harmful alcohol or other substance use should have access to evidence-based interventions, including brief psychosocial interventions involving assessment, specific feedback and advice.
- People likely to witness an opioid overdose should have access to naloxone and be instructed in its use for emergency management of suspected opioid overdose.
- Voluntary HTC should be routinely offered to all key populations both in the community and in clinical settings.
- Community-based HIV testing and counseling for key populations, linked to prevention, care and treatment services, is recommended in addition to provider-initiated

OBJECTIVE 3: KEY POPULATIONS AND ADOLESCENTS

- Adolescents are even more vulnerable than adult members of key populations. Services need to be designed and delivered in ways that take into account the overlapping risks and vulnerabilities that confront adolescents.
- Services also need to reflect the diversity of their needs, based on their age, gender, specific practices and the social and legal environment in which they live.
- As confidentiality is so important to adolescents, it is essential that interventions are voluntary, respectful, non-judgmental and protect them from possible legal penalties.
- Lack of adolescent-friendly services and the negative attitudes of some health workers can prevent adolescents from accessing the care they require.
- Community-based services are particularly well positioned to break down some of these barriers.
- WHO recommends a comprehensive package of essential interventions for key populations.

DAY 3 : MODULE 13

TIME: 8.30 to 10.30 am

Substance Abuse

Time: 2 hours

Objectives:

By the end of this session, participants will be able to:

1. Define substance abuse
2. List at least 5 substances commonly abused by adolescents.
3. Identify at least 4 reasons for substance abuse by adolescents.
4. Identify at least 10 signs and symptoms of substance abuse
5. List at least 5 consequences of substance abuse
6. Describe how adolescents can avoid substance abuse.

CONTENT	METHODOLOGY	RESOURCES
○ Define substance abuse ○ List at least 5 substances commonly abused by adolescents. ○ Identify at least 4 reasons for substance abuse by adolescents. ○ Identify at least 10 signs and symptoms of substance abuse ○ List at least 5 consequences of substance abuse ○ Describe how adolescents can avoid substance abuse. ○ Manage withdrawal symptoms ○ Referrals and linkages.	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Exercise ✓ Presentation and Discussions ✓ Presentation ✓ Presentation ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: DEFINITION

It is when an individual or group of people use alcohol and or other substances for other than the maintenance of normal health. Substance abuse affects all aspects of life: economic, social, emotional and physical.

Commonly used Substances in Swaziland

- Dagga
- Alcohol
- Glue and Petrol
- Cocaine
- Crack
- Heroine
- Cigarettes
- Other drugs e.g. Diazepam , morphine etc

OBJECTIVE 2: CAUSES OF DRUG ABUSE

- A shortcut to feelings
- Peer Pressure
- Advertisement through television
- Information Packaging
- Stress
- Poor urban environment
- Lack of good family upbringing
- Discounts and price promotions

OBJECTIVE 3: SIGNS AND SYMPTOMS

- Sudden change in mood such as aggressiveness, irritability, happy or sad mood
- Sudden change in behavior, disrespectful, poor personal hygiene
- Lose of interest in friends and family or activities which does not involve obtaining drugs/substances
- Sudden drop in performance at school and or work
- Lying and secretiveness
- Red blood shot eyes
- Slurred speech
- Drowsiness
- Needle scars for PIDs
- Sudden mood change
- Altered sleeping patterns
- Change in appetite
- Unusual irritability
- Unexplained disappearance of money

OBJECTIVE 4: EFFECTS OF SUBSTANCE ABUSE

Effects on the Brain

- Alcohol consumption during pregnancy lead to fetal alcoholic syndrome
- Cannabis abuse lead to impaired cognitive development and increases vulnerability to development of mental illnesses

Effects on Work, School and Family

- Living with someone who abuses drugs is very difficult.
- Abusers lose interest in work and other activities.
- They lack concentration often complaining of loss of energy
- They lack ambitions in life which may lead to poor performance in school, work and family

OBJECTIVE 5: CONSEQUENCES OF SUBSTANCE ABUSE

Health risks	**Social risks**
Engaging in unprotected sex	Being ostracized by family& friends
Unintended pregnancies	Loss of social acceptance
Susceptibility to STI/HIV	stigmatization
Mental illness	Dependence on substance
Suicide	Loss of self esteem
Death	Changes in appearance
CRIMINAL TENDENCIES	**ECONOMIC RISKS**
Violence	Loss of income or employment
Rape	Dependence on others
Theft	

Drug Abuse and HIV

- Most individual who abuse substances engage in risky sexual behavior
- Excessive alcohol abuse can diminish personal control over multiple concurrent sex partners
- Protected sex may have condom failures
- Sharing of needles by PIDs has high impact on contracting HIV & AIDS

OBJECTIVE 6: SUBSTANCE ABUSE AND MENTAL ILLNESS

- Substance abuse may precipitate the existing mental illness, predisposing abusers to mental illness such as mood disorders, anxiety disorders, schizophrenia etc.
- Substances may be used by mentally ill patients as a coping mechanism hence worsen the clinical condition

HOW ADOLESCENTS CAN AVOID SUBSTANCE ABUSE

Keeping one-self busy through:

- Recreational activities e.g. sports, hobbies, clubs and reading.
- Income-generating projects
- Self-empowerment
- Making adolescents aware of the need to have self-esteem (Avoid negative peer pressure; remain in control; and set life goals and work towards achieving them)

ROLE OF HEALTH WORKRES

- Mentor adolescents in the right way
- Proper upbringing of children is very important
- Advice on choosing friends
- Counselling and guiding then through the adolescence stage

DAY 3 : MODULE 14

TIME: 11.00am to 12.00 noon

Adolescent Youth Friendly services

Time: 1 hour

This module focuses on Adolescent Sexual and Reproductive Health Services; It describes the distinctive features so that health workers are capacitated to attract, meet the needs of, and retain young people as clients. Adolescent and youth friendly reproductive health services are services that are accessible to and acceptable by young people. In this module participants will learn about the characteristics of adolescent and youth friendly services in terms of relevance to target population.

Objectives:

1. Define youth friendly SRH services (YFS)
2. Describe the guiding principles of Youth Friendly SRH Services (YFS) provision.
3. Outline 4 characteristics of Youth Friendly SRH Services.
4. Identify at least 4 existing support systems in the community.
5. ASRH Service Package for the School, Community and Health Facility.

CONTENT	METHODOLOGY	RESOURCES
○ Define youth friendly SRH services (YFS) ○ Describe the guiding principles of Youth Friendly SRH Services (YFS) provision. ○ Outline 4 characteristics of Youth Friendly SRH Services. ○ Identify at least 4 existing support systems in the community. ○ ASRH Service Package for the School, Community and Health Facility.	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Brainstorming and Presentation ✓ Group work and discussion ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 14.5.1

OBJECTIVE 1: DEFINITION OF TERMS

- ***Define Youth Friendly SRH Services***
- ***Discuss the guiding principles of Youth Friendly SRH Service provision.***

Youth Friendly Services (YFS) are services that are accessible, acceptable and appropriate for young people. They are in the right place, at the right time, at the right price (free where necessary) and delivered in the right style to be acceptable to young people. It meets the needs of young people and is able to retain their youth clientele for follow up and repeat visits.

Guiding principles of Youth Friendly SRH Services

- Provide integrated SRH services, information and management of STIs including HIV, and general primary health care for young people from a human rights, continuum of care and developmental approach
- Integration of life skills and livelihood programmes into SRH programmes is vital for sustainable SRH behavior change.
- Gender and cultural sensitivity is fundamental in ASRH programmes, to ensure equal access and acceptability of social services and opportunities by young people.
- Adopt an evidence-based, participatory and multi-sectoral approach to ASRH programming, ensuring meaningful and active participation of young people, parents and community at all levels.
- Foster accountability and transparency at all levels

OBJECTIVE 2: CHARACTERISTICS OF YOUTH FRIENDLY SRH SERVICES

- *Make a presentation on characteristics of Youth Friendly SRH Services.*
- *Discuss the characteristics and ask participants to share information on ASRH services provided at their institution.*

Programmatic characteristics

- Adolescents are involved in programme design, boys and girls, married and unmarried are welcomed and served.
- Parental involvement is encouraged
- Wide range of services offered or necessary referrals are available.
- Adequate supply of commodities available
- Short waiting times
- lEC available on sight
- Services are well promoted in areas where youth gather
- Linkages are made with schools, youth clubs and other youth friendly institutions.
- Alternative ways to access information, counseling and services are provided.

Service provider characteristics

- Staff are trained in adolescent issues
- Respect is shown to young people
- Privacy and confidentiality are maintained

- Adequate time is given for client provider interaction
- Peer educators'/counselors are available

Health facility characteristics

- Convenient hours
- Convenient location
- Adequate space
- Sufficient privacy
- Comfortable surroundings

Youth perceptions of the programme

- Privacy is maintained at the facility
- Confidentiality is honored
- Youth are welcome regardless of marital status
- Service providers are attentive to adolescent needs

Strategies/Approaches in Youth Friendly SRH Service Provision

- ***Present the three approaches for Youth Friendly SRH Service Provision.***
- ***Use Handout to prepare your presentation***

Swaziland, has adopted three key approaches for providing friendly SRH services to young people: health facility, community and school based. However, a strong and effective referral system between the three approaches.

OBJECTIVE 3: MEANINGFUL INVOLVEMENT OF ADOLESCENTS, PARENTS AND COMMUNITIES IN ASRH SERVICE PROVISION-Brainstorming

- ***Brainstorm the importance of working with adolescents, parents/guardians and community members***
- ***Ask participants to brainstorm in pairs how adolescents can be involved meaningfully in A SRH service provision***

Meaningful and active participation of young people in addressing SRH issues affecting their lives is a key prerequisite for the success of ASRH programmes. This reaffirms young people's participation as a right enshrined in the Convention on the rights and welfare of children, article 12: ***"right to be listened to and to be taken seriously"***.

The International Conference on Population and Development paragraph 7.48 seeks to ***"promote programmes directed to the education of parents, with the objective of improving the interaction of parents and children to enable parents to comply better with their educational duties to support the process of maturation of their children, particularly in the areas of sexual behavior and reproductive health."***

OBJECTIVE 4: COMMUNITY SUPPORT SYSTEMS IN YFS PROVISION - Discussion

- *Break participants into groups. Put participants coming from the same locality into one group.*
- *Ask participants to map support systems available in the community to support the provision of Youth Friendly Services to adolescents.*
- *Each group to make a presentation, highlighting the benefits of working with community support systems. List the benefits on a flip chart.*
- *Discuss.*

A community is a group of people who share the same norms, values and culture and live in the same geographical area. A support system is a network of personal or professional contacts available to a person or organization for practical, social and moral support. In every community, there are government departments, non-governmental organizations, community based organizations, religious groupings and support groups that health institutions can collaborate with in supporting sexual and health provision to adolescents. Examples are:

OBJECTIVE 5: DISCUSSION ON ASRH SERVICE PARKAGE

HANDOUT 14.5.1: MINIMUM PACKAGE OF SRH SERVICES FOR YOUNG PEOPLE

Health Facility Approach	**Community Approach**	**School Based Approach**
Education and counseling services e.g. on: • Sexuality and growing up • Abstinence, consequences of abortion • Contraception, STIs/HIV • Skill attendance • Ante and post-natal care, Nutrition	Education and counseling services e.g. on • Sexuality and growing up, relationships, abstinence, consequences of abortion • Contraception, STIs/HIV • Substance and drug abuse	Education and counseling services e.g. On: • Sexuality and growing up, relationships • Prevention of pregnancy and STIs • Abstinence, consequences of early pregnancy, abortion • Substance and drug abuse
Provision of information and education on SRHR	Provision of information and education on SRHR	Life skill training e.g. on goal setting, decision making, negotiation and assertiveness
Provision of life and livelihood skills	Provision of life and livelihood skills	School health talk on issues like: SRHR, Careers, STI/HIV prevention, sexuality and growing up
Provision of IEC, audio/visual materials	Provision of IEC, audio/visual materials	Facilitate a strong and effective linkage with health facilities and community youth centers
Provision of contraceptives	Provision of contraceptives	Providing edutainment services
Emergency contraception	Pregnancy testing	
Pregnancy testing		
Screening and treatment of STIs	Select clinical services *(in line*	

Comprehensive post rape care	*with the requirements, protocols and standards set by the Ministry of Health at any given time)*	
HIV and Aids services – HIV Testing and Counseling (HTC), PMTCT and treatment (ART)	HIV Testing and Counseling and Counseling services on PMTCT and ART	
Promoting community based/school based BCC activities – (outreach services)	Integrate ASRH services with other services	Integrate ASRH services with other services
Male circumcision	Providing edutainment services	
Providing edutainment services		
Facilitate a strong and effective linkage with schools and community youth centers	Promoting community based/school based BCC activities (outreach services)	
Integrate ASRH services with other services		
Refer where necessary	Refer where necessary	Refer where necessary

DAY 3 : MODULE 15

TIME: 12.00am to 1.00 pm

Framework for working with Youth Life skills

Time: 1 hour

Objectives:

By the end of this session, participants will be able to:

1. Define life skills
2. Describe the types of life skills
3. Describe critical techniques involved in the decision making process.

CONTENT	METHODOLOGY	RESOURCES
○ Define life skills ○ Describe the types of life skills ○ Describe critical techniques involved in the decision making process.	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Exercise ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 15.3.1 ○ HO 15.3.2

LIFE SKILLS NECESSARY FOR HEALTHY DEVELOPMENT

OBJECTIVE: DEFINING LIFE SKILLS

Begin with a power point presentation:

Life skills in adolescents refer to the skills and competencies needed to build or adopt positive behaviors that enable them to deal effectively with the challenges of everyday life. The development of life skills allows adolescents to cope with their environment by making responsible decisions, having a better understanding of their values, and being better able to communicate and get along with others. Early adolescence is singled out as a critical moment of opportunity for building skills and positive habits, since at that age there is a developing ability to think abstractly, to understand consequences, and to solve problems.

OBJECTIVE 2: TYPES OF LIFE SKILLS

Life skills fall into three basic categories, which complement and reinforce each other. These are social or interpersonal skills, cognitive skills and emotional coping skills (see Table 2.2.1).

Table 2.1 Types of life skills. (Adapted from *Life Skills Approach to Child and Adolescent Healthy Human Development,* Pan-American Health Organization, 2001)

Social skills	Cognitive skills	Emotional coping skills
Communication skills	Decision-making and problem-solving	Managing stress
Negotiation and refusal skills	Understanding the consequences of actions	Managing feelings, including anger
Assertiveness skills	Determining alternative solutions to problems	Skills for increasing self-management and self-monitoring
Interpersonal skills (for developing healthy relationships)	Critical thinking	
Cooperation skills	Analysing peer and media influences	
Empathy/understanding and perception	Analysing one's perceptions of social norms and beliefs	
Self-evaluation and values clarification		

BRAINSTORMING SESSION: As a health professional, you are expected to explain and teach life skills to adolescents who come seeking your help.

How would you address the following concerns of adolescents?

- A girl who is not feeling confident to end a relationship that she thinks will put her at risk of STIs, including HIV, because her partner doesn't like to use condoms

- A boy who is about to start or has already started *smoking marijuana* just because he wants to imitate what his friends are doing.

ANSWERS:

- These are just two instances where you could make a difference in adolescents' behaviours by telling them that it is perfectly OK to say 'No' when they have to. This could be done through individual or group counselling at your Health Post, in schools or in the community.

- You need to explain the need to be **assertive**. Being assertive involves expressing beliefs, thoughts and feelings in a direct, clear way at an appropriate moment and does not mean imposing beliefs or views on another person. To be assertive implies the ability to say 'yes' or 'no' depending on what one wants. For example: 'I don't want to have sex' or 'Yes, I want to have sex but only if we use a condom'.

- Being able to express what is truly felt or desired can have important consequences for adolescent reproductive health. Being clear and assertive can increase self-respect and help resist peer pressure to engage in sex, *substance* use, etc. Adolescents who are assertive can effectively negotiate safer sex to prevent unwanted pregnancy and STIs, including HIV, and resist unwanted sexual proposals from adults. They are also more likely to identify and obtain services needed for pregnancy prevention, prenatal and postpartum care, and STI/HIV diagnosis, counselling and treatment.

OBJECTIVE 3: CRUCIAL TECHNIQUES INVOLVED IN DECISION MAKING:

- **Critical thinking** is the ability to think through situations adequately, weighing the advantages and disadvantages so as to be able to make appropriate decisions concerning other people or one's own situation. Adolescents are confronted by multiple and contradictory issues, messages, expectations and demands of a sexual nature or otherwise. They need to be able to critically analyze the challenges that confront them. Examples in critical thinking are ability to distinguish between myths and facts; assessing the promises of a partner; and judging a situation that may be risky.

- **Problem solving** refers to one's capacity to identify problems, their causes and effects as well as the capability to look for possible solutions. It is the ability to identify, cope with and find solutions to difficult or challenging situations. Problem solving is related to decision-making and the two may often overlap. It is only through practice in making decisions and then solving problems that adolescents can develop the skills necessary to make the healthiest sexual choices for themselves. Examples of abilities in problem solving are skills in planning how to prevent getting STIs and unwanted pregnancy by using condoms properly and consistently.

- **Negotiation** or **conflict resolution** is a 'win-win' or 'no lose' method of settling disagreements. Every relationship has conflicts. However, conflicts do not have to end with someone losing and with both parties hating each other. Many do end this way. Adolescents need to begin by understanding that they have their own way of dealing with conflicts in their lives. Knowing their own style and motives as well as the style and motives of the person they are in conflict with will help them handle the situation.

HANDOUT15.3.1: THE 3 C'S DECISION-MAKING MODEL (CHALLENGE, CHOICES & CONSEQUENCES)

1. **Challenge** (or decision) being faced:

---

2. **Choices:**

1. ---
2. ---
3. ---

3.Consequences of each choice:

Consequences of choice #1:

Positive	Negative
---	---
---	---

Consequences of choice #2:

Positive	Negative
---	---
---	---
---	---

Consequences of choice #3:

Positive	Negative
---	---
---	---
---	---

The decision is:---

The reason is:---

3 C's TO GOOD DECISION-MAKING (THE PROCESS ANSWERS)

1. **Challenge** (or decision being faced): should I have sex?

2. **Choices:**

- To have sex
- Not to have sex.
- To seek advice.
- To have protected sex.

3. **Consequences** of each choice

CHOICE A (to have sex)

Positive Consequences	Negative Consequences
• Sexual gratification • Prove one is an adult • Prove manhood/boast (boys) • Acceptance by peers • Gain experience • Satisfy curiosity • Recreation • Stop pressure from friends/partner • Communicate loving feelings in a relationship • Get affection • Avoid loneliness • Hold on to a partner • Become a parent • Get material rewards (girls)	• STI/HIV • Remorse • Unwanted pregnancy • Lose trust with your parents • Expulsion/drop out of school • Early parenthood • Lose friends • Lose partner • Lost virginity • Early/forced marriage • Abortion • Baby-dumping • Destitution/prostitution • Depression/suicide • infanticide

CHOICE B (not to have sex)

Positive Consequences	Negative Consequences
• Follow religious beliefs • Follow personal/family values • Wait until ready for intercourse • Keep a romantic relationship from changing • Avoid pregnancy • Avoid STIs/HIV infection • Avoid hurting parents • Avoid hurting reputation • Avoid feeling guilty • Reach future goals/career mobility • Find the right partner • Wait for marriage • Keep virginity • Keep real friends • Feel empowered • Positive self-esteem • Maintain trust • Avoid responsibilities of early parenthood	• Lack experience • Can't boast • No material gains • Contempt of peers • Boredom • Lose partner • Feel guilty/develop stress

CHOICE C (seek advice)

Positive Consequences	Negative Consequences
• Get informed • Make good decisions • Physical and mental maturity • Safe sex	• Influence of others (may not be true to oneself) • Not responsible for own decision • Incorrect information from others • Loss of confidentiality

HANDOUT 15.3.2: INFLUENCES ON YOUNG PEOPLE REGARDING SEXUAL ACTIVITY AND WAYS A YOUNG PERSON COULD COMBAT THESE INFLUENCES

YOUR DECISION + OTHER INFLUENCES = YOUR BEHAVIOR

1. Peer pressure
   --
   --
   --

2. Media messages
   --
   --
   --

3. Pressure from a romantic partner
   --
   --
   --

4. Parents' wishes
   --
   --
   --

5. Influence of drugs or alcohol
   --
   --
   --

6. Self (feelings and values)
   --

DAY 3 : MODULE 16

TIME: 2.00pm to 3.00 pm

Interpersonal Communication skills

Time: 1hour

Objectives:

By the end of this session, participants will be able to:

1. Define all important terms related to the subject
2. Mention and describe important aspects of the Interpersonal Communication Process.
3. Demonstrate appropriate Interpersonal Communication Skills when Communicating to Adolescents.
4. Barriers to Effective Communication and how to Overcome them

CONTENT	METHODOLOGY	RESOURCES
○ Define all important terms related to the subject	✓ Presentation and discussion	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 16.2.1 ○ HO 16.3.1
○ Mention and describe important aspects of the Interpersonal Communication Process.	✓ Brainstorming and Presentation and Exercise	
○ Demonstrate appropriate Interpersonal Communication Skills when communicating to adolescents.	✓ Role Play ✓ Presentation ✓ Handouts and Discussions	
○ Barriers to Effective Communication and how to Overcome them	✓ Presentation and Discussions	

OBJECTIVE 1: INTERPERSONAL COMMUNICATION SKILLS

1. DEFINITION - Brainstorming, Discussion

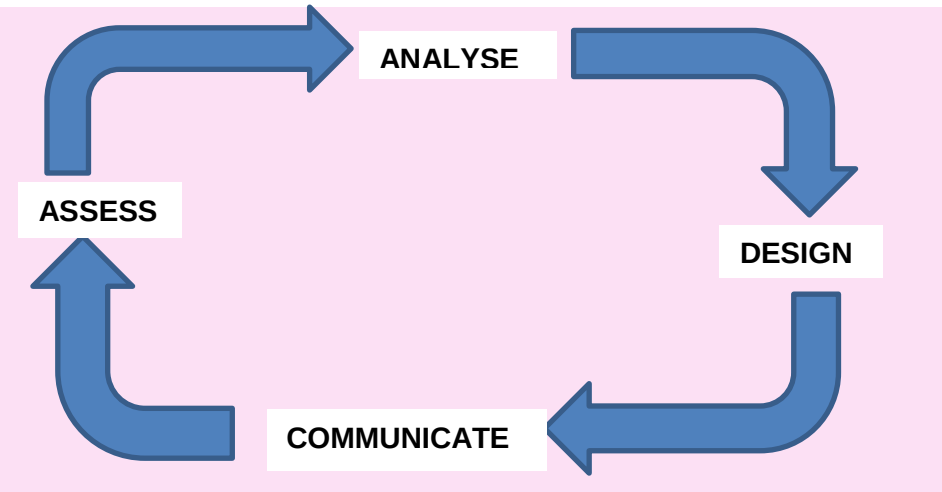
- Ask the participants to define communication and record their responses on Flip charts
- Show definitions on PowerPoint, and point out similarities with their own.
- Ask the group to define interpersonal communication and record their answers.
- Define interpersonal communication and point out the differences between communication and interpersonal communication, and emphasize that this session will cover interpersonal communication.

Communication: a process of transmitting information or thoughts on a particular topic through words, actions, or signs.

Interpersonal Communication: is a verbal or nonverbal exchange of information between two or more people in each other's physical presence.

OBJECTIVE 2: INTERPERSONAL COMMUNICATION PROCESS - Presentation, Discussion

- *Ask group members to list different ways in which they communicate with adolescents. Write their responses on a Flip Chart. Their answers might include: one - to—one, group talks, leaflets, posters, and videos.*
- *Show the PowerPoint slide with the diagram of the Interpersonal Communication Process.*



Many people are familiar with the communication process of sender, channel, message and receiver. This is different from the interpersonal communication process. The Interpersonal communication process is a two-way, interactive cycle in which the communicators exchange messages. All parties involved are both senders and receivers. In this process the receiver interprets previous messages and responds with new messages. The messages communicated are both verbal and nonverbal.

There are five steps in the interpersonal communication process:

- **Assess:** The service provider collects information about the adolescent(s), past reproductive health service experience, attitudes toward and knowledge of youth friendly services.

- **Analyze:** The service provider interprets the information gathered about the adolescent to identify information needs.

- **Design:** The provider decides the purpose of communication and the messages. She decides when and where to deliver the messages. She forms a plan.

- **Communicate:** The plan is put into action.

- **Assess/Evaluate:** The service provider assesses the effectiveness of her/his communication (i.e. was the young person interested? Was the message understood? Will the young person act on the information?). Results will assist the service provider to improve communication with others.

Activity:

- Ask participants what they think is the importance of each step.
- Record their answers on a Flip Chart. As you do this, explain each step to the participants.

Point out that:

1. The process is a cycle and therefore continuous
2. The assessment and analysis steps are essential to the communication process but are often forgotten, and
3. Because of the cyclical nature of the process, assessment is ongoing and occurs throughout communication.

- Summarize the cycle using the example of an adolescent who comes to the clinic with a malnourished baby. The provider first assesses the child's nutritional status and then analyses the mother's information and counseling needs (information on providing better nutrition for her child).

- Next, the provider designs messages to meet those needs (information on breastfeeding and foods) and delivers the messages.

- Finally, the provider asks questions to evaluate the adolescent's understanding and to determine whether there are other reasons for the child's nutritional status.

Note: The Facilitator can use any other relevant example that would be ideal to the target group

OBJECTIVE 3: INTERPERSONAL COMMUNICATION SKILLS - Presentation, Role Play, Exercise, Discussion

There are a number of communication skills and not all are discussed in this session. Depending on availability of time, the Facilitator may choose one or two activities and not necessarily all.

- Ask the participants to name some interpersonal communication skills and give examples of each.
- Record their responses on a Flip Chart
- Add any that they have missed.

- Distribute Handout on Interpersonal Communication Skills'
- Have participants practice some skills through exercises.

There are a number of techniques the provider can use to facilitate good communication with adolescents.

Active Listening/Attending Behavior

Providers let the youth know through verbal and nonverbal expressions that they are listening.
Facial expressions and posture: the health worker should show the youth that he/she is interested and paying attention. Some examples are maintaining eye contact, nodding as client speaks.

Summarizing and Paraphrasing - Exercise handout

The purpose of this exercise is to practice active listening skills as well as paraphrasing and summarizing techniques.

Prepare a list of controversial topics (e.g. abortion, prostitution, condoms and marriage and teens and family planning). Ask participants to pair off, select a topic and then take turns making statements about the selected topic. Before each new statement, however, each participant must paraphrase or summarize what the other person just said.

After 5 minutes, stop the exercise and ask the following questions:

1. How did you feel doing this exercise?
2. Was anything difficult? Why?
3. What was useful about it?

Possible responses:
It forces you to really listen
Helps practice non-judgmental communication
Helps identify biases on controversial topics

Following the discussion questions for this and other exercises, the facilitator can give feedback on non-verbal communication and attending behaviors observed during the practice sessions.

The provider restates what the adolescent has said in his/her own words. Summarizing usually restates many thoughts in a shorter form. This assures the adolescent that s/he has heard and understood what the adolescent has said. For example:

Questioning-Exercise: Open-ended Questions

Ask participants to review the differences between open and close-ended questions. Divide participants into groups of three. One person is the referee, one the interviewer and one the interviewee. The interviewer and interviewee have a conversation in which the interviewer asks closed-questions. (Sample topic: what you did this weekend). The referee should stop them if an open-ended question is used.

After two minutes, stop the group, and have them switched to only open-ended questions.

After two or more minutes, stop the group, and ask the following questions:

1. Was it more difficult to use closed-ended or open-ended questions? Why?
2. What can you conclude from this exercise?

The provider encourages adolescents to talk about themselves by asking questions. Questions can be open or closed ended.

Open- ended questions gives a provider a wide range of information from the adolescent without influencing his/her responses. Open-ended questions usually begin with the words 'how', 'what' or 'why'. For example, 'how have you been?'

Closed-ended questions are leading and limit possible responses. They may cause the adolescent to give answers he/she thinks the provider wants to hear. For example, 'have you been well?'

NB: Closed-ended questions can be used to shorten a discussion. But if used too often, the provider might miss important information.

Probing questions or statements are used to elicit further details from the adolescent. They can be open or closed-ended, but are usually open-ended.
When probing get information the adolescent might feel is personal or private, probes should be worded carefully.

HANDOUT 16.3.1: COMMUNICATION SKILLS CHECKLIST

Open-Ended Question

Probing

Summarizing/Paraphrasing

Reflecting Feelings

Giving Information Clearly and Assessing Adolescent Understanding
---

Praise/Encouragement/Reassurance

OBJECTIVE 4: BARRIERS TO EFFECTIVE COMMUNICATION AND HOW TO OVERCOME THEM

- Give participants a copy of the checklist on communication skills and ask them to mark the right box every time they observe one of the communication skills listed.
- Ask participants to comment on the skills displayed. Point out that good communication does not always require a lot of time.
- Introduce the topic by asking participants what gets in the way of understanding and being understood. Record their answers, on a flip chart, in two columns. List barriers in the left column. Make sure that all the barriers described in these notes are included on the list. Then ask the group to identify strategies to overcome them, and record them on the right-hand side next to each of the barriers.
- Distribute the handout on 'Barriers to Communication and Strategies to Overcome Them'.

ROLE PLAY: The trainer and co-trainer role play a counseling session that demonstrates some communication barriers. Tell participants to write down the barriers as they identify them. The trainer should act out as many barriers as possible.

a) **Personal Barriers**
   - **Knowledge** - Service providers cannot communicate effectively if their knowledge of the subject is inadequate.
   - **Strategies:** Make sure your knowledge is up-to-date. If you do not know something, tell the young person that you do not know at present, but that you can find out for them.

   - **Attitude** - A service provider's negative attitudes can affect the impact of the message. Good communication must be non-judgmental.

   - **Strategies:** Be aware of your attitudes and biases, and keep them out of your communication. Never impose your opinions on controversial topics.

b) **Socio-Economic Barriers**

   - **Age -** Some adolescent do not feel comfortable with people either younger or older than themselves.

   - **Strategies:** Show proper respect. Identify yourself as a health professional who deals with sensitive topics, explain that when there are serious health consequences, there is a need to discuss issues that are sometimes personal. Involve senior members of the group in discussions.

   - **Religion and Culture** - sometimes religious and cultural backgrounds may interfere with communication.

- **Strategies:** It helps to have background information on the religious and cultural beliefs of young people. Try to acknowledge when religious and cultural values might interfere with communication and work with them (do not ignore them). **NB: Always refer to health issues in culturally sensitive ways. Respect people's values, even when you do not agree with them.**

- **Sex** - Some prefer to communicate with people of the same sex, especially on sensitive subjects.

- **Strategies:** Again, acknowledge that the discussion might be embarrassing but explain that, because of health consequences, it is necessary to discuss sensitive topics. Acknowledging embarrassment usually helps adolescents to overcome it.

- **Language** -Adolescents may misunderstand technical language. It is important to speak in terms that they understand and to use acceptable terminology. Also keep in mind that adolescents might speak another language.

- **Strategies:** Keep language simple. Confirm whether terms are familiar and understood by adolescents. If they are not, explain them or use other, more familiar words. If adolescent speaks a different language, find a reliable person who can translate (confidentially, when necessary).

- **Economic Status** - Adolescents might find it hard to relate to a person who appears to be of another economic status.

- **Strategies:** Show respect no matter how poor the adolescent may be. Avoid fancy dress. Sit among group members, instead of standing over them or sitting apart from them. Wearing traditional dress in community settings can help break barriers.

- **Note:** To minimize social and economic barriers, whenever possible involve a provider or person who can relate to the adolescents. You must know your audience, however, to determine who can relate to them most effectively.

c) **Logistical Barriers – Some of the logistical barriers include:**
- **Time** - The meeting time may not be suitable for the young people.
- **Strategy:** When possible, let the adolescents choose the time. Remember, good communication can occur even when little time is available.
- **Venue** - Noise, excessive temperatures, and inadequate seating facilities can interfere with effective communication.
- **Strategy:** Make sure the venue is private, comfortable and in an accessible location. Use of Interpersonal Communication Skills in Youth Service Situations
- **Possible Situations (be familiar with all of them)**
  - ✓ Counseling
  - ✓ Health Education
  - ✓ Group Talks

DAY 3 : MODULE 17

TIME: 3.00pm to 5.00 pm

Counselling Process

Time: 2 hours

Clear and effective communication is basic in helping young people to achieve healthy sexual and reproductive lives. In this session participants will learn how they can establish good relationships with young people to enable effective counselling on sexual and reproductive health issues to take place. The basic principles of communication and counselling will be taught to health workers.

Objectives:

By the end of the session, participants will understand the following:

1. Counselling as a concept
2. Steps of Counselling
3. Giving A Group Talk

CONTENT	METHODOLOGY	RESOURCES
○ Counselling as a concept ○ Steps of Counselling ○ Giving A Group Talk	✓ Presentation and discussion ✓ Brainstorming and Presentation and Exercise ✓ Role Play ✓ Presentation ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 17.2.1 ○ HO 17.3.1

OBJECTIVE 1: COUNSELLING AS A CONCEPT

- *Introduce the topic by asking participants to place themselves in the role of youth counselor. "If you had to describe how it feels to counsel a young person, discussing sensitive matters like sexuality in just one word, what would that word be"?*
- *Ask participants for the words they selected, why, and how it feels to discuss these issues with young people.*
- *Do you think youth ever feel uncomfortable discussing these issues? Why or why not?*

Definition

- *Remind participants of past training they might have received in the past.*
- *Ask them to explain what counseling is. Record their responses on a flip chart. Summarize the points.*
- *Define counseling*

Counseling is one person helping another make a decision or solves a problem, to explore their feelings and find ways of dealing with them with an understanding of the facts and emotions involved. In this instance, the person to be counseled is an adolescent.

The Aim of Counselling

A counseling relationship assumes that it is the adolescent's responsibility to make decisions. In the advising relationship, the helper gives advice as an "expert" and takes on more responsibility for the youth behavior. Both counseling and advising involve giving information; in counseling the adolescent should take responsibility for his/her behavior.

Counseling aims to help adolescents:

- Understand their situation more clearly
- Identify a range of options for improving that situation
- Make choices which fit their values, characteristics, feelings and needs.
- Make their own decisions and act upon them
- Cope better with problems
- Develop life skills such as being able to talk about sex with a partner

The GATHER PROCESS - Mini Lecture, Discussion

- *Ask the participants how they would organize the counseling process.*
- *Post the acronym "GATHER" and remind them of previous training events where they had learned this model.*
- *Explain the model, with some emphasis on "R", because of the need to help adolescents get the services they need.*

- *Ask participants to give examples of adolescents needing referrals; List possible referral points in their community: health center, crisis centers, church, school authorities, community elders, youth organizations or a police officer.*

G	Greet the adolescent.
A	Ask adolescents about themselves.
T	Tell adolescents about their options.
H	Help adolescents make a decision.
E	Explain and answer questions.
R	Refer youth to another provider if necessary or schedule a return visit.

OBJECTIVE 2: COUNSELLING STEPS

GREET adolescent:

- Introduce yourself.
- Offer a seat.
- Make eye contact.
- Encourage the young person to speak freely.
- Establish rapport; ensure confidentiality and privacy, as well as youth comfort.

ASK adolescent about themselves:

Explore their:

- Reason for visiting.
- Knowledge about reproductive health. Concerns.
- Reproductive goals.
- Partner's attitudes, if any.
- If breastfeeding, how fully and for how long.
- The behavioral risks of both adolescent and partner for STIs and HIV infection.

If adolescent in on a repeat visit, ask about problems, satisfaction and changes in reproductive health goals. Ask any other pertinent and relevant questions

TELL adolescents about reproductive health issues and about their options:

- Review all Reproductive Health Information that the adolescent is unfamiliar with. Encourage the adolescent to ask questions.
- Explore the adolescent attitudes toward health issues. Give correct, unbiased information.
- Give information relevant to the adolescent reason for visiting. Use visual aids appropriately and effectively.
- Discuss ways the adolescent can reduce the risk of STIs/HIV infection.

HELP the adolescents to make a decision:

- Ask what the adolescent wants.
- Encourage and ensure youth makes his or her own decision.
- Ask if the adolescent discussed the issue with anybody.
- If desired option is inappropriate, explain why and help the adolescent make another decision.
- If breastfeeding, review the methods and assist the adolescent to choose a suitable contraceptive method.

EXPLAIN the chosen option and answer questions:

- Give full information about the options, warning signs and how to manage them.
- Explain full information about the option.
- Use appropriate visual aids effectively (such as models and samples).
- Give adolescent leaflets or pamphlets to take home.
- Ask the adolescent to repeat important information to make sure he or she understood completely.

REFER adolescent for additional support services or schedule a return visit:

- Refer adolescent to other providers or centers for further management or services if necessary.
- Give the adolescent a return appointment if necessary.
- Encourage the adolescent to come anytime with questions or problems.
- Follow up

OBJECTIVE 3: CHALLENGES IN ADOLESCENT COUNSELLING: BRAINSTORMING

- *Ask the group to describe a difficult situation they have experienced as counselors.*
- *Encourage participants to be as specific as possible.*
- *Ask participants how these situations make them, as counselors, feel or behave.*
- *Inform participants that this session is a "walk on the dark side" of counseling or dealing with the inevitable surprises. Every counselor has experienced difficult moments, which exposes some challenges. The skill is how the counselor copes with these situations. So, it's not IF something happens but WHEN something happens, what can be done?*
- *Tell participants that this session will be a discussion of various scenarios identified by the participants.*
- *Have them select a recorder and reporter.*

Highlight typical difficult situations with adolescents:

- Silence- adolescent does not talk.
- Youth cannot stop crying.
- Counselor believes there is no solution to the problem.
- The adolescent threatens suicide.
- The counselor makes a mistake.
- Counselor does not know the answer to a factual question.
- The adolescent refuses help.
- The adolescent is uncomfortable with the counselor's sex or age.

- The counselor is short of time.
- The counsel or cannot establish rapport.
- The counselor and the adolescent know each other socially.
- The adolescent talks continuously and inappropriately.
- The adolescent asks personal questions about the counselor.
- The counselor is embarrassed by the subject matter.

The purpose of the session is to:

- Develop awareness about one's own particular dislikes, blind spots, or fears about making counseling mistakes or dealing with "unexpected" situations; and
- Develop strategies to respond.

HANDOUT 17.2.1: COUNSELING PROCESS

Greet the adolescent:

- Introduce yourself.
- Offer a seat
- Make eye contact.
- Encourage the youth to speak freely.
- Establish rapport; ensure confidentiality and privacy as well as youth comfort.

Ask the adolescent about:

- Reason for visiting.
- Knowledge about Reproductive Health.
- Concerns.
- Reproductive goals.
- Partner's attitudes, if applicable.
- If breastfeeding.
- The behavioral risks of both youth and partner for STD including HIV infection.

If adolescent is on a return visit, ask about:

- Problems.
- Satisfaction.
- Changes in reproductive health goals.

Tell the adolescent about reproductive the health issue:

- Give correct, unbiased information
- Encourage the questions
- Explore the young person's attitudes toward health issue
- Give information relevant to the adolescent reason for visit
- Use visual aids appropriately and effectively
- Discuss ways the adolescent can reduce her or his risk of HIV infection

Help the adolescent make decision:

- Ask what the adolescent wants to do. If undecided, clarify the reasons.

- Encourage and ensure that the adolescent makes her or his own choice.
- Ask if the adolescent discussed with anybody.

Explain how to use or get the chosen option:

- Give full information about the option.
- Use appropriate visual aids effectively (such as models and samples).
- Give adolescent leaflets or pamphlets to take home.
- Ask the adolescent to repeat important information to make sure the youth understood completely.

Refer schedule return visit:

- Refer to another center or provider for further services if necessary.
- Encourage the adolescent to come anytime with questions or problems.
- Give the youth a return appointment if necessary.

HANDOUT 17.2.2: CHALLENGING MOMENTS IN ADOLESCENT COUNSELING

Sometimes there are challenging times when an Adolescent Counselor will experience difficulty in counseling the youth. Some typical examples of difficult situations are discussed below.

1. Silence

The adolescent may be unwilling or unable to speak for a period of time. This is generally common among young people who may be angry or anxious. If this happens at the beginning of the session, it is best for the counselor, after waiting a little while, to draw the attention of the adolescent by saying:

"I can see that it is a bit difficult for you to talk (reflected feeling), It is often that way when someone first comes to see me."
The counselor may alternatively say, "I wonder if you are not feeling a bit anxious?" Generally the counselor should wait and observe carefully whether the adolescent makes an effort to express her or his feelings or thoughts. The counselor should not try to break the silence because the silence may be a result of some thoughtfulness on the part of the adolescent.

2. The Adolescent Cries

Crying is usually a way of releasing emotions. If the adolescent cries or sobs, the counselor should offer verbal comfort and let the person finish. The counselor needs to exercise extreme care when offering comfort. Touching of the opposite sex on the hand or shoulder may be misinterpreted and may frighten the adolescent. The counselor should stick to verbal comfort and establish a professional relationship rather than a social one. Crying may also be done to elicit sympathy or stop further exploration of a discussion topic.

3. Counselor Believes There is No Solution to the Problem

It is important for the counselor not to fall into the trap of "Not Knowing How to Proceed". This usually happens when the adolescent counselor focuses on the problem but not the person. One of the methods of dealing with such an adolescent who insists on solving his or her problem is to say, "While I am not able to

change some things in your experience, getting to know you is always better and helpful". Another important thing for the counselor to remember is not to jump to conclusions before exploring more fully the youth. For example a youth may hint on an incestuous feeling, and the counselor assumes that sexual intercourse took place.

4. The Adolescent Threatens Suicide

If an adolescent threatens to commit suicide it may be appropriate to say, "It is virtually impossible to stop anyone from taking his or her own lives if one wishes to do so. But however, I would be terribly sad if that were to happen". The Youth Counselor should not panic when the adolescent threatens to do so. Focus should still be on showing the youth that you care and giving the youth hope. It is always important that the counselor shows concern for the adolescent and mentions that he or she respects the adolescent's feelings. If rapport had already been built, the counselor is in a better position to use his or her discretion on how best to deal with the situation.

5. The Counselor Makes a Mistake

The youth counselor can make a mistake, such as a factual error about something or giving incorrect information. The youth counselor must always acknowledge that he or she has made a mistake. In general the youth counselor should realize that his or her most important role in establishing a good relationship with the youth is to be honest and show respect and confidence to the adolescent.

6. The Counselor Does not Know the Answer to a Factual Question

It is good practice for a youth counselor to always admit that she/he does not know but will get the information for the adolescent. Alternatively the counselor could identify other sources of information for the adolescent and refer.

7. Adolescent Refuses Help

The adolescent counselor needs to probe gently for the reason why help is being refused. It may be appropriate to say, "Well, I can understand how you feel, and I am not sure whether I can help. But perhaps we could take a few minutes just to see what you think, and together we can decide whether it might be worth while talking a bit more". If the youth still refuses to talk, then stress the positive. "At least you did come, we have met each other". Try to suggest another appointment, if possible, and leave it open to the adolescent.

8. The Adolescent Is Uncomfortable with the Counselor's Sex

The youth counselor may start by saying something like this, "I wonder if you were expecting to see a man or woman". Once the issue is open, the counselor may proceed as follows, "Some young people are at first more comfortable with someone of the same or opposite sex, but in my experience that usually becomes less important once we get to know each other. Why don't we try to continue and see how we get on". Encouraging the youth to talk usually helps the adolescent to feel accepted. The youth counselor should keep on trying to give confidence to the adolescent.

9. The Counselor is Short of Time

It is beneficial for the youth to know how much time he or she will be with the counselor. It is important for the youth counselor to state at the onset the reason for the shortage of time. Apologize and indicate that you can meet again. Suggest a specific date and time.

10. The Counselor Cannot Establish Rapport

If rapport is difficult to establish, the counselor should ask for help from others in reviewing the sessions to understand better where the difficulty may lie.

If discussions with a different experienced counselor prove difficult to arrange, the youth counselor should continue working to help the youth feel better about expressing himself or herself.

11. The Counselor and Adolescent Know Each Other

The adolescent counselor and youth might come from the same community and know each other well. Counseling may be difficult but if the youth and the youth counselor have a causal relationship, the counseling session may proceed, taking into account that confidentiality will be respected. If this is not possible, arrange for someone else to do the counseling.

12. The Adolescent Talks Continuously and inappropriately

This situation may arise from anxiety that may make talking difficult. The counselor may interrupt after a while, for example, by saying: "Excuse me, I wonder if you realize that for some time you have been repeating the same thing. Are you feeling a bit nervous or finding it hard to talk about other things?" This may help the adolescent focus on the conversation about herself or himself and may help stop the inappropriate talk.

13. The Adolescent Asks a Personal Question of the Counselor

Usually it is not advisable for the youth counselor to respond to personal questions about herself or himself because:

I. It takes the attention away from the adolescent.

II. It may lead to a series of questions that may be private in nature, which the counselor may refuse or be embarrassed to answer.

If the questions are answered, this may send the wrong message to the adolescent, suggesting that something is wrong with the youth counselor. It is better to respond to a personal question by saying that is not helpful to the adolescent for the counselor to talk about herself or himself.

14. The Counselor is embarrassed by the Subject Matter

Sometimes the adolescent may say something that embarrasses the counselor. If that happens, it is usually necessary for the counselor to acknowledge his or her discomfort. This is especially true since the youth probably will be aware of the youth counselor's discomfort, especially if the counselor has responded visibly or emotionally. This situation may be turned to an advantage if the counselor can acknowledge his or her own feelings and then return to the subject the youth raised earlier.

OBJECTIVE 3: GROUP TALK

1. Definition of Group Talk – Brainstorming

- *Ask participants to define a group talk. Discuss the importance of group participation.*

A group talk involves communication among a number of people, usually encouraged by a leader or "facilitator", with a lot of group interaction and participation.

Group participation is important because:

- Participants become involved in the discussion.
- Participants share common ideas and concerns and come up with solutions.
- The facilitator receives immediate feedback on the group's interests and concerns.
- Participants share their feelings and reveal social attitudes.
- Participants can be influenced by others in the group to change their attitudes and behavior.
- Misconceptions can be corrected.
- Better understanding results when members ask questions and join in discussions

2. Personal Experience - Discussion

- ***Ask participants when in their work as Service Providers they might give group talks and lead discussions. Possible answers include certain times of the week or day, or perhaps never.***
- ***Ask participants if they have given group talks in the past, were they successful? What were the difficulties? Were they scared to give the talk? Ask if anyone has attended a good group talk. Ask if anyone has attended a poor one. What made it a good talk or a poor talk?***

People are often scared of giving group talks. This is a time when participants can talk about some of their past experiences and let go of some of the anxiety they may feel about this session.
They will recognize that many others share their feelings and frustrations about giving group talks. It is common even for professionals knowledgeable in their field to experience anxiety when speaking before a group.

The Group Talk Process involves four steps:

1. Assess the target audience and their needs.
2. Plan and prepare for the talk.
3. Conduct the talk.
4. Evaluate its effectiveness.

Assess the Target Audience

The facilitator collects information about the audience in order to identify their priority information needs. For a talk on Adolescents Sexual and Reproductive Health, the facilitator might collect information on the audience's knowledge; attitudes; language; culture; religious beliefs; educational level; average family size and approximate ages.

Possible **sources/ways** of collecting audience's information needs before planning a talk are:

- Reviewing recent research reports conducted in the area, such as Reproductive Health Survey Reports or a focus group discussion report.

- Examining records and registration books for common problems and the average age.
- Observing common trends in the community. Which questions are frequently asked? What kinds of problems have you and other community leaders seen recently?
- Reviewing the cultural and social characteristics of the community. What is the social background of your audience? What are their religious beliefs? What is the average family size?
- Discussing with knowledgeable people in the community.

The group facilitator can also assess the audience's information needs during a group talk using the following techniques:

- Paying attention to the audience members' facial expressions and body language.
- Asking the audience specific questions about the topic to determine their level of knowledge.

- Asking the audience directly about what they want to learn and what they already know about the topic.
- Asking questions to encourage discussion among members that will reveal their information needs.

3. Plan and Prepare - Individual And Group Work

- *Show the "7 Steps to Preparing a Group Talk". Explain each step and distribute companion handout*
- *Ask participants to brainstorm the barriers they might encounter in preparing for a talk. Have them discuss frustrations they might have encountered in previous talks. Examples might include: inability to secure a quiet place, insufficient preparation time and obstacles to limiting group size.*
- *Distribute the handout on "Group Talk Outline" and discuss each step in the handout.*
- *Exercise: Present a group talk topic to the larger group. Separate the participants into groups of four or five, assigning each group an imaginary audience. Have each smaller group brainstorm together to fill out the group talk outline. Have each group present their outline to the larger group. Discuss the differences and similarities among the groups. How do the objectives change with different audiences?*

Plan and Prepare for the Talk: Steps in planning and preparing a group talk

1. Identify the topic.
2. Choose a conducive venue with enough space
3. Identify the audience and their characteristics.
4. Set objectives, content and teaching methodology
5. Implementation.
6. Go over the main points of topic.
7. Have questions for discussion.
8. Identify and prepare visual aids where necessary.

DAY 4 : MODULE 18

TIME: 7.45am to 8.30 am

Nutrition & Adolescents

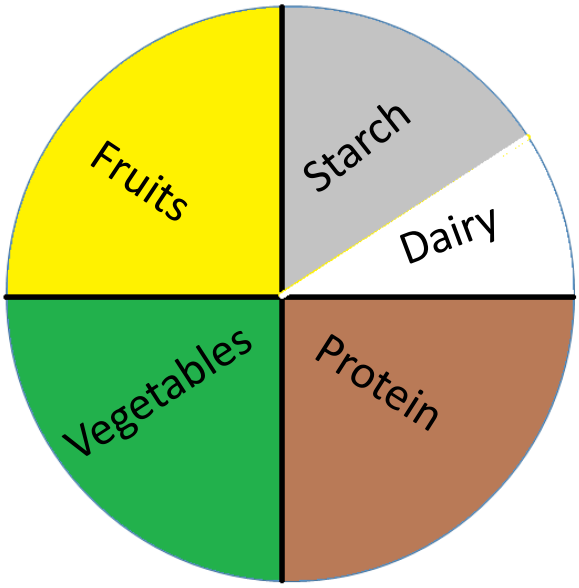
Time: 45 minutes

Objectives:

By the end of the session, participants will understand the following

1. Defining Healthy Eating
2. Eating Disorders among Adolescents

CONTENT	METHODOLOGY	RESOURCES
○ Defining Healthy Eating ○ Eating Disorders among Adolescents	✓ Presentation and discussion ✓ Activity Exercises and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers



OBJECTIVE 1: DEFINING HEALTHY EATING

- Healthy eating is not about deprivation, following strict nutrition rules or starving yourself to lose weight.
- It is about getting healthy and staying healthy by making smarter food choices,
- Including watching portion sizes, limiting fat consumption, eating natural, whole foods like fruits, veggies and whole grains and reducing processed food in the diet.

Balancing food

- A balanced diet is one that gives your body the nutrition it needs to function properly.
- Without healthy food, your body is more prone to disease/infection, fatigue, and poor performance.
- Children and Adolescents with a poor diet run the risk of growth and developmental problems. Bad eating habits can continue for the rest of their lives.

Fruits and Vegetables

- Fruits and vegetables are loaded with vitamins, fiber and minerals but contain few calories.
- Making fruits and vegetables part of your regular diet can reduce the risk of developing certain chronic diseases.
- Plant foods are also filling because of their high fiber content, so they stave off hunger and reduce the temptation to binge eat later.

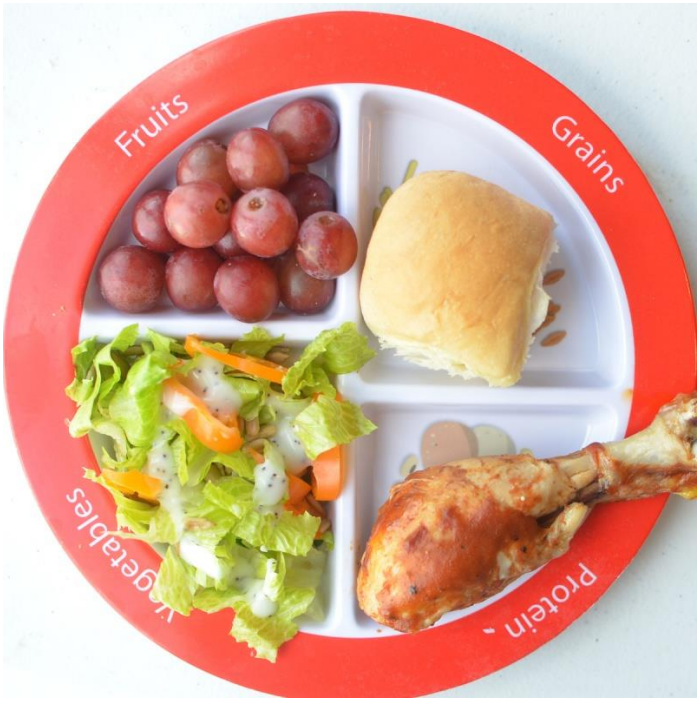
Limiting Fat

- While fat is essential to a healthy diet, certain types of fat should be avoided.
- Healthier fats should be consumed in moderation include fats from nuts, sunflower oil, canola oil, fish, olive oil and avocado.
- Avoid frying food

Whole Grains

- Whole grains like oatmeal, brown rice and pasta
- Non-refined mealie meal

Portion Control
Moderation is one of the foundations of a healthy diet, and portion control will help you enjoy the foods you



OBJECTIVE 2: EATING DISORDERS COMMON AMONG ADOLESCENTS

Activity 1: List Eating Disorders Common among Adolescents?

Activity 2: In Groups of 4, Prepare a Health Talk to Educate Adolescents with the Intention of Preventing and Controlling these Eating Disorders

DAY 4 : MODULE 19

TIME: 8.30 am to 10.30am

Adolescents and Contraception

Time: 2 hours

Two issues have a profound impact on young people's sexual health and reproductive lives: family planning and HIV/AIDS. Teenage girls are more likely to die from pregnancy-related health complications than older women. This module therefore focuses on the contraceptive options for adolescents aimed at preventing teenage pregnancy and STI's including HIV.

Objectives:

By the end of the session, participants will be able to:

1. Describe contraceptive options
2. Reasons why adolescents may not use contraception
3. Common side effects and impact on adolescents
4. Responding to misconceptions and rumors

CONTENT	METHODOLOGY	RESOURCES
○ Describe contraceptive options ○ Reasons why adolescents may not use contraception ○ Common side effects and impact to adolescents ○ Responding to misconceptions and rumors	✓ Presentation; Handout and discussion ✓ Brainstorming and Presentation and Exercise ✓ Presentation ✓ Presentation and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 19.1.1

OBJECTIVE 1: CONTRACEPTIVE OPTIONS

BRAIN STORMING SESSION:

Ask Participants:

- What do you think a pregnant adolescent is going through?
- Do you think educating adolescents on contraceptives is a good thing?

Protection against infection and pregnancy involve many of the same strategies and services. Traditionally, young women have come to the clinic for prenatal care or contraception, thus presenting an opportunity to also prevent and treat STIs. You men can also be involved in both contraception and STI prevention if their need for information and treatment is addressed. **See handout on Contraceptive Methods.**

HANDOUT 19.1.1: CONTRACEPTIVE METHOD

contraceptive methods

temporary "user-controlled" methods that block the sperm from reaching the egg

METHOD	What it is and how it works	Protection against STIs/HIV?	Other characteristics
Male condom 	A thin latex sheath rolled onto the erect penis before intercourse that prevents sperm from entering the vagina.	Yes	It is one of the two methods that offer double protection, against pregnancy and infection, thus may also protect against infertility and cervical cancer. It enables men and boys to protect themselves and their partners. It is easily available. It must be put on during sexual activity prior to intercourse. Some people find that it reduces sensation. It may break or leak, especially if used incorrectly.
Female condom 	A lubricated plastic sheath with two rings. One remains outside the vagina, covering part of the labia, and the other is placed in the vagina, covering the cervix. It forms a pouch that collects the semen.	Yes	It can be inserted hours before sexual activity begins. It enables women and girls to protect themselves and their partners. It is noticeable during sex, and insertion may require practice. It is expensive in comparison with the male condom.
Diaphragm or Cervical cap 	Diaphragm: A shallow, soft, rubber cup that is filled with spermicide and inserted into the vagina before intercourse. It covers the cervix to prevent sperm from entering, and the spermicide kills sperm. Cervical Cap: A thimble-shaped latex cup that is inserted into the vagina, fitting snugly over the cervix and held in place by suction to block sperm. It should be used with a spermicide.	It is not yet known whether the cap or diaphragm offers any protection against infections	It can be inserted before sexual activity begins. It is not widely available. It may be dislodged during sex. It must be fitted by a health care provider.
Spermicides 	Chemical foams, creams, jellies, film, or suppositories inserted into the vagina before intercourse, creating a barrier and killing sperm. A spermicide can be used alone or with a barrier method, such as a condom, to increase its effectiveness.	No	Repeated use of nonoxynol-9 (N-9) spermicides can lead to genital lesions, which can increase the risk of HIV transmission. They should not be used by women at high risk for HIV infection. Some are messy.

OBJECTIVE 2: REASONS WHY ADOLESCENTS MAY NOT PRACTICE SAFER SEX

Ignorance	• Think they are not vulnerable to pregnancy or STIs/HIV. “It can’t happen to me” or "I don't have sex often enough to get pregnant or contract a STI/HIV." • May not have adequate or accurate information about protection. ✓ School sex education is often non-existent or inadequate. ✓ Parents and others are reluctant to provide practical information. Some believe that providing information encourages sexual activity, though this has been proven to be untrue. ✓ Media gives unrealistic notions of sexuality and usually omits any mention of protection. • May have misinformation or myths about methods and their side effects. • Don't know that methods are available. • Don’t know where, how, or when to get methods. • Myths about dangers of contraception are common and difficult to defuse. • May not believe that protection is needed with a regular partner. • May not believe that protection is needed if their partner looks healthy. • May think that STI/HIV transmission only occurs among "certain people" (i.e. commercial sex workers, poor people, or "other" ethnic groups). • May not be aware of alternatives to risky sex, such as mutual masturbation, etc.
Denial	• "Sex just happened." • "I only had sex once." • “My partner would not expose me to any risk.” • "Sex should be spontaneous." • Peers are not using protection so why should they? • Don't think they will get pregnant or contract a STI. • Didn't expect to have sex.
Lack of Access	• Access to contraceptive services for adolescents is limited by law, custom, or clinic/institutional policy. • Availability and cost of different methods may restrict access. • Irregular supply of methods available. • Spontaneous act—method not available when needed. • Attitude of provider may prevent her/him from distributing protective methods to adolescents.
Coercion	• Boyfriend wants her to get pregnant. • Boyfriend/girlfriend won't let her/him use protection. • Boyfriend makes her have sex. • May have the attitude that condoms ruin sex or are unromantic. • Family coercion to conceive.
Fear	• Fear of rejection by partner. • Fear of the lack of confidentiality at the place where they obtain methods. • Fear of using something that they have never used before—fear of the unknown.

	• Fear of side effects. • Fear about the proper use of protective methods. • Fear of where to keep protective methods so that no one sees them. • Fear that something may go wrong if they start using certain methods or products too early in life. • Fears that their parents will find out they are having/planning to have sexual relations. • Fear that their peers will know they are sexually active. • Fear of physical examination, especially pelvic exam. • Fear of being asked questions by medical staff. • Fear of being labeled as "cheap" or "loose."
Embarrassment	• Service providers are sometimes judgmental and/or moralistic about adolescent sexual activity. • Embarrassed to buy condoms. • Retail outlets often place protective methods behind the counters so that customers must request it. • May be embarrassed to use a method at the time of intercourse.
Other factors	• Lack the skill and expertise to negotiate condom use. • Stopped using contraceptives because of the side effects. • Are impulsive and sexual activity is often unplanned. Even when sex is anticipated, often do not have protection available. • Believe that the suggestion of protection implies mistrust of one's partner and her/his faithfulness. • May desire conception. For a girl, it may be a way to keep a relationship or a boyfriend; for a boy, conception may be a way to prove manhood; or they may already be married. • May lack the communication and negotiation skills to discuss protection. • Thinks the partner "is taking care of protection." • Ambivalence about becoming pregnant. • Do not know how to dispose of condoms.

OBJECTIVE 3: COMMON SIDE EFFECTS AND THEIR IMPACT ON ADOLESCENTS

BRAIN STORMING SESSION:

Ask Participants:

If you had not attended this session, what would you tell the adolescent client about the side effects of contraceptives?

Side effects are the major reason that clients stop using a method, therefore providers should:

- ✓ Treat all client complaints with patience, seriousness, and empathy.
- ✓ Offer clients an opportunity to discuss their concerns.

- ✓ Reassure the client that side effects are reversible.
- ✓ Differentiate side effects from complications.
- ✓ Offer clients good technical and practical information, as well as good advice about how to deal with side effects.
- ✓ Provide material for the client on side effects in local languages.
- ✓ Provide follow-up.

HEALTH RISKS OF EARLY PREGNANCY

- **Cephalopelvic disproportion (CPD):** Adolescents younger than 17 often have not reached physical maturity and their pelvises may be too narrow to accommodate the baby's head. In these cases, obstructed delivery and prolonged labor are more likely, thereby increasing the risk of hemorrhage, infection, and fistula.
- **Pre-eclampsia (hypertension of pregnancy):** If pre-eclampsia is left uncontrolled, it can progress to extreme hypertension, seizures, convulsions, and cerebral hemorrhage.
- **Anemia:** The World Bank reports that anemia is 2 times more common in adolescent mothers than among older ones.
- **Unsafe abortion:** Few young women have sufficient money to pay for an abortion. They tend to wait later in their pregnancy before seeking an abortion and often resort to cheaper and more dangerous methods.
- **Premature Birth:** Infants born to adolescent mothers are more likely to be premature, of low birth weight, and suffer consequences of retarded fetal growth.
- **Spontaneous Abortion and Still Births:** Young adolescents under the age of 15 are more likely to experience spontaneous abortion and still births than older women.

Why it is important to delay pregnancy and childbearing: *First allow participants to deliberate on this issue and reflect on their observations and experiences*

Psychological, Social, and Economic Consequences of Adolescent Pregnancy

For Girls

- Pregnancy often means the end of formal education.
- Adolescent pregnancy changes a girl's choice of career, opportunities, and future marriage. In many countries, unmarried mothers resort to low paying and risky jobs, domestic work, and even to prostitution to support their children.

- Early marriage due to an unplanned pregnancy is frequently an unhappy, unstable one that leads to divorce. Both mother and child face the stigma of illegitimacy.
- Young mothers are often ill prepared to raise a child, which may lead to child rearing problems of child abuse or neglect.
- Girls resorting to commercial sex work are at higher risk for gender-based violence, substance abuse, and STIs such as HIV.

For Boys

- In some societies, early fatherhood may enhance a young man's social status, which may encourage boys to practice unprotected sex.
- Some boys refuse to take responsibility for the pregnancy which contributes to hardship for the mother and child and also can lead to future remorse.
- Boys who become fathers lose opportunities for education and future economic advancement. Those who marry leave school to support their new families.
- Young fathers are often ill prepared to raise a child which may lead to child rearing problems of child abuse or neglect.
- Premature marriages are frequently unstable and end in divorce.

OBJECTIVE 4: RESPONDING TO MISCONCEPTIONS AND RUMOURS ON CONTRACEPTION

BRAIN STORMING SESSION:

Ask participants to clarify the difference between Rumors and Misconceptions; they should be able to give examples of each.

Rumors are **unconfirmed stories** that are **transferred** from one person to another **by word of mouth**. Rumors are common among adolescents because so much information (or misinformation) is passed between and among them. In general, rumors arise when:

- An issue or information is important to people, but it has not been clearly explained.
- There is nobody available who can clarify or correct the incorrect information.
- The original source is perceived to be credible.
- Clients have not been given enough options for contraceptive methods.
- People are motivated to spread them for political reasons.

M**isconceptions on the other hand are mistaken interpretations of ideas or information**. If a misconception is filled with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor. Rumors develop and can play a big role with adolescents because they are often ignorant about such matters as

reproductive health and are eager to fill "in the blanks".Unfortunately, rumors or misconceptions are sometimes spread by health workers who may themselves be misinformed about certain methods or who have religious or cultural beliefs pertaining to contraception which they allow to impact on their professional conduct.

The **underlying causes** of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about contraception make rational sense to clients and potential clients, especially to ill-informed young people. People usually believe a given rumor or piece of misinformation due to **immediate causes** (e.g., confusion about anatomy/physiology).

Methods for Counteracting Rumors and Misconception

- When a client mentions a rumor**, always listen politely. Don't laugh.**
- **Define** what a rumor or misconception is.
- **Find out where the rumor came from** and talk with the people who started it or repeated it. Check whether there is some basis for the rumor.
- **Explain the facts** using accurate information, but keep the explanation simple enough for young people to understand.
- **Use strong scientific facts** about contraceptive methods to counteract misinformation.
- Always **tell the truth**. Never try to hide side effects or problems that might occur with various methods.
- **Clarify information** with the use of demonstrations and visual aids.
- **Give examples of people who are satisfied users** of the method (only if they are willing to have their names used). This kind of personal testimonial is most convincing.
- **Reassure the client** by examining her and telling her your findings.
- **Use good counseling** techniques to inform the client about methods of contraception.
- **Use visual aids** and actual contraceptives to explain the facts.
- **Take the rumors seriously**

DAY 4 : MODULE 20

TIME: 11.00am to 12.00 noon

Cancers of the Reproductive Health System

Time: 1 hour

Clear and effective communication is basic in helping young people to achieve healthy sexual and reproductive lives. In this session participants will learn how they can establish good relationships with young people to enable effective counselling on sexual and reproductive health issues to take place. The basic principles of communication and counselling will be taught to health workers.

Objectives:

By the end of the session, participants will understand the following:

1. Define Cancer
2. Describe the common types of Cancers in Swaziland
3. Describe Prevention and Management Strategies

CONTENT	METHODOLOGY	RESOURCES
○ Define Cancer ○ Describe the common types of Cancers in Swaziland ○ Describe Prevention and Management Strategies	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Presentationand Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

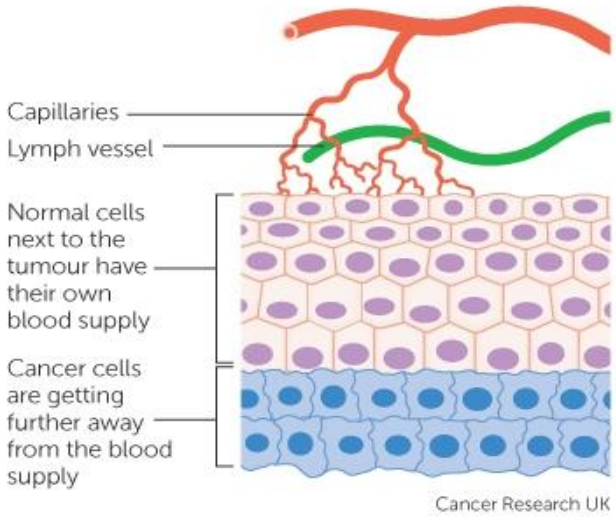
OBJECTIVE 1: DEFINING CANCER

- Cancer is when abnormal cells divide in an uncontrolled way. Some cancers may eventually spread into other tissues. There are more than 200 different types of cancer.

- As the tumor gets bigger, the center of it gets further and further away from the blood vessels in the area where it is growing.

- So the center of the tumor gets less and less of the oxygen and the other nutrients all cells need to survive

Blood Supply and Cancer



Angiogenesis: is the physiological process though which new blood vessels form from pre-existing blood vessels.

- Drugs that stop blood vessel growth (anti angiogenic drugs) can stop a cancer from growing into surrounding tissue or spreading. They can't usually get rid of a cancer completely, but may be able to shrink it or stop it growing in some cases.

OBJECTIVE 2: TYPES OF CANCERS

Currently Common Reproductive Cancers in Swaziland

A. Cervical cancers
B. Breast cancers
C. Prostate cancers

Benign tumours

- Usually grow quite slowly
- Don't spread to other parts of the body
- Usually have a covering made up of normal cells
- Benign tumours are made up of cells that are quite similar to normal cells.
- They will only cause a problem if they grow very large
- Become uncomfortable or unsightly
- Press on other body organs
- Take up space inside the skull (such as a brain tumour)
- Release hormones that affect how the body work

Malignant tumours are made up of cancer cells. They:

- Usually grow faster than benign tumours
- Spread into and damage surrounding tissues
- May spread to other parts of the body in the bloodstream or though the lymph system to form secondary tumours. Spreading to other parts of the body is called metastasis

How Cancer gets Bigger

- To start with, cancer cells are contained within the body tissue from which they have developed – for example, the lining of the bladder or the breast ducts. It may also be called carcinoma in situ.

- The cancer cells grow and divide to create more cells and will eventually form a tumour.

- A tumour may contain millions of cells. All body tissues have a layer keeping the cells of that tissue inside called the basement membrane.

- Once the cancer cells have broken through the basement membrane it is called an invasive cancer.

A: CERVICAL CANCER

Figure showing the cervix on the Female Reproductive Tract

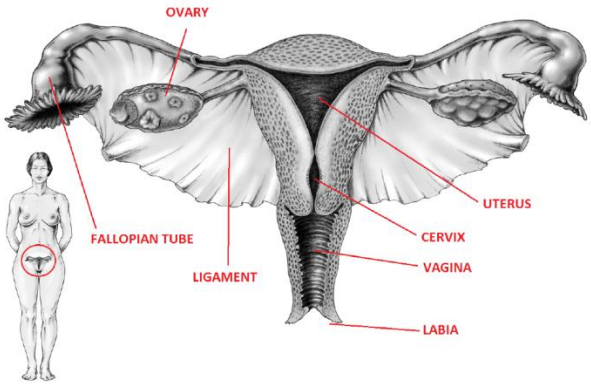
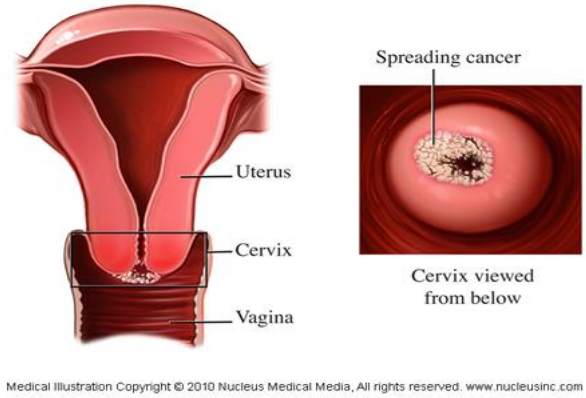


Figure Showing Cervical Cancer



Risk Factors
Brainstorming: What are the risk factors of cervical cancer?

- HPV infection
- Early sex debut (<20).
- Early pregnancy
- Multiple sexual partners
- Too many pregnancies and at short intervals
- Smoking
- Immunosuppression
- HIV/AIDS
- Chronic corticosteroid use (asthma and lupus)
- Poor diet/ low fruits and vegetables
- Diethylstilbestrol (DES)
- Family history/ genetic predisposition

Risk Factors for HPV Infection
Sexual activity that increases the risk for infection with HPV includes the following: early onset of sexual intercourse (especially if near the time of first menses), having multiple sexual partners or having sex with a promiscuous partner.

- Early onset of sexual intercourse
- Multiple sexual partners

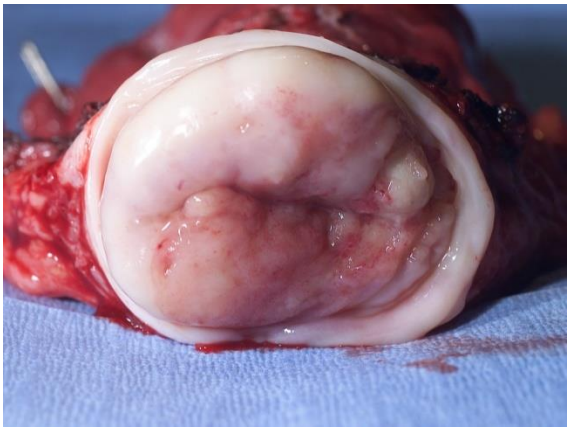
- Partner with multiple partners
- Multiple pregnancies
- HIV infection

Cancer of Cervix

- Natural history of cervical cancer
- The 4 major steps of cervical carcinogenesis are
- HPV infection of epithelium in transformation zone via sexual contact
- Persistence of the viral infection
- Progression of HPV to cervical pre-cancer
- Invasion through the basement membrane of the epithelium

These steps can occur backwards through clearance of the HPV infection and/or regression of a pre-cancer to normal, though this is uncommon.

Figure showing Cancer of the Cervix



Symptoms of Cervical Cancer

- No early signs and symptoms of cervical cancer. Most times when they occur or are reported they are usually it is at an advanced stage
- But as the cancer progresses, symptoms may include:
- Unusual vaginal discharge
- Vaginal bleeding between menses
- Bleeding after menopause
- Bleeding or pain during sex
- Mid cycle bleeding yet not on any contraceptive method,
- Lower abdominal pain

Prevention

- Screening (early detection is key)
- HPV vaccine (Gardasil or Cervarex)
- ART (boosted immune system)

- Condom
- Nutrition
- Exercise – healthy lifestyle

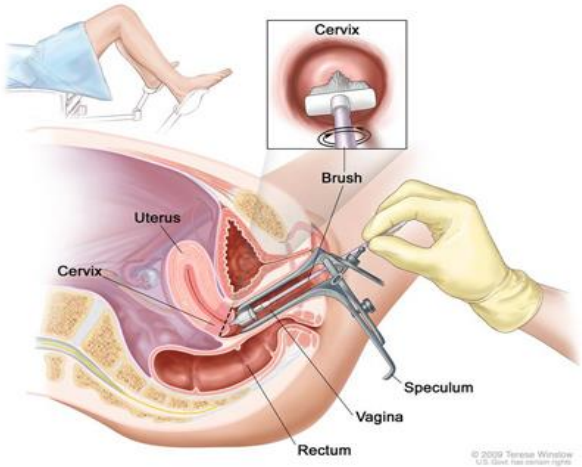
Screening for Cervical Cancer

- Cytology (pap smear)
- Visual Inspection with Acetic Acid (VIA)
- Colposcopy
- Digital Cervicography
- HPV DNA testing
- Laser induced fluorescence: The Laser-Induced Fluorescence (LIF) petroleum sensor is attached to a probe that is pushed into the ground with a truck-mounted hydraulic system .The chemical sensor consists of a laser that fires short pulses of light into an optical fiber that runs through the probe.

Diagnosis of Cervical Cancer

Screening (pap smear, colposcopy- VIA)

- A Pap test is a procedure to collect cells from the surface of the cervix, inclusive of the transformation zone. A brush or a small wooden stick is used to gently scrape cells from the cervix. The cells are viewed under a microscope to find out if they are abnormal.
- Cytology screening with the Pap test has been the mainstay of cervical cancer screening for many years in developed countries and has been proven to reduce cervical cancer incidence and mortality.
- In order for cytology-based screening to be effective as a cervical cancer prevention modality several cervical components may be in place: a laboratory with the capacity to efficiently process and accurately interpret cytological and histological specimens, a quality assurance mechanism in the lab to ensure standards are upheld, a patient recall system, a referral clinic with the capacity to evaluate patients with abnormal Pap smears.

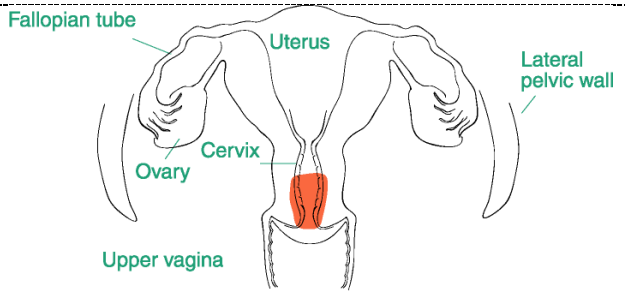


- Biopsy
- Diagnostic and treatment procedures
- LEEP

- Conisation - in which the inner lining of the cervix is removed to be examined pathologically.
- Cryotherapy

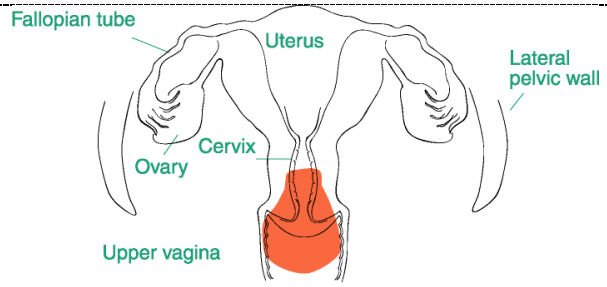
CANCER STAGES AND CONTROL INTERVENTION

DIAGRAMS SHOWING STAGES OF CANCER



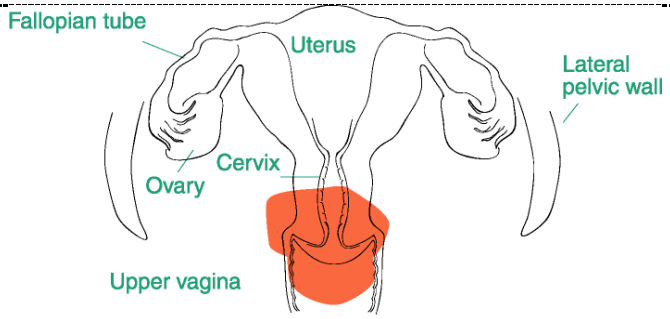
Stage I

Stage I cervical cancer is confined to the cervix.



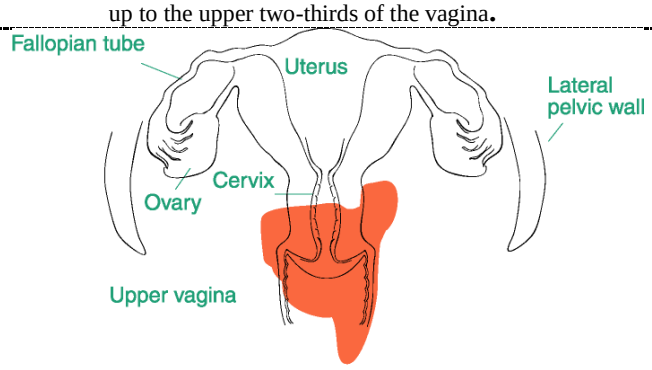
Stage IIA

- Stage II is carcinoma that extends beyond the cervix, but does not extend into the pelvic wall. The carcinoma involves the vagina, but not as far as the lower third.
- Stage IIA: No obvious parametrial involvement. Involvement of up to the upper two-thirds of the vagina.



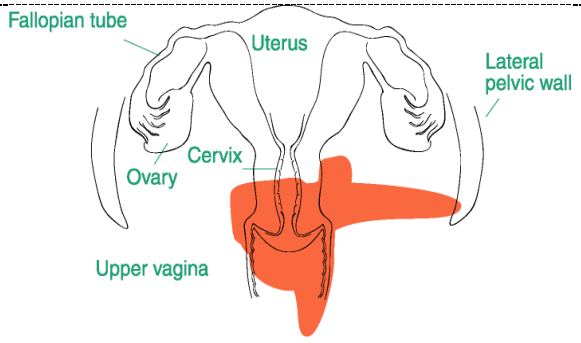
Stage IIB

Stage IIB: Obvious parametrial involvement, but not into the pelvic sidewall.



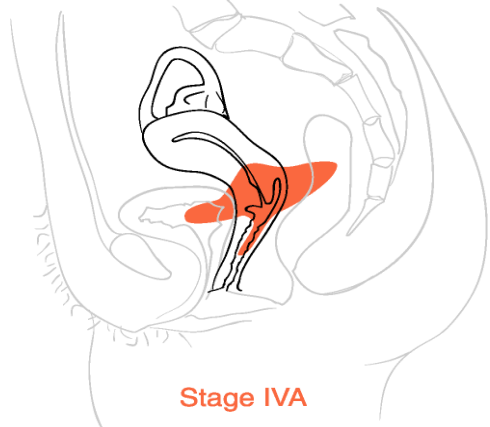
Stage IIIA

- Stage III is carcinoma that has extended into the pelvic sidewall.
- On rectal examination; there is no cancer-free space between the tumour and the pelvic sidewall. The tumour involves the lower third of the vagina.
- Stage IIIA: No extension into the pelvic sidewall but involvement of the lower third of the vagina.



Stage IIIB

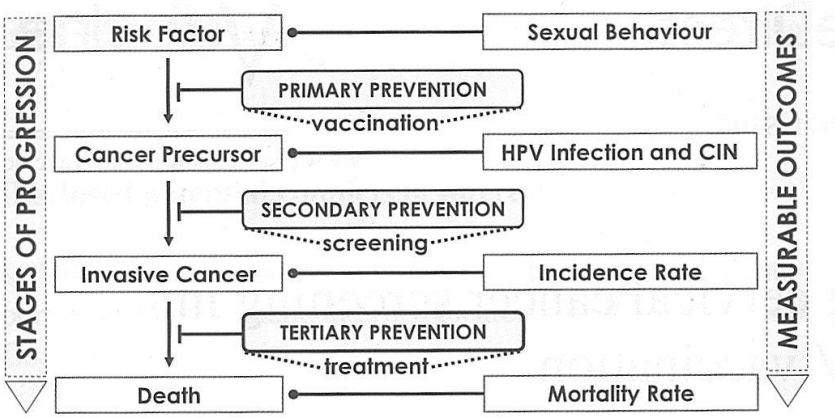
- The tumour involves the lower third of the vagina.
- All cases with hydronephrosis or a non-functioning kidney are Stage III cancers
- Stage IIIB: Extension into the pelvic sidewall or hydronephrosis or non-



Stage IVA

- Stage IV is carcinoma that has extended beyond the true pelvis or has clinically involved the mucosa of the bladder and/or rectum.
- In Stage IVA, there is spread of the tumour into adjacent pelvic organs.

Control Measures



Treatment of Cervical Cancer

- Treatment of cervical cancer depends on the stage of the disease.

- A hysterectomy is a surgery to remove the uterus, including the cervix. If the uterus and cervix are taken out through the vagina, the operation is called a vaginal hysterectomy. If the uterus and cervix are taken out through a large incision (cut) in the abdomen, the operation is called a total abdominal hysterectomy. If the uterus and cervix are taken out through a small incision in the abdomen using a laparoscope, the operation is called a total laparoscopic hysterectomy. A radical hysterectomy is a surgery to remove the uterus, cervix, and part of the vagina. The ovaries, fallopian tubes, or nearby lymph nodes may also be removed

- Radiation may be used alone, or after surgery, or chemotherapy. Radiation is delivered by a machine outside the body (called external beam radiation) or by radioactive "seeds" implanted in the uterus and vagina (called brachytherapy). After surgery, radiation may be used to decrease the risk for recurrence. Side effects include fatigue, swelling, and skin reddening.

- Chemotherapy uses toxic drugs to destroy cancer cells. Chemotherapy is administered intravenously, through injection, or in pill form. Side effects may be severe and include nausea, vomiting, diarrhea, and leukopenia (low white blood cell count).

B: BREAST CANCER

- Common in women but can occur in men
- It starts off as a lump
- Successful treatment depends on early detection of the cancer
- Once diagnosed, the cancer can be removed surgically

Signs and symptoms

- The woman may notice a lump, often on the inner upper side of the breast

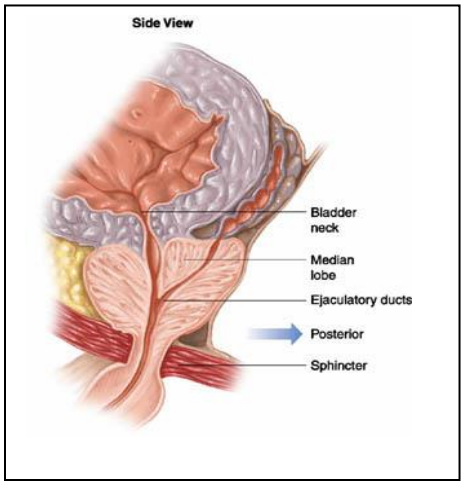
- The lump grows slowly
- At first it is not painful
- Later becoming painful and may start to feel hot
- Large painless small lumps/swellings appear in the armpit
- The breast may have an abnormal dent or dimple (skin retraction)
- An orange skin may appear on the breast

Diagnosis
NB: EMPHASIS SHOULD BE ON SELF-BREAST EXAMINATION

- Signs and symptoms (self-breast examination)
- Mammogram tests
- Fine needle aspiration
- Biopsy

C: PROSTATE CANCER (ca Prostate)

- Data on Ca Prostate is limited and needs further cleaning, analysis and understanding
- New initiative to improve Ca Prostate case finding and management
- Sub Committee set up to work on this
- A work plan has been developed and finalized, due for presentation to MoH Senior Staff
- Identified as entry point to address men issues



The Prostate Gland

- The Prostategland is found only in men
- Sits below the urinary bladder, in front of the rectum
- Normal size of the gland is walnut-size
- Cells in the prostate make fluid contained in seminal fluid which nourishes sperm

Early Signs and Symptoms of Prostate Cancer

Late Signs and Symptoms

COMMON	RARE
o Difficulty in starting and stopping the urinary stream, o Increase in frequency of urination, and pain while urinating. o Poor urine stream o urinary retention o Urinary dribbling o Bladder fullness after urination o Recurrent urinary tract infections(UTI).	o Hematuria o painful ejaculation, o Impotence (inability to have an erection) o Fatigue and malaise o Weight loss.

Barriers in prostate cancer Diagnosis and Treatment

- Cultural practices
- Sensitivity
- Poor health seeking behaviour
- Reactive patient screening
- Cost
- Limited expertise for disease management
- Growing disease burden

DAY 4 : MODULE 21

TIME: 12.00am to 1.00 pm

How to establish a teen club and linked with the community

Time: 1 hour

Objectives:

By the end of the session, participants will understand the following:

1. Why Teen Clubs
2. Establishment of Teen Clubs
3. Linking Teen Clubs with the Community

CONTENT	METHODOLOGY	RESOURCES
○ Why Teen Clubs ○ Establishment of Teen Clubs ○ Linking Teen Clubs with the Community	✓ Brainstorming and Presentation ✓ Brainstorming and Presentation ✓ Activity exercise and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: WHY DO WE NEED TO DEVELOP COMMUNITY LINKED TEEN CLUBS?

Why Teen Clubs

- To encourage young people to participate and access Youth Friendly SRH information and high quality HIV, GBV Clinical Services.
- To empower youth on knowledge and life skills related to SRH issues.
- To advocate for YSRHR (choice, access, dignity, safety,. Information, comfort, confidentiality, privacy, opinion, continuity of care.

The mission of a Teen Club is to empower adolescents to:

- Build positive relationships,
- Improve their self-esteem and acquire life skills through peer mentorship,
- Adult role-modeling and structured activities,
- Ultimately lead to improved clinical and mental health outcomes as well as a healthy transition into adulthood.

Educational components may include topics on HIV education, disclosure, adherence, life skills, college preparation, personal finance management and goal-setting and more.

OBJECTIVE 2: ESTABLISHMENT OF TEEEN CLUBS

- Identify a site.
- Registration (age specific)
- Membership / subscriptions
- Committee election.
- Identification and training of Peer Educators

Principles of establishing Teen Clubs

- Gender Equality.
- Youth Focus: responsive to their needs
- A right based approach.
- Pro-poor and sensitive to vulnerable groups
- High standard of quality of care
- Accountability
- Ownership
- Role models
- Empowerment

Activities in a Teen club

- Peer health talks
- Outreach activities.
- Community mobilization
- Condom Distribution.
- Distribution of IEC material.
- Facilitate during schools and community outreaches.
- Referrals
- Creation of Social media communication.
- Honor Important calendar or community days
- Compile monthly Reports
- Partner or network with other community stakeholders.
- Referrals
- Compile and distribute reports to relevant partners

Advocacy: Always advocate for:

- Youth Participation
- Formation of SRH committee.
- Community Conversations
- Suggestion Box

Challenges associated with establishing and managing Teen Clubs

- Lack of Motivation
- Limited or no funding
- Attrition rate
- Lack of innovation
- Non youth friendly Staff
- Lack of support from leaders

How to motivate participation

- Capacity building
- Delegation of duties and variety of activities.
- Incentives
- Presentations for career purposes
- Follow up on Personal Documents.
- Attend Local, Regional or international meetings.

OBJECTIVE 3: LINKING TEEN CLUBS WITH THE COMMUNITY

Activity:

- List key people and structures which need to be considered when developing a teen club
- What is the importance of each of the listed key persons/structures?
- How we ensure sustainability of Teen Clubs

DAY 4 : MODULE 22

TIME: 2.00pm to 3.00 pm

SRH for Adolescents in difficult circumstances

Time: 1 hour

Objectives:

By the end of the session, participants will to:

1. Define Adolescents living in Difficult Circumstances
2. Describe the needs of Adolescents living in Difficult Circumstances

CONTENT	METHODOLOGY	RESOURCES
○ Define Adolescents living in Difficult Circumstances ○ Describe the needs of Adolescents living in Difficult Circumstances	✓ Role Play and Discussion ✓ Presentationand Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: ADOLESCENTS IN DIFFICULT CIRCUMSTANCES: WHO ARE THY?
Role Play

Divide the participants into groups and assign a category of adolescent living in difficult circumstances to each group (e.g. Group 1 – abused children; Group 2 – physically challenged and so on.

Ask each group to prepare a role play that will bring out the sexual and reproductive health needs of the adolescents. The role play should bring out proposed ways of addressing the identified health needs.

- Present the role plays in plenary and discuss
- Highlight the ASRH needs
- Share how the needs will be addressed
- Indicate the community support system that are critical in each scenario
- Highlight aspects from the presentation that have not been discussed.

A. Orphaned and Vulnerable Children:

Forms of child abuse: Physical; Emotional; Psychological; Economic and Sexual abuse. These can lead to children going to live on the street. The definition of abused children includes children on the streets. ASRH Needs for Orphaned and Vulnerable Children

- Post Exposure Prophylaxis (PEP)
- Emergency contraception
- Continued counseling-Referral to family support
- Psychosocial support (shelter, Victim Friendly Units)
- The emerging trend of drug and substance abuse especially among adolescent boys living on the streets.

B. Mentally and Physically Challenged:

Key considerations:

- Parental/guardian consent
- Breach of human rights

Services that can be offered to mentally and physically challenged:

- Appropriate IEC materials
- Interpreter
- Counseling
- HIV services-PEP, FP-emergency contraception
- User friendly infrastructure

C. Adolescents in Emergencies/Humanitarian Settings:

Emergencies in Swaziland include:

- Floods
- Droughts
- Economic crisis (unemployment of youth)
- Violence/unrest (involvement of youth)
- Informal settlements

Why is ASRH still important in emergency situations?

Emergency situations may disturb the health service delivery system in terms of access to SRH services (including safe motherhood), family planning and HIV Prophylaxis and treatment. YET:

- Pregnant women and girls still need care and be able to give birth safely,
- People continue to have sex. Sex might even increase for several reasons (no rule of law, more free time, coping mechanism for de-stressing, families fall apart, sexual violence),
- Some may still be in need of family planning services,
- People might not want children in humanitarian crises because they don't have the means to care for them,
- Higher risk of sexual violence leading to unintended pregnancy, unsafe abortions, STIs, HIV, stigmatization, psychosocial problems.

Adolescents are particularly vulnerable in emergencies because they don't have the means and experience to cope with risky and stressful situations like this.
Adolescents will find themselves in risky and stressful situations that they are not prepared to deal with including:

- Breakdown of social norms and rule of law
- Separation from family/community (loss of livelihood, security and protection)
- Might have to take adult roles without support networks or positive adult role models
- Public services discontinued, including education leading to more free time and less structure, boredom and idleness
- Living in crisis may lead to fatalistic views/no positive future perspectives

This all leads to more high-risk behavior

- More and unsafe sex, multiple partners
- Risk of sexual violence and abuse (in community or by fighting parties or even protection forces or humanitarian workers)
- Selling sex to meet basic needs of food or protection

While in the meantime there is poor access to RH services and information:

- Breakdown in health care services/overburdened health care system
- Finding food and shelter may get priority over reproductive health care

Vulnerable groups in emergencies or humanitarian settings are:

- Very young adolescents (10-14 years)
- Pregnant adolescent girts
- Marginalized adolescents, e.g.:
    - Living with HIV
    - Those with disabilities
    - Separated from their families
    - Survivors of gender-based violence
    - Adolescents selling sex
    - Youth associated with armed forces/groups

ASRH Services in Emergencies:

Family planning:

- Condoms should be available in places that are accessible to young people, for the prevention of unwanted pregnancies and STls including HIV.

D. Adolescents who have experienced any form of Gender Based Violence (GBV):

- Protection of survivor is priority (principles of safety, confidentiality, respect and dignity)
- Multi-sectoral response:
    - Medical referral services available free of charge (no parental consent needed);
    - Treatment of physical injuries; PEP and emergency contraception; Presumptive treatment of STl's including HIV
    - Psychosocial support
    - Protection (e.g. shelter)
    - Legal/justice support
    - Victim friendly units

DAY 4 : MODULE 23

TIME: 3.00pm to 5.00 pm

M & E and Sustaining ASRH Programmes

Time: 1 hour

This module defines the main terms used in planning, monitoring and evaluation. The key terms to define are planning, monitoring, evaluation, indicator, M&E Framework, input, process, output, outcome and impact.

Objectives:

By the end of this session, participants will be able to:

1. Define key concepts for Planning, Monitoring and Evaluation
2. Describe the project circle
3. State at least 5 reasons for conducting Monitoring and Evaluation (M & E)
4. Describe the Monitoring and Evaluation Framework
5. State and define key ASRH indicators
6. State mechanism for sustaining ASRH programs

CONTENT	METHODOLOGY	RESOURCES
○ Define key concepts for Planning, Monitoring and Evaluation ○ Describe the project circle ○ Describe the Monitoring and Evaluation Framework ○ State and define key ASRH indicators ○ State mechanism for sustaining ASRH programs	✓ Presentation and discussion ✓ Brainstorming and Presentation and Exercise ✓ Role Play ✓ Presentation ✓ Handouts and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ HO 23..2.1 ○ HO 23..3.1

INTRODUCTION – Brainstorming

- *Ask participants what comes to their minds when someone mentions the words: planning, monitoring and evaluation?*
- *Ask participants their understanding of planning, monitoring and evaluation. What is it? Why is it done and what does it entail? When and who carries it out? Who needs uses M&E Information?*

DEFINE KEY CONCEPTS SN PLANNING, MONITORING AND EVALUATION

This section defines the main terms used in planning, monitoring and evaluation. The key terms to define are planning, monitoring, evaluation, indicator, M&E Framework, input, process, output, outcome and impact.

THE PROJECT CYCLE

- *In pairs, ask participants to discuss the project cycle, giving justification for each stage.*
- *Show the slide with the project cycle and discuss each stage, with participants sharing what they discussed in the buzz groups.*
- ***Refer to project cycle handout***

The Project Cycle

i. **Assessment/Situational Analysis and Planning:** Where are we now? Where do we want to go? How will we get there?
ii. **Implementation and Monitoring:** Is the project is on the right track, is it meeting its objectives and using its resources as planned?
iii. **Evaluation:** What changes have occurred as a result of project activities?
iv. **Adaptation:** What are the lessons learnt, can they be replicated in future?

REASONS FOR CONDUCTING PLANNING

- *Lead a discussion on the reasons for conducting Planning, M & E.*
- *Introduce the Logical Framework refer to handout*
- *Discuss how relevant is M and E in ASRH programming.*

Planning: It means setting performance expectations and goals for groups and individuals to channel their efforts toward achieving organizational objectives. Refer to Handout for the characteristics and steps in planning as well as the use of the logical framework.

Monitoring - is a continuous process that aims primarily to provide project management and give the main stakeholders early indications of progress or lack of progress towards achieving project objectives. Monitoring also detect early signs of the project's success or failure. Monitoring assists to address any impediments to progress and make adjustments so that results can be achieved within the designated timeframe. Monitoring is an internal process that also looks at project processes (both programmatic and financial) and makes changes in assumptions and risks associated with target groups, institutions or the surrounding environment.

Evaluation - is a time-bound exercise that attempts to assess the relevance, performance and success of current or completed projects, systematically and objectively. Evaluation determines to what extent the intervention has been successful in terms of its impact, effectiveness, sustainability of results, and contribution to capacity development. Evaluation, more than monitoring, asks fundamental questions on the how and why of the overall progress and results of an intervention in order to improve performance and generate lessons learned. When carried out after project completion, evaluation can contribute to extracting lessons to be applied in other projects. Evaluations at the midpoint of the project or programme also provide timely learning that can suggest mid-course adjustments.

Monitoring and Evaluation serves the following purposes:

- To measure progress against set targets or objectives (what, how, where, when, why)
- To check whether programme activities are on schedule
- To identify challenges so as to make timely corrective action (making informed decisions on the way forward)
- For accountability to community - donors, community leadership, board members and other stakeholders: to demonstrate effective and efficient use of resources; preserving institutional memory and learning purposes: To influence policy
    - ✓ What did we do?
    - ✓ What did we achieve?
    - ✓ What did we do well
    - ✓ What worked well?

In general, evaluation should address five fundamental criteria:

i. **Relevance:** What is the value of the intervention in relation to stakeholders' needs, to national priorities, to partners' policies, and to global references such as the MDGs? To what extent are the objectives of the project/programme still valid?

ii. **Effectiveness:** What target groups have been reached? To what extent has the project or programme achieved satisfactory results in relation to its stated objectives?

iii. **Efficiency:** To what extent has the project/programme used its resources economically to achieve its objectives?

iv. **Impact:** What are the wider social, economic, and environmental effects on communities and nature?

v. **Sustainability:** Are the activities and impacts likely to continue after external support is terminated? Will aspects of the project/ programme be replicated elsewhere (perhaps with adaptations)?

THE MONITORING & EVALUATION FRAMEWORK

- ***Ask participants to go into groups and plan an ASRH programme for their organization.***
- ***Groups are to present their planned programme in plenary.***
- ***Discuss***

The M & E framework is a structure used to measure performance of ASRH programmes. It defines inputs, processes, outputs, outcomes, and impact and the tools to use for data collection. It also defines how people, data and time interact so that the performance of the health providers and services can be meaningfully assessed and improved.

UNDERSTANDING M&E DATA COLLECTION TOOLS/CHECKLISTS – Discussion

To guide the discussion, ask the following questions:

- ***Why is it important to collect ASRH data? What are the key ASRH indicators?***
- ***What tools are we currently using for ASRH data collection? Go through some examples.***
- ***What are the challenges in ASRH data collection and how to address them?***

How do we monitor and evaluate

- Routine collection, processing, analysis, dissemination, feedback and utilization of data: forms, registers, etc.
- Quality assurance: coverage; completeness;
- Observation e.g. young people's behaviours.
- Rapid assessments at intervals.
- Surveys

To increase collection of accurate data, service providers need to:

- Appreciate the importance of data collection
- Familiarize with reporting systems and requirements (flow of data)
- Familiarize with indicators (core ASRH indicators)
- Familiarize with forms and tools to correctly complete them and accurately interpret data on them
- Have ability to assess data accuracy, precision, reliability, validity and integrity

Service Providers need to closely monitor

- Distribution and use of materials
- Youth Services on demand
- Accessing of services by youth
- Acceptance of the messages by youth
- Number of referrals
- Issues in the suggestion box and views on the programme

SUSTAINABILITY OF ASRH PROGRAMMES -Discussion

- ***Participants to brainstorm on experiences and challenges in sustaining ASRH programmes***

ASRH programmes may be sustained through:

i. **Community involvement, especially young people in:**
a) Planning (Advocacy and sensitization of local leadership; Local resource mobilization strategies: Use of existing local resources, - Multiple sectoral approach and in developing an exit strategy),
b) Implementation
c) Monitoring & Evaluation.

ii. Capacity building of service providers

iii. Setting up and working with structures and committees on ASRH programming

iv. Establishing internal mechanism for funding ASRH service provision

1. **PLANNING EXERCISE FOR ASRH PROGRAMMES - Group work**

- Put participants into groups and ask them to design/plan a YFS at their respective facility and list the changes tobemade.
- Makethem use YFS handouts
- Groups make their presentations followed by discussion.

HANDOUT:Basic Planning, Monitoring and Evaluation Concepts

Planning - process of setting out targets, developing approaches, outlining the implementation arrangements and allocating resources to achieve targets for ASRH programmes. **It is important to understand the planning cycle**

Monitoring - is a continuous process that aims primarily to provide project management and give the main stakeholders early indications of progress or lack of progress towards achieving project objectives. A progress analysis during project implementation through monitoring serves to validate the initial assessment of relevance, effectiveness and efficiency or to fill in the gaps. It may also detect early signs of the project's success or failure. Monitoring assists to address any impediments to progress and make adjustments so that results can be achieved within the designated timeframe. Monitoring is an internal process that also looks at project processes (both programmatic and financial) and makes changes in assumptions and risks associated with target groups, institutions or the surrounding environment.

Evaluation - is a time-bound exercise that attempts to assess the relevance, performance and success of current or completed projects, systematically and objectively. Evaluation determines to what extent the intervention has been successful in terms of its impact, effectiveness, sustainability of results, and contribution to capacity development. Evaluation, more than monitoring, asks fundamental questions on the how and why of the overall progress and results of an intervention in order to improve performance and generate lessons learned. When carried out after project completion, evaluation can contribute to extracting lessons to be applied in other projects. Evaluations at the midpoint of the project or programme also provide timely learning that can suggest mid-course adjustments.

Indicator - An objectively and verifiable measure of achievement of set objectives, indicators provide the measuring stick to determine whether the goal, targets, and outputs have been achieved. A good indicator should be: Valid: Measures the effect it is supposed to measure; Reliable: Gives same result if measured in the same way; Precise: Is operationally defined so people are clear about what they are measuring; Timely: Can be measured at an interval that is appropriate to the level of change expected ; Comparable: Can be compared across different target groups or project approaches. Indicators can be quantitative (statistical measures) or qualitative (explanatory/ interpretative judgment). They include key inputs, process, outputs, outcomes and impact.

M&E Framework - A structure used to measure performance of ASRH programmes. Include Inputs, processes, outputs, outcomes, and impacts

Input - Resources required to implement ASRH programmes, e.g. human resources, financial resources, infrastructure.

Process - Transforming inputs into activities e.g. recruiting and training of service providers, distribution of lEC materials, recruitment of Youth Centre Staff, training and orientation of Youth Center Staff and implementation of intervention activities.

Output - Immediate results of the activities implemented, such as the number of personnel trained, number of deliveries conducted at programme level, number of youth reached by Peer Educators, number of youth counseled on HIV and AIDS, number of youth that accessed family planning services; number of youth treated for STls; number of male condom pieces distributed to youth; number of female condom pieces distributed to youth

Outcome - Intermediate results of activities implemented. Unlike outputs, outcomes are measured at the population level such as contraceptive prevalence rates or percent of births with skilled birth attendants; rate of unintended or unwanted pregnancies among youth; number of STI cases among youth; rate of HIV transmission among youth; HIV prevalence rate among adolescents

Impact- long-term effects that are the logical consequence of the achievement of the outcomes, such as the Adolescent Fertility Rate

HANDOUT 23.2.1: THE PROJECT CYCLE

A Project is a set of actions undertaken by any group - including managers, researchers, community members, and any other stakeholders - to achieve defined goals and objectives. A project cycle is a four stage process through which practically every project goes through. However, the four phases of the project cycle should however be viewed as iterative steps, not as a linear set of sequential steps. The cycle defines key decisions, information requirements and responsibilities for informed decision making at each stage. The project cycle consists of four stages: **assessment and planning, implementation and monitoring, evaluation, and adaptation**. Each stage has its own characteristics and requires specific knowledge and skills.

The assessment phase is sometimes also called the identification phase, as in this period the "why?" of the project is the important question to ask. In this stage the real problems and issues that need to be addressed, are identified. The assessment phase is followed by a planning phase in which goals and objectives are defined and the feasibility of the project is carefully researched. Then an action plan is made, resources are determined and the use of the resources is planned. At this stage it is already important to think about and identify indicators to be used to monitor and to evaluate the project.

In the **implementation** phase, during which the project is actually carried out, continuous **monitoring** needs to take place, in order to watch whether the project is on the right track, is meeting its objectives and is using its resources as planned.

During the **evaluation** phase the project is measured against its objectives, both to see if objectives have been met, but also to see how this was done and what the impact of the project is. In other words what changes have occurred as a result of project activities?

On the basis of the evaluation, **adaptation** of the project can take place and lessons learnt can be identified and used for future planning. The project cycle is a continuously ongoing one; after evaluation and adaptation, the planning starts again, followed by implementation etc.

DAY 5 : MODULE 24

TIME: 8.30am to 10.30am

Drug Adherence

Time: 2 hours

Objectives:

At the end of the session , participants will be able to :

1. Define adherence
2. Understand the importance of adherence
3. Describe adherence monitoring
4. Describe the relationship between Adherence and Psychosocial Support

CONTENT	METHODOLOGY	RESOURCES
○ Define adherence ○ Understand the importance of adherence ○ Describe adherence monitoring ○ Describe the relationship between Adherence and Psychosocial Support	✓ Presentation and discussion ✓ Brainstorming and Presentation ✓ Presentation and Discussions ✓ Presentation and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers

OBJECTIVE 1: DEFINING ADHERENCE

Adherence is: taking >95% of the right medications, the right dose, the right way, at the right time.

There should be:

- No missed appointments for follow-up
- Drugs taken for the whole duration of treatment
- Healthy preventive habits, actions implemented
- Active participation

Key Concepts in Adherence

A. ADHERENCE TO CARE
B. ADHERENCE TO TREATMENT
C. NON-ADHERENCE

OBJECTIVE 2: THE IMPORTANCE OF ADHERENCE
Who needs Adherence?

- Pre-ART clients : clients with high CD4 and eligible clients
- ART clients
- PMTCT clients
- TB and HIV core infected clients
- PEP clients
- Pediatrics and adolescents

Why is Adherence so important?

- Near-perfect adherence is required for ART to be successful.
- To attain good viral suppression in a person's body.
- To avoid the body becoming resistant to certain medicines.
- To increase the CD4 cells and decrease the Viral Load

OBJECTIVE 3: ADHERENCE MONITORING
Five Types of Non-adherers

1. **Consistent Underdoser**
   - Regularly neglects to take one of the prescribed doses, such as the evening dose
   - Regularly takes only some of the prescribed medications
2. **Consistent Overdoser**
   - Regularly takes a drug more often or in larger doses than prescribed
3. **Random Doser**
   - Takes the medications when she or he thinks of it
4. **Abrupt Overdoser**
   - Does not take medications properly and then takes an overdose prior to a clinic visit
   - Doubles up for missed doses
5. **Tourist (takes "drug holidays")**
   - Abruptly stops all medications for a few days or weeks
   - Takes one day off per week

Factors of poor adherence to medications

I. Patient factors
   - Active drug and alcohol use
   - Active mental illness
   - Poor social support, living alone
   - Patients who do not believe in the effectiveness of a treatment
   - Lack of self-efficacy
   - No change in health status
   - Lack of motivation to adhere to a TB medication

II. Medication factors
   - Medication side effects
   - Dose frequency more than twice a day
   - Pill burden
   - Food requirement

III. Health provider factors
   - Poor patient/health care provider relationship.
   - Lack of access to health care can also be a significant barrier

Strategies to Improve Adherence

I. Patient focused strategies
   - Treatment of mental disorders
   - Involve family and friends to support the treatment plan.

- Daily schedule that integrate and links activities and meals with administration of medications. Fit medication schedule into existing life style. “Individualize the drugs to fit the patient and not expect the patient to fit the drugs”
- Provide reminders
- Patient focused strategies
- Medication focused strategies
- Clinician and Health Team focused strategies

II. Medication focused strategies
- If possible, reduce dose frequency (BID or even OD) and number of pills.
- Simplify food requirements.
- Treat side effects.
- Security stock

III. Clinician and Health Team focused strategies
- Establish trust.
- Adherence assessment should be a routine part of each follow-up visit
- Intensify management in periods of low adherence(i.e., more frequent visits, recruitment of family/friends, deployment of other, home visits)
- Home visit
- Telephone call for the purpose of support between clinic visit

OBJECTIVE 4: PSYCHOSOCIAL SUPPORT

- Psychosocial support addresses the ongoing psychological and social concerns and needs of people living with HIV, their partners, their family, and caretakers of children living with HIV.
- Psychosocial care is an ongoing process and encompasses all the following:
  - ✓ Patient focused strategies
  - ✓ Medication focused strategies
  - ✓ Clinician and Health Team focused strategies
  - ✓ Patient focused strategies
  - ✓ Medication focused strategies
  - ✓ Clinician and Health Team focused strategies

DAY 5 : MODULE 25

TIME: 11.00am to 12.00 noon

Disclosure andTransition to adult care

Time: 1 hour

Objectives:

After completing this module, participants will be able to:

1. Apply a developmental approach to the process of disclosure preparation
2. Work through the disclosure process with children and young adolescents
3. Provide counseling and support to adolescents on disclosing their HIV-status to others

CONTENT	METHODOLOGY	RESOURCES
○ Apply a developmental approach to the process of disclosure preparation	✓ Presentation and discussion	○ PowerPoint Presentation ○ Flip chart and Markers
○ Work through the disclosure process with children and young adolescents	✓ Brainstorming and Presentation and Exercise	
○ Transitioning to Adult Care	✓ Presentation and Discussions	

OBJECTIVE 1: DEVELOPMENTAL APPROACH TO THE PROCESS OF DISCLOSURE PREPARATION

DISCUSSION QUESTIONS

- What have been some of your personal experiences and challenges working with caregivers who need assistance disclosing to children/adolescents?
- What about with adolescents who know they have a chronic illness and need assistance disclosing to others?

Disclosure is an ongoing process of:

- Telling a child/young adolescent that he or she has an illness/had a difficult/traumatic experience i.e. HIV-infected, cancer, they were raped when they were younger
- Helping him or her understand what this means
- Helping him or her disclose such to others

Disclosure is a 2-way conversation that involves:

- Speaking truthfully with the child/adolescent, over time, about his or her illness or traumatic experience
- Disclosing the diagnosis at an appropriate time, or helping the caregiver to do so
- Helping the adolescent prepare to disclose to others and providing follow-up support

NB: The disclosure process should begin early by addressing the child's health status and his or her need for care, support and treatment (where applicable). In the early stages, very simple terms should be used.

- Through the process, the child/young adolescent should come to know about:
- The diagnosis, the infection and disease process, and health changes that could occur
- Strategies to lead a healthy life (e.g., adherence, ongoing counselling/therapy) and his or her responsibilities now and in the future
- How to cope with the possible negative (and positive) reactions of others

Reasons to Disclose a Child's Health Status

○ Can result in health and psychological benefits for the child ○ Children/adolescents have a right to know ○ Adolescents often want and ask to know what is wrong ○ Non-disclosure may lead to incorrect ideas, feelings of being alone, learning one's status/traumatic experience by mistake, or poor adherence ○ May improve social functioning and school performance	○ Children are exposed to unintended "clues" of their diagnosis/situations ○ Orphans and other vulnerable children may wonder why they've lost a parent or been rejected by family (in the case if HIV) ○ They can then take an active role in their care and live positively or have a positive outlook towards life ○ Levels of anxiety, depression, and low self-esteem are higher in adolescents who have not been disclosed to

- Caregivers can provide comfort and reassurance

Partial and Full Disclosure

Partial disclosure:

- Appropriate for younger children
- Refers to giving information about a child's illness without using the specific details
- Helps move the disclosure process forward; prepares client and caregivers for full disclosure later on
- Is an effective strategy to help caregivers who do not feel ready for full disclosure
- Is useful for creating a context in which full disclosure can be more meaningful for the child
- Consider partial disclosure by the time a child is 6 years old, particularly if he or she has started asking questions related to his or her health.

Full disclosure:

- When a child/young adolescent is told that he or she has a chronic illness and is given further illness-related details
- Caregivers are ideally the ones who should decide when it is time for full disclosure
- It is generally recommended that full disclosure happen by the time a client is 10-12 years old (in cases of HIV status disclosure)
- Full disclosure should be considered when the child/young adolescent starts asking specific questions about his or her illness
- Easiest if child/young adolescent has been partially disclosed to over time and has been supported throughout the disclosure process

Debriefing

- Health workers should start talking about disclosure with caregivers (and in some cases young clients) WELL before a particular child has become an adolescent.
- Health workers play an important role in helping children, adolescents, and their families negotiate the challenges and barriers to moving through the disclosure process.
- Knowledge of their status may help promote clients' adherence to care and treatment, while not knowing or having a confused understanding may cause difficulties with adherence, psychosocial well-being, and positive living.

OBJECTIVE 2: THE ROLE OF HEALTH WORKERS DURING THE DISCOSURE PROCESS
Health Worker's Role in Supporting Caregivers with Disclosure

- Build trust by getting to know them; find out what HIV means to them
- Assess their psychosocial situation and ability to cope; answer their questions; identify their sources of support
- Discuss implications of disclosure and possible reactions of the child and others
- Assess client's readiness for disclosure and share impressions with the caregiver
- Help caregivers develop a plan for disclosure

- Arrange follow-up visits
- If there is disagreement between family members, assess concerns and discuss benefits and risks
- Respect and try to understand their reasons for fearing or resisting disclosure

Remember: If the caregiver is not ready to disclose, the process cannot be forced. However, the health worker should always advocate for what is in the best interest of the child/young adolescent.

Health Worker's Role in Supporting Children and Young Adolescents with Disclosure

- Prepare the child/young adolescent for disclosure.
- Actively assess the client's readiness for partial or full disclosure.
- In some cases, be part of the disclosure discussions with the client.
- Provide post-disclosure services as required.
- Provide Ongoing Disclosure Support to children/Adolescents

Remember: Health workers can and should be advocates for the needs of their child/adolescent clients, including their disclosure needs.

Providing Ongoing Disclosure Support to Children/Adolescents

Disclosure does not begin or end with a single conversation. As children/adolescents grow and develop, they need to be able to continue to ask questions and discuss their feelings.

At each visit, ask the client questions about disclosure, such as:

- Why do you think you take these medications? What do you know about HIV?
- How have you been feeling since you learned about your HIV-status?
- Who else do you talk to about HIV and who do you ask if you have questions?

Disclosing to others

CONSIDER THE FIVE 'WS":

- WHO do you want to tell?
- WHAT do you want to tell him/her? WHAT are you expecting from the person you are planning to disclose?
- WHEN do you plan to tell them?
- WHERE do you think is the most comfortable and safe place to have this conversation?
- WHY do you want to tell him/her?

OBJECTIVE 3: TRANSITIONING TO ADULT CARE

Key principles of Transitioning

It is important for clinical care staffs who work with HIV-positive youth in transition to recognize that:

- Transitioning is a process, not an event,
- Health care providers and family members must "let go",
- Transition should take place when the client is healthy and the client should be involved in the process,
- The client should be prepared for the change from a paediatric/adolescent health care provider to an adult provider,
- Coordination of health care, education, social services, and vocational services is essential.

Principles of Successful Transition to Adult-Oriented Health Services

1. Health care services for adolescents and young people need to be developmentally appropriate and inclusive of the young person's family where appropriate.
2. Young people with chronic illnesses and conditions share the same health issues as their healthier peers.
3. Health care services require flexibility to be able to deal with young people with a range of ages, conditions and social circumstances.
4. Transition is generally optimised when there is a specific health care provider who takes responsibility for helping the adolescent or young person and his or her family through the process.
5. Active case management and follow up helps optimise a smooth transfer to adult health services as well as promoting retention within adult services.
6. Engagement with a general practitioner can address holistic health care needs and help reduce the risk of failure of transfer to adult services
7. Close communication between paediatric and adult services will help bridge cultural and structural difference of the two health systems, resulting in smoother transition of young people to adult services.
8. An ultimate goal of transition to adult health care services is to facilitate the development of successful self-management in young people with chronic conditions.

DAY 5 : MODULE 26

TIME: 12 noon to 1.00 pm

Action planning for Youth friendly services

Time: 1 hour

Objectives:

By the end of the session, participants will understand the following:

- Develop an Action Plan for Youth Friendly Services
- Describe the Essential community Support Systems in Youth Friendly Service Provision

CONTENT	METHODOLOGY	RESOURCES
○ Develop an Action Plan for Youth Friendly Services ○ Describe the Essential community Support Systems in Youth Friendly Service Provision	✓ Individual exercise and Discussions ✓ Group work and Discussions	○ PowerPoint Presentation ○ Flip chart and Markers ○ Answer sheets

OBJECTIVE 1: DEVELOPING AN ACTION PLAN FOR YOUTH FRIENDLY SERVICES

- Administer answer sheets to participants.
- Let each participant develop an action plan on how they hope to improve ASRH services in their various places of work or even the community at large
- Remind participants to utilize the information and handoutsgiven in Module 23
- The activities should be clearly stated with clear objectives and indicators
- They should also state how they hope such activities will be sustainable

OBJECTIVE 2: COMMUNITY SUPPORT SYSTEMS IN YOUTH FRIENDLY SERVICE PROVISION
Group work and Discussion

- A community is a group of people who share the same norms, values and culture and live in the same geographical area.
- A support system is a network of personal or professional contacts available to a person or organization for practical, social and moral support.
- In every community, there are government departments, non-governmental organizations, community based organizations, religious groupings and support groups that health institutions can collaborate with in supporting sexual and health provision to adolescents

  - ✓ *Break participants into groups. Put participants coming from the same locality into one group.*
  - ✓ *Ask participants to map support systems available in the community to support the provision of Youth Friendly Services to adolescents.*
  - ✓ *Each group to make a presentation, highlighting the benefits of working with community support systems. List the benefits on a flip chart.*
  - ✓ *Discuss.*

Information gathering Checklist on Adolescent Sexual and Reproductive Health and Rights

1. What information do we have about adolescents in the country/region?
   - Demographic data broken down by age and sex
   - Social and economic status (including opportunities for - and levels of - education, employment, family and social support, and access to basic necessities such as clean water, food and shelter)
   - Health status (including the leading causes of disease and death)
   - Groups and subgroups of adolescents who are especially vulnerable to health and social problems (for example adolescents living with HIV, adolescents in difficult circumstances)

2. What information do we have about the health services that are available to and used by adolescents?

3. What information do we have about:
    - Existing laws and policies relating to adolescent sexual and reproductive health and rights (for example the age of consent to sexual intercourse, access to contraception)

    - Principles and practices of national institutions, such as national medical associations, which affect the availability and accessibility of health information and services for adolescents (such as confidentiality in the context of sexual and reproductive health, HIV status)

4. What information do we have about ongoing actions to promote and safeguard the health of adolescents, and to help them develop into well-adjusted adults?
    - Which government departments carry out or support programs in this field at the national level?

    - What are the responsibilities of provincial and regional level government departmentsin this field and what mechanisms are in place?

    - Which nongovernmental organizations carry out or support activities in the field, atnational and/or provincial and district levels?

5. What training opportunities are there to help health care providers and other professionals serving adolescents to respond more effectively and sensitively to the needs of adolescents

REFERENCES

1. Central Statistical Office (CSO) [Swaziland] and Macro International Inc. (2008) Swaziland Demographic and Health Survey 2006-07: Chapter 14 HIV Prevalence and Associated Factors. . Mbabane, Swaziland: Central Statistical Office and Macro International Inc.
2. National Emergency Response Council on HIV and AIDS (NERCHA) (2010) National Multi-Sectoral Strategy Framework HIV Aids 2009-2014. Mbabane, Swaziland, NERCHA.
3. Auvert B, Taljaard D, Lagarde E, Sobngwi-Tambekou J, Sitta R et al. (2005) Randomized, Controlled Intervention Trial of Male Circumcision for Reduction of HIV Infection Risk: The ANRS 1265 Trial. PLOS Med; 2(11):
4. Bailey RC, Moses S, Parker CB, Agot K, Maclean I, Krieger JN et al. (2007) Male circumcision for HIV prevention in young men in Kisumu, Kenya: a randomised controlled trial. Lancet; 369(9562).
5. Central Statistical Office (CSO) (2009) 2007 Swaziland Population Census. Mbabane, Swaziland: CSO.
6. Ministry of Health (MOH) (2011). p. 2010. Round of the HIV Sentinel Sero-surveillance Survey. Mbabane, Swaziland: MOH.
7. Ministry of Health (MOH) (2012) ART Programme Annual Report Mbabane, Swaziland: MOH.
8. Ministry of Health (MOH) (2012) Swaziland National ART Program Evaluation of the Clinical and Immunological Outcomes of HIV-infected Adults patients Enrolled in the Swaziland National ART Program, 2004-2010. Mbabane, Swaziland: MOH.
9. Rosen S, Fox MP, Gill CJ (, Oct2007) Patient Retention in Antiretroviral Therapy Programs in Sub-Saharan Africa: A Systematic Review. PLOS Med, 4(10).
10. USAID (2013) 'HIV Among Sex Workers and Men who have Sex with Men in Swaziland'
11. UNAIDS (2014) 'The Gap Report'
12. USAID (2013) 'HIV Among Sex Workers and Men who have Sex with Men in Swaziland'
13. Swaziland Ministry of Health (2014) ‘Swaziland Global AIDS Response Progress Report’
14. National Emergency Response Council on HIV and AIDS (2014) ‘The Extended National Multisectoral HIV and AIDS Framework’
15. The International Treatment Preparedness Coalition (2010) 'Rationing Funds, Risking Lives: World backtracks on HIV treatment'
16. Swaziland Ministry of Health (2014) ‘Swaziland Global AIDS Response Progress Report’
17. International Planned Parenthood Federation, 2008. IPPF Sexual Rights: An IPPF declaration.
18. UNFPA, 2008. Distance Learning on Population Issues Module 1: Sexual and Reproductive Health Background and key Issue
19. UNFPA, Human Rights: The Foundation for UNFPA's Work: Putting Rights into Practice: Improving Reproductive Health care, http://www.unfpa.org/rights/practice.htm
20. The Population Council. 2009. It's All One Curriculum: Guidelines and Activities for a Unified Approach to Sexuality, Gender, HIV and Human Rights Education. The Population Council, New York.
21. Adapted from PHN Centre focus on young adults project 2000
22. Engender Health, 2002, Youth Friendly Services: A Manual for Service Providers
23. Family Health International, 2008. *Training manual for the providers of Youth Friendly Services*. UNFPA Egypt and FHI.

24. Pathfinder, 2007. *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators.*
25. WHO (2002).*Adolescent Friendly Health Services-An Agenda for Health*.

EVALUATION CRITERIA

EVALUATION OF THE PARTICIPANTS UNDESTANDING AND PERCEPTION ABOUT TRAINING MODULES AND WORKSHOP

1. PRE/POST TEST

Step 1:

- ***Explain the evaluation methods of a workshop which include the pre-test, daily evaluations, endof workshop evaluation anda post-test.***
- ***Highlight the importance of a pre-test and posttest in a workshop. Indicate to participants that they are expected to work out an answer sheet for pre/post test***
- ***Mark and grade the pre-test survey and record them for comparison with the post-test written at the end of the training.***
- ***Share with participants the results of the two assessments.***

2. DAILY EVALUATION -Brainstorming, Discussion (15 minutes)

Step 2:

- ***Brainstorm on methods of workshop evaluation on a daily basis.***
- ***Discuss the importance of such assessments throughout the training workshop.***
- ***Highlight that other methodologies may be used in place of the one highlightedbelow.***

Below are three suggested ways of keeping track of the participant's perceptions on the training workshop on a daily basis as it progresses. By getting their early reactions you will be able to make changes immediately, rather than receiving complaints at the end of the workshop when it is too late to respond to them. These assessment methods are the mood meter, individual note and group discussions.

a. The Mood Meter

As its name suggests, the Mood Meter allows you to get a sense of the group's mood as it changes during the workshop.

Draw three faces on a flip chart depicting a happy face, neutral and a sad face. Explain that the three faces indicate the following:

 Satisfied	 Neutral	 Not satisfied

Put the *Mood Metter* in an accessible location but one that is not in a busy place like a corridor.

At the end of each day or each session, ask each participant to mark a spot, according to how they feel, on the Mood Meter. Draw a line through the middle of the spots to create a simple graph that charts the "ups" and "downs" of the group. Use the Mood Meter as a means of tracking the group's feelings about how the workshop is proceeding, and as a starting point for discussion. Address those issues that you can rectify immediately.

b. Individual Notes

Another way of assessing the participants' mood on the training programme is to ask each participant at the end of the day, to write down on a piece of paper

- What they enjoyed most about the day;
- What they did not like
- And a suggestion for improvement

Review the notes and address areas of concern pointed out.

c. Discussion groups

If you are interested in getting more in-depth feedback from the participants after a particular module, you could hold a discussion group with a small group of interested persons. Ask about five participants if they are willing to talk about the session, and let them discuss a small number of questions. You can use the questions given below to guide your discussion, or you could develop your own questions.

- How do you feel about this module?
- Which sessions worked best?
- Which sessions did not work well?
- What could we have done differently?
- What did you get out of the module?

Remember that the point of such a discussion is for you to hear the participants' opinions. Try not to talk much yourself, and listen to criticism without becoming defensive. There is no need to respond directly to any criticism.

3. OVERALL WORKSHOP EVALUATION -Discussion (15 minutes)

Step 3:

- ***Discuss the need for an overall workshop evaluation at the end of the workshop.***
- ***Highlight the importance of using findings from the evaluation for planning and facilitate future workshops.***

National Adolescent Sexual and Reproductive Health Training Manual for Health Care Workers

APPENDICES

APPENDIX 1 – Hints on Preparing for the Workshop.

Hints on Preparing for the Workshop

1. Identify training needs
2. Identify target group (participation)
3. Select dates for training workshop
4. Develop budget and obtain necessary approvals
5. Organise workshop file
6. Reserve training space
7. Make tentative lodging arrangements
8. Develop workshop
9. Arrange programme agenda
10. Develop curriculum, session plans
11. Identify resource persons and special guests
12. Arrange for logistical support (e.g., drivers, secretarialhelp) as necessary
13. Send invitation to speakers, resource persons, andspecial guests
14. Send confirmation letter to participants with programmesummary and arrangement information
15. Finalise lodging arrangements
16. Make arrangements for meals and refreshments for breaks
17. Order and prepare certificates
18. Arrange transportation to airport, train, bus pickups, field trips
19. Order training materials and supplies such as news print, markers, markers, masking tape, transparencies
20. Arrange for equipment by reviewing session content to identify what is needed and when it is needed. This includes projectors, models, posters, video equipment, etc.
21. Prepare trainer material and handouts
22. Plan and organise opening ceremony
23. Arrange for press coverage, as appropriate
24. Plan and reserve space/transport/food/ for special events
25. Make room arrangements, including large conference roomwith adequate seating, smaller rooms for group work, adequateventilation/heating or air-conditioning if available, lighting, etc.
26. Arrange for daily room cleanup
27. Prepare orientation packet with information on the area andthe training site
28. Prepare participant folder; name tags, welcome letter,programme schedule, participant list, pens and paper
29. Make sure evaluation forms are prepared

DURING THE PROGRAM

1. Make sure that all the equipment and materials are available and working before needed.
2. Manage and monitor registration, reception, opening ceremonies, sessions
3. Manage and monitor meals, breaks, special events and closing ceremonies
4. Maintain workshop files
5. Prepare participants address list
6. Monitor expenses in relation to established budget
7. Assist participants with departure arrangements
8. Optional: Arrange for group photo
9. Arrange programme agenda

AFTER THE PROGRAM

1. Meet with the staff to discuss problems and success and giver general feedback
2. Pay final bills, closing
3. Send thank you letters to all those who helped with the programme
4. Complete or update materials or manuals for trainers
5. Tabulate evaluation results
6. Draft, edit, and reproduce final report and recommendations
7. Evaluate training impact

APPENDIX 2: Daily Evaluation Form

Instructions: **For each item, tick the box that best reflects your opinion. Your comments are also welcome.**

1. **Objective of the sessions were:**

☐ Very clear ☐ Not clear ☐ Clear

Comments:

---

2. The objectives of the sessions were:

☐ Completely met ☐ Insufficiently met ☐ Mostly met

Comments:

---

3. The length of the sessions was:

☐ Too long ☐ Adequate ☐ Too short

Comments:

---

4. Clearness of Presentation was:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

---

5. Organization of the content:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

---

6. Trainer's knowledge of the subject:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

---

7. Five key lessons learnt:

THANK YOU FOR YOUR PARTICIPATION

APPENDIX 3:Final Workshop Evaluation Form

Instructions: **For each item, tick the box that best reflects your opinion. Your honest responses will help us improve future training. Your comments are also welcome.**

1. Objective and goal of the training were

☐ Very clear ☐ Not clear ☐ Clear

Comments:

---

2. The objectives of the sessions were:

☐ Completely met ☐ Insufficiently met ☐ Mostly met

Comments:

---

3. The length of the sessions was:

☐ Too long ☐ Adequate ☐ Too short

Comments:

---

4. Clearness of Presentation was:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

---

5. Organization of the content:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

---

6. Trainer's knowledge of the subject:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

---

7. Training Methods used:

☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

---

8. The workshop content maintained my interest:

☐ All the time ☐ Most of the time ☐ Some of the time

Comments:

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9. The material presented in the course was:

☐ Almost all new to me ☐ Mostly new to me ☐ Mostly known to me

Comments:

---

10. Trainer's knowledge of the subject:

☐ Directly applicable to my everyday ☐ Somewhat applicable to my everyday work

☐ Not very applicable to my everyday work

Comments:

---

11. The training facilities were:

☐ Very satisfactory ☐ Somewhat satisfactory ☐ Unsatisfactory

Comments:

---

12. The logistical arrangements (transportation, lodging, etc.) were:

☐ Very satisfactory ☐ Somewhat satisfactory ☐ Unsatisfactory

Instructions: **Please answer the questions below:**

13. Which topics or activities did you find least useful?

---

14. In future workshops, would you allow more time for some topics or activities? If yes, which ones?

---

15. What suggestions for improvement do you have for the trainers?

---

16. Would you recommend your colleagues to attend the same training?

☐ Strongly agree ☐ Agree ☐ Disagree ☐ Strongly disagree

---

17. What additional suggestion do you have for improving future trainings?

APPENDIX 4:

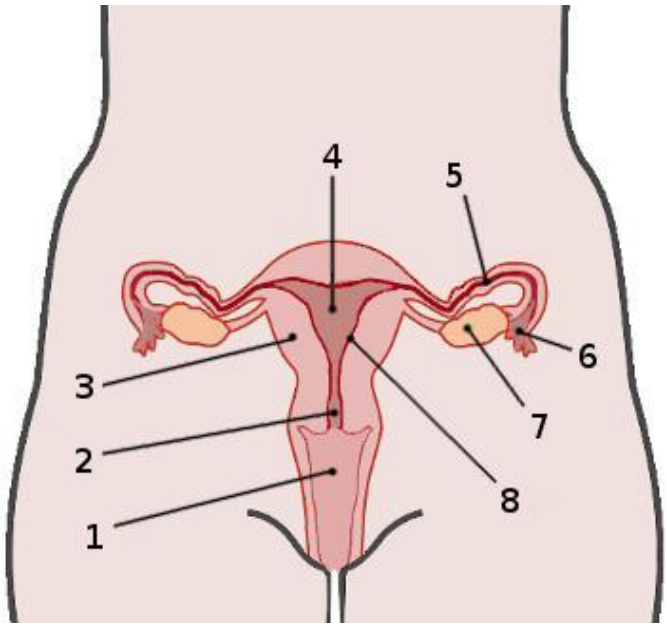
STANDARD NATIONAL ASRH TRAINING PRE/POST TEST QUESTIONNAIRE

TOTAL MARKS = 40

NAME:…… DATE:…….

DESIGNATION:……

1. Label the following parts of the female reproductive system (8 marks)



1.
2.
3.
4.
5.
6.
7.
8.

Answers:

1.	Vagina
2.	Cervix
3.	Uterus (Myometrium)
4.	Uterine cavity
5.	Fallopian tube
6.	Fimbriae
7.	Ovary
8.	Uterus lining (Myometrium)

2. Match the following moral values with their correct meaning (8 marks)

Justice	**A.** Commitment to treat others well.
Love	B. Commitment not to cheat, steal or deceive.
Compassion	C. To be without prejudice, discrimination or dishonesty.
Responsibility	D. Undeviating allegiance to a person, contract or oath.
Dignity	E. According to appropriate worth to self and to others.
Integrity	**F.** thinking rationally and being accountable for one's behavior
Honesty	G. Caring for those smaller and weaker than ourselves and not abusing or taking advantage of anyone.
Faithfulness	H. Consistency in what one says and does and the commitment to be honest and conscientious in what one does or say.

Answers: Key Moral Values

- Love: commitment to treat others well.
- Honesty: commitment not to lie, cheat, steal or deceive.
- Justice: to be without prejudice, discrimination or dishonesty.
- Faithfulness: undeviating allegiance to a person, contract or oath.
- Dignity: according appropriate worth to self and to others.
- Responsibility: thinking rationally and being accountable for one's behavior.
- Compassion: caring for those smaller and weaker than ourselves and not abusing or taking advantage of anyone.
- Integrity: consistency in what one says and does and the commitment to be honest and conscientious in what one does or say.

3. Differentiate between Sex and Gender (2 marks)

……
……
……
……

4. Differentiate between Transsexual and Transgender (2 marks)

……
……
……
……

Answers:

Gender - This describes certain attitudes, roles and responsibilities assigned through a social process to males and females, and can often result in different opportunities and behavior for both men and women. Gender role is determined by society and influenced by cultural, economic, political and environmental factors. It also varies within and between societies.

Sex – This describes the biological characteristics of being a boy or girl, male or female. This is a crucial element in everyone's sexuality.

Transgender- are persons who have a gender identity, or gender expression, that differs from their assigned sex. They are referred to as **Transsexual** if they have now undergone medical assistance to transition from one sex to another.

Question 4: When counselling adolescents, the use of the GATHER process is highly recommended. This process represents six steps which the counsellor should follow to ensure effective counselling. Mention the steps represented by each letter represented by GATHER (6 marks)

G	
A	
T	
H	
E	
R	

Answers:

G	Greet the adolescent.
A	Ask adolescents about themselves.
T	Tell adolescents about their options.
H	Help adolescents make a decision.
E	Explain and answer questions.
R	Refer youth to another provider if necessary or schedule a return visit.

1. **Define the following M&E terms (10 marks)**

    1. Inputs

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    2. Processes

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    3. Outputs

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……

    4. Outcome

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……..

    5. Impacts

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……
……

Answers:

- **Inputs** are resources provided for an activity, and include cash, supplies, personnel, equipment and training.
- **Processes**: these are activities that transform inputs into outputs.
- **Outputs** are the specific products or services that an activity is expected to deliver as a result of receiving the inputs.
- **Outcomes** refer to peoples' responses to a programme and how they are doing things differently as a result of it. They are short-term effects related to objectives.
- **Impacts** are the effects of the service on the people and their surroundings. These may be economic, social, organizational, health, environmental, or other intended or unintended results of the programme. Impacts are long-term effects.

6. **List four principles you would consider when establishing a teen club in your community. (4 marks)**

……
……
……
……
……
……
……

Answer: Principles of establishing Teen Clubs

- Gender Equality.
- Youth Focus: responsive to their needs
- A right based approach.
- Pro-poor and sensitive to vulnerable groups

- High standard of quality of care
- Accountability
- Ownership
- Role models
- Empowerment

LAST DAY TRAINING EVALUATION

PLEASE CONTRIBUTE TOWARDS IMPROVING ASRH TRAININGS BY RESPONDING TO THE FOLLOWING QUESTIONS:

A. Which topics or activities did you enjoy the most and why?

……
……
……
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……

B. Which other topics would you add to the training and why?

……
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C. Please give suggestions on how to further improve the ASRH trainings.

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