• State-of-the-Art Family Planning and Reproductive Health





Services • State-of-the-Art Family Planning and Reproductive

Adolescent Sexual & Reproductive Health:

A Training Manual for Program Managers

CATALYST
consortium

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ACKNOWLEDGMENTS

As part of the CATALYST Consortium[1], the Center for Development and Population Activities (CEDPA)[2] and Profamilia/Colombia[3] collaborated to produce and present a manual for trainers on Adolescent sexual and reproductive health programs and services.

The manual was based on Profamilia/Colombia's South-to-South Cooperation Program, funded by the Dutch Government through the United Nations Population Fund (UNFPA). The South-to-South Program fosters the exchange of knowledge, experiences and processes between developing countries to ensure sustainable institutional development and, ultimately, the sexual and reproductive health of all women, men and young people. The South-to-South approach promotes the development of partnerships between institutions through exchanges such as training, technical assistance and observational visits.

Much of the module is based on training processes directed by Profamilia/Colombia over the past decade. Many of the session designs and activities in this module were previously piloted in Colombia with participants from throughout Latin America and enhanced with CEDPA's training experience and technical expertise in Advocacy, Rights and Gender and Youth programs.

CEDPA training employs a participatory, experiential methodology based on the principles of adult learning. Individual participants are encouraged to manage their own learning and share responsibility with the trainer. This methodology draws on the participants' experiences and encourages active problem-solving and critical and analytical thinking. CEDPA's Youth Development and Reproductive Health (YDRH) training workshops apply this unique training methodology and provided a basis for the structure of this manual.

This manual is intended to be used as a "living document" and trainers are encouraged to adapt the content to the reality of each region or country so that it responds to the specifics of their particular setting or culture.

The CATALYST Consortium is particularly grateful for the contributions made by the Latin American professionals who participated in the pilot version of the module carried out by Profamilia/Colombia in Bogotá from August 26-September 6, 2002. Germán López and Susana Moya, Profamilia/Colombia, served as the lead trainers for the pilot module in 2002. The module was adapted based on this

[1] The CATALYST Consortium is comprised of five organizations funded by the United States Agency for International Development (USAID). Consortium organizations possess expertise in offering technical leadership on sexual and reproductive health and are committed to increasing the use of sustainable quality family planning and reproductive health services and practices through both clinical and non-clinical programs.

[2] CEDPA works with international partners to bring about empowerment for women through programs in reproductive health and family planning, literacy and education, individual and institutional capacity building, micro-enterprise development and political participation. Since 1975, CEDPA's unique approach has successfully strengthened the aspirations, potentials and talents of millions of women in more than 150 countries.

[3] Profamilia/Colombia is an affiliate of IPPF. Profamilia promotes high-quality, accessible family planning and sexual and reproductive health services, particulary for low-income groups. For many years Profamilia/Colombia has developed and delivered clinical, preventive and promotional services and programs that focus on empowering people to use individual decision making skills in issues of reproductive rights. Over the past decade Profamilia/Colombia has expanded their programs to include and focus on youth.

experience with the cooperation of Julie Hanson Swanson, CATALYST Senior Advisor for Adolescent Reproductive Health and Judy Palmore, a CATALYST Consortium consultant. Final writing, review and editing for the English version of the manual was conducted by Marie-France Semmelbeck, CATALYST Senior Advisor for Sustainability and South-to-South, Maryce Ramsey, CATALYST Senior Advisor for Empowerment, Judy Palmore and Kathrin Tegenfeldt, CEDPA Youth Advisor. Rosa María Cifuentes, Profamilia/Colombia, was responsible for the original writing of the module in Spanish. The following professionals took part in the construction, review and adaptation process: Profamilia/Colombia – María Cristina Calderón, Rodrigo Castro, Rosa María Cifuentes, Helbert García, Germán López, Iris Medina, Susana Moya, Gabriel Ojeda, Carolina Orjuela, Marcela Rueda, Marcela Sánchez and Juan Carlos Vargas; CATALYST Consortium – Orlando Hernández, Reynaldo Pareja and Lindsay Stewart. Additional thanks go to Advocates for Youth, Family Health International and YouthNet for permission to reprint some of their publications.

This training manual was made possible through support provided by the Center for Population, Health and Nutrition, Bureau for Global Program, U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement No. HRN-A-00-00-00003-00 awarded to the CATALYST Consortium. The opinions expressed are those of the authors and do not necessarily reflect the views of the U. S. Agency for International Development.

INTRODUCTION

Defining Adolescence

The World Health Organization (WHO) defines "adolescence" as occurring between the ages of 10-19 and categorizes "young people" as those between the ages of 10-24. Developmentally, adolescence can also be divided into four more specific categories: pre-puberty before age 10; early adolescence, ages 10-14; middle adolescence, ages 15-19; and late adolescence, or young adulthood, ages 20-24.[4]

WHO further breaks down the evolving nature of adolescence:

- Progression from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity;
- Development of adult mental processes and adult identity;
- Transition from total socioeconomic dependence to relative independence.

While generally these descriptions may serve as characteristic benchmarks for "adolescents" and "young people", the term "youth" has no formal definition and may be attributed to people who fall in or slightly out of these categories. The meaning of these terms may also be used differently depending on the cultural context. For example, a 16-year old in one culture who is married may be perceived or labeled as an adult and therefore not entitled to adolescent services. The same 16-year old individual in another culture may – despite being married – still be societally identified as an adolescent and receive age-specific and appropriate services.

Developmentally, one's experience as an adolescent or the ease in which one passes through adolescence is dependent on a host of psychosocial elements, such as class, gender, socioeconomic status, opportunity and health.

Why Focus on Sexual and Reproductive Health Services for Adolescents?

One of the most important reasons to focus on youth is that young people, ages 10-24, make up one-quarter of the world's population. There are more than 1.7 billion young people between the ages of 10 and 24, eighty-six percent living in less developed countries.[5]

More than half of new HIV infections worldwide occur among young people under age 25.[6] WHO estimates that up to 60 percent of all new sexually transmitted infections occur among youth ages 15-24.[7] Sixty-two percent of HIV infected youth are young females.[8] Contributing to the high risk of HIV infection in young girls and young women includes, but is not limited to, biological vulnerability, a lack of skills to negotiate safety (postponement of sex or safer sex), a fear of domestic violence or isolation, a

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[4] James-Traore, T. A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents.* [FOCUS Tool Series 4]. FOCUS on Young Adults.
[5] Boyd, A. 2000. *The World's Youth 2000*. Washington, DC: Population Reference Bureau.
[6] UNAIDS et al. 2002. *Young People and HIV/AIDS: Opportunity in Crisis*. Geneva: UNAIDS.
[7] Boyd, A. 2000.
[8] Cheetham, N. 2003. Youth and the Global HIV/AIDS Pandemic. *Transitions* 15(2).Advocates for Youth.

loss of financial support or schooling and lack of access to reproductive health care. Young boys, however, are not immune to a higher prevalence of HIV infection. HIV infection remains higher in young males even in more developed countries, for example in Eastern Europe.[9]

Thirty-three percent of teenage girls in the developing world will give birth before the age of 20; many of these pregnancies are unplanned.[10] Early pregnancy and childbearing are typically associated with less education, lower future income and negative health consequences for a young girl. Compared to women in their 20s, 15- to 19-year-olds are twice as likely to die from pregnancy-related complications; girls under 15 are at 25 times the risk.[11] Each year the inability to guarantee contraceptive services and/or confidentiality costs the lives of thousands of adolescents and robs many more of their general reproductive health. Denial of these basic services and/or confidentially can literally mean the death of an adolescent girl or cause severe and permanent damage.[12]

Adolescents and young adults face a wide variety of reproductive health challenges, yet historically reproductive health services have omitted services for this population. The evidence of the problems they face, such as early and unwanted pregnancies, sexually transmitted infections, HIV/AIDS, sexual abuse and gender-based discrimination, has led governments, international agencies, foundations and private organizations to undertake and initiate actions designed to help adolescents.

This manual is an attempt to address this inequity in adolescent sexual and reproductive health (ASRH) programs and services offered to adolescents and young adults around the world. For example, in 1990 Profamilia/Colombia,[13] mindful of adolescents' needs for medical services, guidance, information and education in the field of ASRH, created the YOUTH CENTER program, which focuses on adolescents and young adults. During this time Profamilia/Colombia began to offer regional trainings on ASRH to raise the awareness of professionals who work with adolescents and build their capacity to better serve the ASRH needs of youth in Latin America.

Learning Objectives of the Module

The overall purpose of this ASRH module is to build the capacity of professionals in managerial positions so they are better equipped to identify and design programs that respond to the ASRH rights of young people. In addition to making program managers aware of and responsive to the specific needs and rights of adolescents, this module builds the capacity of the participants to efficiently and effectively manage the programmatic aspects of youth programs. Participants will explore and develop various strategies and interventions at the national, local, organizational, community, family and individual level.

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[9] Cheetham, N. 2003. Youth and the Global HIV/AIDS Pandemic. *Transitions* 15(2).Advocates for Youth.
[10] Boyd, A. 2000. *The World's Youth 2000*. Washington, DC: Population Reference Bureau.
[11] Boyd, A. 2000.
[12] Cook, R. and B.M. Dickens. 2000. Recognizing Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Health Care. *International Journal of Gynecology and Obstetrics 70*:13-21.
[13] PROFAMILIA/Colombia: Asociación Probienestar de la Familia Colombiana, an affiliate of IPPF, is a private, not-for-profit partner in the CATALYST Consortium. It promotes high-quality, accessible family planning and sexual and reproductive health services and programs, particularly for low-income groups.

Learning Objectives

By the conclusion of the module participants will be able to:

- Understand the concept of ASRH programs and services as a human right.
- Define and identify effective youth/adult partnerships and youth involvement.
- Describe the link between ASRH and gender and develop strategies to develop gender-sensitive ASRH programs and services.
- Identify the sustainability components intrinsic to ASRH programs and develop strategies to improve the sustainability of ASRH programs and services.
- Understand adolescent behavior change as a multi-layered dynamic.
- Design strategies and programs providing adolescent-friendly ASRH services.
- Identify the steps of advocacy and its use as a strategy towards individual behavior change and improving community health.
- Develop an action plan that incorporates lessons learned and bridges across the four cross cutting themes: Human Rights, Gender, Youth/Adult Partnerships and Sustainability.

The Four Cross Cutting Themes of the Module

GENDER – Gender is about the roles individuals play (daughter, son, girlfriend, boyfriend, etc.), the relationships between these roles and the norms for behavior dictated for those roles. Even in the presence of universal access to quality services and supplies, if gender norms prescribe that a"good" girlfriend should not talk to her partner about condom use or that a"macho" boy does not worry about pregnancy, then the availability and quality of the services and commodities become irrelevant. Managers of adolescent programs must understand the gender constraints that boys and girls live within, in order to offer programs that meet the sexual and reproductive health needs of young people and also promote gender equity. Gender roles and expectations, while prescribed by society and can also be challenged by that society.

HUMAN RIGHTS – Often ASRH services are provided in order to fix "troubled youth" or because of charity, rather than to respond to a young person's basic human right to be healthy, have equal access to services and control in decision making. The philosophy behind the services – whether they are being provided out of charity or because the client has a right to them – can influence: how an individual accesses the services; whether the individual will pay and how much; the quality of the information and services provided; and the client/provider interaction. In recognition of the importance of such a philosophy, this training will address adolescent sexual and reproductive health issues through a rights-based approach.

YOUTH/ADULT PARTNERSHIPS – Adolescents are often viewed as walking problems: irresponsible, difficult and sometimes violent. But what would happen if they were viewed as walking assets: creative, energetic and enthusiastic? Not only do adolescents have a right to be fully involved in the planning, implementation and evaluation of ASRH programs, but programs in which youth are active participants are also more effective. However, just as youth programs, designed without their involvement, are less

effective; programs that are run solely by youth are not likely to succeed either, whether due to lack of skills, experience or economic resources, etc. The most successful ASRH programs are built on the promise of adult/youth partnerships utilizing the assets of adolescents, their parents or guardians, ASRH staff and providers, families, communities and local institutions.

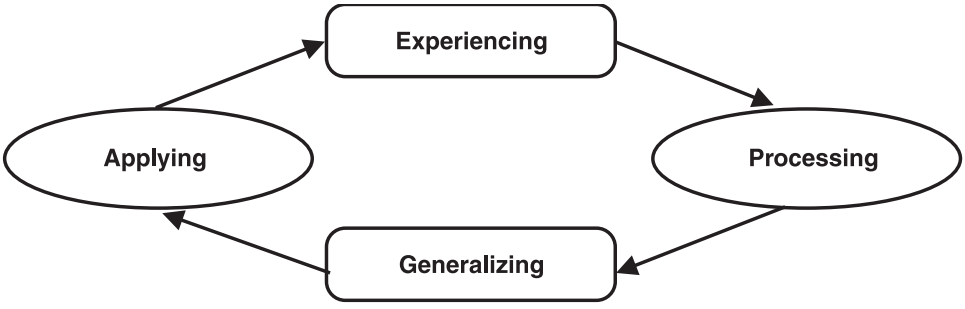
SUSTAINABILITY – If institutions are to continue to be able to deliver programs that meet the ongoing needs and rights of adolescents, then managers of those programs must, from the onset, plan for financial, institutional and programmatic sustainability. For example, managers must be aware of the financial and institutional resources needed for program implementation and continuation. To ensure programmatic sustainability, mangers need to continuously scan the environment in which they function: are staff, parents, policy makers and/or the community supportive of the program? If not, what strategies can a manager design to garner support? Managers may also want to identify and work with *existing* youth serving organizations that are are already sustainable to incorporate activities.

Connecting the Four Cross Cutting Themes

In order for young people to be empowered to act on their ASRH needs, they must know and acknowledge that they have a right to good ASRH and services; that they have the power to make decisions and take action regardless of gender constraints; that they can work in partnership with adults to achieve good sexual and reproductive health; and that both the behavior they desire and the services they require will be sustained. The four cross cutting themes are addressed throughout the module. These core ideas are thoroughly explored during the first few days and addressed throughout the module.

The Design and Facilitation of this Module

Experiential Learning Cycle[14]: Experiential learning is conceived as a cycle in which the learner progresses through four phases of the learning process to transform information into useful knowledge. A direct experience becomes the basis for reflection where the experience is processed. Based on this analysis, the learner is able to generalize principles which he must then apply.



[14] CEDPA. 1995. *Training Trainers for Development*. The CEDPA Training Manual Series Volume 1. CEDPA.

Adult and experiential learning experts identify that people retain[14]:

- 20% of what they hear
- 30% of what they see
- 50% of what they hear and see
- 70% of what they see, hear and say (discuss)
- 90% of what they see, hear, say and do

This module is based on these assumptions and uses the fundamentals of the experiential learning cycle to ensure comprehension, retention and follow through.

The experiential learning cycle includes the following stages:

1. **EXPERIENCING**: Experiencing involves engaging in an exercise or activity together and/or sharing personal experience and feelings. **DO!**
2. **PROCESSING**: Processing involves digesting the exercise or activity and sharing observations from the "experiencing" stage. **ANALYZE/THINK!**
3. **GENERALIZING**: Generalizing involves extracting a meaning from the experience, comparing it to other experiences and identifying general principles or patterns. **CONCLUDE**!
4. **APPLYING**: Applying involves developing an action or plan beyond the training event, using insights gained from the previous stages. **PLAN A CHANGE OR ACTION!**

Who Should Participate in This Module?

The module is directed to people who work directly or indirectly with adolescents and young adults in positions of manager or coordinator of youth programs. While this module targets managers, other participants who may benefit include physicians, nurses, psychologists, police officers, religious leaders, youth directors, youth advocates, nursing supervisors, political officials, health officials, or young leaders. Participants can come from the public, private and NGO sectors. Generally speaking, participants should be committed to ASRH or youth development programs and have an interest or stake in their successful implementation. Participants will become aware throughout the course of the module that as managers they need to plan, implement or supervise program implementation and evaluate their ASRH programs.

How Many Participants?

The ideal number of participants is 15-25 people.

How Long is the Module?

This module is 5 ½ days, with the option of adding a 3½ hour session on sexuality and a 1½ day field visit component.

Unique Teaching Strategies Within This Module

- **COMMUNITY TIME:** Each morning is committed to Community Time, including a team builder/icebreaker, reporting the evaluation results from the day before and daily announcements by trainers, participants and host organization staff. Two of these tasks are performed by community groups (see description below).

- **COMMUNITY GROUPS:** The module is enhanced by the involvement of participants in three community groups. Below is a description of the groups:

  1. **Environment Group**: This group assists trainers with the logistics of training. This group also moves the nametags around every morning so that participants are seated beside different people each day. The Environment Group helps distribute handouts, sets up equipment and generally keeps the room tidy. This group also reminds fellow participants to be on time and to adhere to other housekeeping details as well as the agenda of the module.
  2. **Energy Group**: This group is in charge of keeping the group energized and motivated. This group facilitates a 3-4 minute team builder or icebreaker during morning community time (as well as any other time needed – often after lunch). This group is also responsible for speaking with the trainers should concerns arise that might affect the group's energy.
  3 **Evaluation Group**: This group is in charge of evaluating the day. This group reviews the evaluations completed at the end of each day, tabulates the results and presents the findings to the entire group the next morning during Community Time.

(Trainers and participants may choose to form permanent Community groups, meaning the same participants serve the same group role for the entire training. Or, participants can rotate so that each participant gets to serve in each of the three group roles.)

- **LEARNING JOURNAL:** The use of a learning journal allows participants to record and process concerns, thoughts, lessons learned, "action" steps and questions for follow-up. Throughout the training, trainers can help participants explore the experiential learning cycle by using the learning journal (specific activities are outlined in each training session). The journal can be a regular or decorative (perhaps made by local craftspeople) notebook that participants personalize on Day One.

  Tips for effective use of the Learning Journal:

  - Allow in-session time for writing and reflecting.
  - Offer focused questions for the learning journal. For example, as a result of today's topic on gender complete the following sentences: I learned..., I am challenged by…, I am encouraged by..., I will change...etc.
  - The learning journal is to be used throughout the day, not just at the beginning and/or end.
  - It is important to inform guest presenters about the incorporation of the learning journal into the training, in case the guest presenters wish to take advantage of it for their session(s).
  - **Caution**: Overuse of the learning journal is possible, so use in moderation. For example, if you use the learning journal twice throughout the day, do not use it again in the closing reflection.

- **PARTICIPANT PRESENTATIONS (Optional):** At the time of acceptance into the workshop, participants are informed that they should arrive prepared to deliver a 15-minute presentation on the

ASRH services delivered by their organization. Participants should bring visual aids, reports, examples of resources/curricula, etc. to share with other participants. These 15-minute presentations will take place following community time, but before the first session of the day. Trainers should provide technical assistance to the participants on presentation preparation.

Optional Sessions

- **SEXUALITY:** This session has been included as an optional session due to its sensitive nature. While it is recommended that the trainer incorporate the sexuality session because it is an important component of ASRH, it may not be appropriate in all settings and cultures. Inclusion is therefore left at the discretion of the trainer.

- **FIELD VISITS:** This is an optional activity that consists of learning from in-country, regional experiences in the setting where the training is being conducted. It is advisable to identify, contact and coordinate these activities well in advance of the training. In the pilot training of this module, Profamilia/Colombia utilized field visits that yielded positive results. Nevertheless, this activity may not be feasible in all setting or locations and for that reason field visits are to be utilized at the discretion of the trainer(s).

Before Conducting the Module

- Ask all prospective participants to complete a survey about their programs and the services their organizations provide (survey to be developed by trainer). This survey will help the trainers become familiar with their participants' various backgrounds and enable them to adjust the training, if necessary.
- Optional: If participant presentations are built into the module, inform participants of this expectation so they will arrive prepared. Inform participants of the audiovisual equipment available to them.
- If the trainers choose to bring in guest presenters to conduct sessions, coordinate with the guest speaker in advance to discuss objectives, methodology, teaching guidelines and resources so that the focus is consistent with the objectives of the session. Ensure that the guest speaker is aware of the four cross cutting themes and is prepared to weave the themes into his/her session.
- The trainer should review handouts, case studies and other materials and adapt them appropriately to the local setting and culture. (e.g. change names, etc.)
- Make copies of the session evaluation form, which is to be completed by the participants for *each* session at the end of the day during Community Time. For example, if Day 1 includes three sessions the participants should complete three evaluation forms at the conclusion of Day 1 (one form per session). The participants should write the name and number of the session they are evaluating beside Session Name & Session #. A general evaluation form is included at the end of the introduction for reference.
- Review sessions and prepare materials (e.g. flipcharts, presentations, etc.) as indicated.
- Build in approximate breaks, lunch, etc. into the overall session outline before the training begins.

While Conducting the Module

- Consult the "**TALKING POINTS FOR THE TRAINER**" boxes to ensure that teachable moments are being covered and key links to the cross cutting themes are being made. The "TALKING POINTS FOR THE TRAINER" boxes appear throughout the manual.
- Keep the experiential learning cycle in mind as you facilitate your session.
- Identify the objectives of each session to the participants at the beginning of that session. At the end of every session, reiterate the objectives to ensure they have been met.
- Pay attention to the daily evaluations and adapt sessions, if needed.

Once the Training Has Been Completed

- Consider establishing appropriate connections and channels of communication with the graduated organizations and participants in order to provide assistance and continue collaboration.
- Tabulate and compile feedback from evaluations and adapt this module for future trainings.

A Note Regarding Youth Involvement

While youth involvement in the training process is not specifically mentioned throughout the sessions, it is highly encouraged that the trainer(s) incorporate young people into the training as much as possible. This could include youth participants, youth presenters, field visits to youth-run organizations, etc.

MODULE OVERVIEW

Day 1

- Welcome (Session 1) – 1 hour, 10 minutes
- Introduction to the Module (Session 2) – 2 hours
- Building the Participant Profile (Session 3) – 1 hour, 15 minutes
- Defining and Understanding Adolescents and Young People (Session 4, Part I) – 2 hours

TOTAL = 6 hours and 25 minutes

Day 2

- Defining and Understanding Adolescents and Young People (Session 4, Part II) – 1 hour
- Human Rights in Programs and Services for Adolescents (Session 5) – 2 hours
- Youth/Adult Partnerships (Session 6) – 1 hour, 50 minutes
- Gender (Session 7) – 2 hours

TOTAL = 6 hours, 50 minutes

Day 3

- Sustainability (Session 8) – 2 hours
- Behavior Change (Session 9) – 2 hours, 30 minutes
- Life Skills (Session 10) – 1 hour, 30 minutes

TOTAL = 6 hours

Day 4

- Youth Friendly Services (Session 11) – 1 hour, 45 minutes
- Monitoring and Evaluation of ASRH Programs and Services (Session 12) – 1 hour, 10 minutes
- Advocacy (Session 13) – 1 hour, 45 minutes
- Values, Attitudes and Ethics (Session 14) – 1 hour, 30 minutes

TOTAL = 6 hours, 10 minutes

Day 5

- STI/HIV Review (Session 15) – 1 hour, 30 minutes
- Access to and Use of Contraceptives by Adolescents (Session 16) – 1 hour, 45 minutes
- Young Married Couples (Session 17) – 1 hour, 30 minutes

TOTAL = 4 hours, 45 minutes

Day 6

- Action Planning (Session 18) – 2 hours
- Evaluation and Close of the Module (Session 19) – 1 hour 30 minutes

TOTAL = 3 hours 30 minutes

Community Time

- Each morning begins with 30 minutes of Community Time (Evaluation Group, Setting the Climate Group, Environment Group and Morning Announcements).
- Each evening ends with 15 minutes of Community Time (Evening Announcements & Evaluation).

Optional Sessions

- Sexuality (Optional Session) – 3 hours, 30 minutes
- Field Visits (Optional Sessions) –1½ days

HANDOUTS

SESSION EVALUATON

SESSION EVALUATION

Thank you for your thoughtful completion of this evaluation form. Your opinion matters and the Trainer(s) will incorporate your comments in future modules.

Session #: _____

Session Name: _____

Facilitator _____

E=Excellent G= Good A=Average P=Poor

ITEM	CRITERIA	E	G	A	P
SESSION CONTENT	Relevant to ASRH				
	Accurate and thorough				
	Applicable to my work				
	Gave resources/built skills				
METHODOLOGIES	Easy flow				
	Participatory				
	Build on participants' knowledge and experiences				
	Met session objectives				
	Linked to other topics covered				
TEACHING MATERIALS	Clear				
	Adequate				
	Relevant				
	Useful				
	Timely				

What I gained from this session (knowledge and skills):

One suggestion for making this session more effective in the future:

SESSION 1: WELCOME

OBJECTIVES:

- Introduce participants to each other and to the Trainer(s).
- Introduce participants to the host organization.

DAY: 1 TIME: 1 hour 10 minutes

MATERIALS

- Prepare session objectives on flipchart (**FLIPCHART 1A**)
- Flipcharts and markers
- Pre-written questions from "Appreciative Interview/Icebreaker" copied onto flipchart (**FLIPCHART 1B**)
- Index cards
- Participant nametags and training manuals

PREPARATION

Invite members of your organization and staff to be present for the arrival of the participants into the training room, shaking hands and welcoming them into the training space. Prepare all needed handouts.

FACILITATING SESSION #1

STEP 1 *(10 minutes)*
WELCOME

- Participants are welcomed by host organizational staff and volunteers as they arrive at the training room.
- Ask each participant to sit in his/her designated space where his/her name tag and participant manual have been placed.
- Welcome the participants into the training room and introduce yourself as the trainer. Bridge to the Participant Introductions (Step 2).

STEP 2 *(45 minutes)*
PARTICIPANT INTRODUCTIONS

- Review the objectives of Session #1 with the participants (**FLIPCHART 1A**).
- Explain that it is now time to meet the people with whom the participants will work most closely — each other. Explain that the objective of this activity is to provide a general introduction to each other and to explore the participants' training expectations and personal goals. Mention that this activity is just the beginning of the training and that participants are encouraged to follow up with their peers throughout the training to share experience and knowledge.
- Facilitate the "Appreciative Interview/Icebreaker" activity below.

Appreciative Interview/Icebreaker:

- Give each participant an index card and a marker and instruct them as follows:
- On the index card, participants should write down three of their own physical characteristics that are easily noticeable. Participants should not write their names.
- After participants are finished, completed index cards are given to the trainer.
- Each participant is given a completed index card (but not his/her own).
- At this point, each participant carries out two activities: 1) S/he locates the person described on the index card; 2) S/he interviews the located participant and is in turn interviewed by the person who "found" them.
- The interviewer asks the following information and records the answers on the index card of the person being interviewed (10 minutes per interview): (**FLIPCHART 1B**)

  1. Name.
  2. Country and institution.
  3. Provide two expectations you have of this workshop.
  4. Provide two thoughts you have regarding adolescent sexuality and reproductive health.
  5. Name one asset or trait that you bring to this training.
- Once the initial round of interviews is complete, another round of interviews is conducted according to the same guidelines (10 minutes per interview).

- Once the interviews are completed, ask the group to form a circle.

> NOTE TO THE TRAINER
>
> If there is an odd number of participants, one of the trainers can participate in order to stay on time.

- One at a time, each individual introduces the person s/he interviewed, describing for the group the recorded answers to the questions that were asked.
- Introductions continue until every participant has been presented.
- Following the completion of these group introductions, participants are asked on their own time (not during this session) to prepare a poster or flipchart describing and celebrating the person they interviewed. The posters can remain in the room for the entire training.

> NOTE TO THE TRAINER
>
> During the introductions, the trainers should note and record the participants' expectations. This information will be used in Session #2.

STEP 3 *(15 minutes)*
INTRODUCING THE HOST ORGANIZATION

- Now it's time for the participants to learn about the trainer(s) and the organization they represent. In front of the group, the trainer(s) may choose to answer the same five questions that were part of the "Appreciative Interview/Icebreaker" activity and then move into a discussion about the organization.
- Next, ask participants to say what they know about the host organization.
- Now provide the participants with a brief summary of the institution's history in ASRH programs. This can be accomplished either through the use of a 15-question true/false activity to involve the participants or through another activity designed by the trainer(s).
- Following the information session on the host organization, ask participants if the host organization and their respective organizations share any similarities. Record the similarities on flipchart to emphasize the common vision everyone shares to improve ASRH services and opportunities.

- Distribute any available information (e.g. relevant handouts, yearly reports, brochures) on host organization.
- Review the objectives for Session #1 to ensure they were met (**Flipchart 1A**).

> NOTE TO THE TRAINER
>
> Step 3, "Introducing the Host Organization", may not be applicable for all trainings. If this is the case, skip step #3.

SESSION 2: INTRODUCTION TO THE MODULE

OBJECTIVES:

- Identify the purpose and objectives of the module and the outline of the training.
- Describe"Community Time" and"Community Groups".
- Analyze the Experiential Learning Cycle and gain an understanding of its use in the module.
- Explore participant goals and expectations.

DAY: 1 – TIME: 2 hours

MATERIALS

- Session #2 objectives printed on flipchart (**FLIPCHART 2A**)
- Overall workshop mission and learning objectives written on flipchart (see Introduction) (**FLIPCHART 2B**)
- List of participants' responses to question #3 ("Provide two expectations you have of this workshop") From the"Appreciative Interview/Icebreaker" on flipchart (**FLIPCHART 2C**)
- List of overall workshop learning objectives (see Introduction) written on large strips of paper
- Module Overview (**HANDOUT 2A**)
- Handout on four cross cutting themes (**HANDOUT 2B**)
- Handout of the Experiential Learning Cycle (**HANDOUT 2C**)
- Description of "Community Groups" as a handout (**HANDOUT 2D**)
- Four cross cutting themes copied onto flipchart (**FLIPCHART 2D**)
- Index cards and markers
- Optional: "Participant Presentation Reflection Guide" (**HANDOUT 2E**)
- Optional: "Tips for Participant Presentations" (**HANDOUT 2F**)
- Optional: Participant Presentation Sign-Up Sheet, prepared by trainer(s)

PREPARATION

Place each individual module-learning objective on a piece of paper and place tape on the back and mount in the room. Prepare other materials as instructed.

FACILITATING SESSION # 2:

STEP 1 *(45 minutes)*
PURPOSE AND OBJECTIVES

- **FLIPCHART 2A**. Review the objectives of Session #2 on flipchart (**FLIPCHART 2A**).
- Inform participants that in order to proceed with the training it is imperative to explore the overall workshop mission and learning objectives of the module.
- Ask a participant to volunteer to read the overall workshop mission and learning objectives of the module prepared on the flipchart (**FLIPCHART 2B**).
- Ask for any comments or clarification regarding the overall workshop mission and learning objectives of the module.
- Now ask participants to slowly rise from their seats and walk around the training room, reading the overall workshop learning objectives (posted on the walls) silently to themselves.
- After this step is complete ask participants to have a seat and to look at the list of their responses (summarized by the trainer) to question #3 ("Provide two expectations you have of this workshop") from the Appreciative Interview/Icebreaker (**FLIPCHART 2C**). Ask participants to re-write their answer to question #3 on an index card and place it beside the overall workshop-learning objective, posted around the room, that best meets this need. If their individual response is not met by an overall workshop-learning objective they can place it to the side.
- Ask participants to comment on what they have observed. What are the expectations of the group? What expectations does the group share in common? What are some unique expectations? Where do the participants' expectations fit in with the overall workshop learning objectives? Are there some expectations that do not fit in with the overall workshop learning objectives?
- Add verbal observations regarding where participants placed their individual answers to question #3 in relation to the overall workshop learning objectives.
- Challenge participants to take personal responsibility for achieving their individual workshop goals both in and out of the classroom (see Note to the Trainer).
- Explain that in addition to overall workshop learning objectives, each session also has its own session objectives and these will be reviewed both before and at the conclusion of each session (as was already modeled during Session #1).
- Distribute the Module Overview (**HANDOUT 2A**) for the entire module. Go over the flow of the overall module, explaining the four cross cutting themes (see Introduction – these will be presented during the first three days of the training) as well as key ASRH concepts. Later, the workshop will provide opportunities for participants to develop strategies and interventions around these themes and concepts. Review the flow of the training in terms of logistics (i.e. breaks, lunch, start/end times, etc.).

- Explain that in this module, there are four cross cutting themes that will serve as the thread to weave all of the individual sessions together (**FLIPCHART 2D, HANDOUT 2B**). These themes are also identified as being the four keys to successful, thorough adolescent sexuality and reproductive health programs and services. The four themes are as follows (explain as described in the Introduction to the Manual and on the handout):
  - Human Rights
  - Gender
  - Adult/Youth Partnerships
  - Sustainability
- Further explain that throughout the training, participants will be asked to express the link between these four themes and ASRH. For example How are youth/adult partnerships linked to sustainability? How is a human rights-based approach linked to gender equity?

> NOTE TO THE TRAINER
>
> For a variety of reasons, not all participant expectatons will be addressed inside the training room. Many goals may be realized informally through talking with peers/colleagues during the evening, breaks and/or field visits, or formally through external appointments arranged by the participant or host organization. It may help to clarify this for the group.

STEP 2 *(45 minutes)*
EXPERIENTIAL LEARNING CYCLE[15]

- Ask participants to personally think about a highly positive learning experience. Then ask participants to think of a negative personal learning experience.
- Ask participants to think again about their positive learning experience and to identify strategies that were used or qualities of this experience that made it positive. The trainer(s) should record participant comments on flipchart. Now ask participants to think again about their negative learning experience and to identify strategies that were used or qualities of this experience that made it negative. Trainers should again record participant comments but on a separate piece of flipchart.
- Explain that the next activity is intended to get participants "warmed up" to talk more about Experiential Learning.
- Facilitate"THE HUMAN KNOT ICEBREAKER," using the following instructions:

The Human Knot Icebreaker

1. EXPERIENCING.

- The group forms a circle.

[15] This session is based on a session developed by Frances Houck for CEDPA's Youth Development and Reproductive Health Workshop.

- The participants close their eyes and begin to walk forward with their hands held in front of their bodies. When a participant finds someone else's hand they hold it. All the participants finish with both of their hands held. A large human knot has been formed. Now participants may open their eyes to see where they've ended up.
- In the next step, participants must untangle themselves, without releasing hands.
- Allow participants to complete the task of untangling themselves and then return to their seats.

2. PROCESSING.

- Ask participants to make observations about the process. Pose a series of questions to solicit feedback. (e.g. What problems arose? What was the process like for you? Did any leaders emerge? What role did the leaders play?).

3. GENERALIZING.

- Build a bridge from the"Human Knot" to the module itself by asking participants how this activity *relates* to the workshop and the goals of the training. Facilitate a discussion and focus on the importance of working together as a team to achieve the overall workshop learning objectives and to meet the personal expectations for the training. Point out that sometimes learning, change, or looking at one's own feelings about a certain issue can create anxiety (possibly like untangling the knot) – this too is part of the learning process. Finally, ask participants about general principles or lessons that can be gleaned from the"Human Knot" activity.

TALKING POINTS FOR THE TRAINER

- Problems can seem huge and daunting when viewed as a whole (for example, the human knot) but are manageable when approached as being made up of smaller issues (each hand held contributes to the bigger knot).
- While individuals can be seen as problems (a really bad hand hold or kink in the knot) they can also be seen as assets or sources of solutions.

4. APPLYING.

- In order to complete the last stage of the experiential learning cycle, ask participants how they can *apply* what they learned in the"Human Knot" activity to the real life activities they will encounter and experience during the training.

TALKING POINTS FOR THE TRAINER

- The importance of teamwork
- Seeing other participants as assets and sources of information and solutions
- The importance of breaking large problems into manageable pieces

- Distribute the handout on the Experiential Learning Cycle (**HANDOUT 2C**). Explain how the"Human Knot" activity took participants completely through the Experiential Learning Cycle. Bring up a few examples of key questions asked by participants or teachable moments observed by Trainer(s) during the activity that fostered the participants' successful completion of the Experiential Learning Cycle.
- Share the retention percentages of the Experiential Learning Cycle (**HANDOUT 2C**).
- Inform participants that the module is designed to foster learning and the Experiential Learning Cycle is used throughout.
- Ask participants to revisit the lists created at the start of Step #2 of successful learning experiences and unsuccessful learning experiences. Ask if any of these experiences can be linked to the Experiential Learning Cycle. Were the successful experiences more experientially oriented? Were the unsuccessful experiences lacking in process or application?
- Emphasize that sometimes it is impossible to delineate specific phases in the Experiential Learning Cycle and that this too is part of the dynamic of learning. Inform participants that it is not unusual to have difficulty clearly identifying where one phase ends and another begins; often these lines of learning and the transition from phase to phase is imperceptible.
- Emphasize that the learning process is not limited to formal settings. Again, encourage participants to extend their experiencing, processing, generalizing and applying outside the classroom and to learn from other participants.
- Ask how the Experiential Learning Cycle applies to work with adolescents. Discuss how the use of the Experiential Learning Cycle links with youth involvement.

TALKING POINTS FOR THE TRAINER

- If people retain 90% of what they see, hear, say and do, adolescent programs will need to provide opportunities for adolescents to see, hear, say and do, rather than have adults doing everything and the youth only in a passive/receptive state.
- Often youth programs do not involve youth as partners, so there is little to no ownership on the part of the young person and they are less likely to participate in the program and/or modify their behavior. INVOLVE!

NOTE TO THE TRAINER

To assist in planning this session or to obtain additional information on the Experiential Learning Cycle, consult the **Training Trainers for Development** text in the CEDPA training manual series (see www.cedpa.org).[16]

[16] CEDPA. 1995. *Training Trainers for Development*. The CEDPA Training Manual Series Volume 1.CEDPA.

STEP 3 *(30 minutes)*
UNIQUE STRATEGIES OF INSTRUCTION

- Explain that in addition to role-plays, case studies, readings and activities there are a few strategies in this module that are unique and warrant explanation. The strategies are as follows (see full description of these in the"Introduction" chapter):
  1. Community groups and community time.
  2. Learning journal.
  3. Participant presentations.
- Explain that each session begins with a review of its objectives (as was done at the beginning of Sessions #1 and #2) and ends with a review of the same objectives (as was done at the conclusion of Session #1). This instructional repetition ensures that session objectives are always tied to the activity.
- Explain that each session will link to the 4 cross cutting theme (**HANDOUT 2B**).
- Describe the various resources to be used during the module as well as their purpose.
- Discuss any upcoming guest speakers and their relevancy to the training.
- Discuss the use of field visits, if applicable.
- Inform participants that supplemental materials will be handed out during various sessions: readings, additional information derived from documents or other organizations, the Internet, etc.

Setting Up Community Groups/Explaining Learning Journals/Describing Participant Presentations (if applicable)

1. Community Time/Community Groups (see further description in the"Introduction" chapter).

- Describe Community Time (**HANDOUT 2A**). Describe what will happen during this time and discuss how long Community Time will last each morning/afternoon.
- Distribute the handout on Community Groups (**HANDOUT 2D**). Explain that Community Groups will be used to help with the facilitation of the module and to enhance the ownership of the participants in the training process.
- Draw the participants' attention to the handout on Community Groups (**HANDOUT 2D**) and describe the following:
  - Evaluation Group: This group is in charge of evaluating the day. This group reviews the evaluations completed at the end of each day, tabulates the results and presents the findings to the entire group the next morning during Community Time. Evaluation forms will be distributed for completion at the close of each day. If there were three sessions on that particular day, there will be three forms to complete. The Evaluation Group will distribute and collect the evaluations during the closing"Community Time" of each day.
  - Setting the Energy Group: This group is in charge of keeping the group energized and motivated. This group facilitates a 3-4 minute team builder or icebreaker during morning Community Time (as well as any other time needed – often after lunch). This group is also responsible for speaking with the Trainers should other climate-related concerns arise.
  - Environment Group: This group assists trainers with the logistics of training. This group also moves the nametags around every morning so that participants are seated beside different people

each day. The Environment Group helps distribute handouts, sets up equipment and generally keeps the room tidy. This group also reminds fellow participants to be on time and to adhere to other housekeeping details as well as the agenda of the module.

> NOTE TO THE TRAINER
>
> The trainers and participants may choose to serve the same role for the entire workshop. Or, participants can rotate so that each participant gets to serve in each of the three roles.

> NOTE TO THE TRAINER
>
> At the outset of the training, Community Groups may have difficulty understanding their exact roles. Thus, it may be necessary to assign trainers and/or a host organization staff member to each Community Group for two to three days for mentoring.

2. Learning Journals (see further description in the "Introduction" chapter).

- Distribute the Learning Journals to the participants.
- Explain the purpose of the Learning Journal. Time has been built into session designs for its use. The use of a learning journal allows participants to record and process concerns, thoughts, lessons learned,"action" steps and questions for follow-up. The journal is theirs to keep and they can decorate/personalize it how they wish.
- Ask participants if they have ever kept a learning journal and/or diary. Ask for comments or experiences in this area. Discuss advantages of the Learning Journal. Ask participants how the Learning Journal links to the Experiential Learning Cycle.

> NOTE TO THE TRAINER
>
> Participant presentations can be an invaluable addition to this module, but the inclusion of this strategy is optional and up to the discretion of the trainer(s).

3. Participant Presentations

- Distribute the "Participant Presentation Reflection Guide" and explain (**HANDOUT 2E**).
- Distribute the"Tips for Participant Presentations" handout and discuss (**HANDOUT 2F**).
- Describe the process for the Participant Presentations. Explain that the presentations are 15 minutes in length plus five minutes of questions (20 minutes total) and will be facilitated each day following Community Time.
- Ask participants to brainstorm what they believe are the intended goals of the Participant Presentations. Summarize what participants expect to get from this process.
- Add any intended goals of the Participant Presentations not mentioned by the participants.
- Pass around a sign-up sheet allowing participants to register the day when they want to present.

> NOTE TO THE TRAINER
>
> If the trainer(s) decide to include Participants Presentations as part of this module, it is recommended that trainers meet with participants at the end of Day 1 and Day 2 to preview the outline of their presentation. This process allows the participant ample time to incorporate feedback and corrections. Post the completed sign-up sheet in the room and remind participants at the close of each day who will be presenting the following day. Trainers should also offer technical assistance to participants with copies, AV equipment, etc.

- Review the objectives for Session #2 to ensure they were met (**FLIPCHART 2A**).

Handout 2A

MODULE OVERVIEW

Day 1

- Welcome (Session 1) *–1 hour, 10 minutes*
- Introduction to the Module (Session 2) *–2 hours*
- Building the Participant Profile (Session 3) *–1 hour, 15 minutes*
- Defining and Exploring the Concepts of Adolescence and Young Adulthood (Session 4, Part I) *–2 hours*

TOTAL = 6 hours and 25 minutes

Day 2

- Defining and Exploring the Concepts of Adolescence and Young Adulthood (Session 4, Part II) *–1 hour*
- Human Rights in Programs and Services for Adolescents (Session 5) *–2 hours*
- Youth/Adult Partnerships (Session 6) *–1 hour, 50 minutes*
- Gender (Session 7) *–2 hours*

TOTAL = 6 hours, 50 minutes

Day 3

- Sustainability (Session 8) – *2 hours*
- Behavior Change (Session 9) – *2 hours, 30 minutes*
- Life Skills (Session 10) – *1 hour, 30 minutes*

TOTAL = 6 hours

Day 4

- Youth Friendly Services (Session 11) *–1 hour, 45 minutes*
- Monitoring and Evaluation of ASRH Programs and Services (Session 12) *–1 hour, 10 minutes*
- Advocacy (Session 13) *–1 hour, 45 minutes*
- Values, Attitudes and Ethics (Session 14) *–1 hour, 30 minutes*

TOTAL = 6 hours, 10 minutes

Day 5

- STI/HIV Review (Session 15) *–1 hour, 30 minutes*
- Access to and Use of Contraceptives by Adolescents (Session 16) *–1 hour, 45 minutes*
- Young Married Couples (Session 17) *–1 hour, 30 minutes*

TOTAL = 4 hours, 45 minutes

Day 6

- Action Planning (Session 18) – *2 hours*
- Evaluation and Close of the Module (Session 19) – *1 hour 30 minutes*

TOTAL = 3 hours, 30 minutes

Community Time

Each morning begins with 30 minutes of Community Time (Evaluation Group, Setting the Climate Group, Evaluation Group and morning announcements).

Each evening ends with 15 minutes of Community Time (evening announcements & evaluation of the day's sessions).

Handout 2B

The Four Cross Cutting Themes of the Module

Gender – Gender is about the roles individuals play (daughter, son, girlfriend, boyfriend, etc.), the relationships between these roles and the norms for behavior dictated for those roles. Even in the presence of universal access to quality services and supplies, if gender norms prescribe that a"good" girlfriend should not talk to her partner about condom use or that a"macho" boy does not worry about pregnancy, then the availability and quality of the services and commodities becomes irrelevant. Managers of adolescent programs must understand the gender constraints that boys and girls live within, in order to offer programs that meet the sexual and reproductive health needs of young people and also promote gender equity. Gender roles and expectations, while prescribed by society, can also be challenged by that society.

Human Rights – Often ASRH services are provided in order to fix "troubled youth" or because of charity, rather than to respond to a young person's basic human right to be healthy, have equal access to services and control in decision making. The philosophy behind the services – whether they are being provided out of charity or because the client has a right to them – can influence: how an individual accesses the services; whether the individual will pay and how much; the quality of the information and services provided; and the client/provider interaction. In recognition of the importance of such a philosophy, this training will address adolescent sexual and reproductive health issues through a rights-based approach.

Youth/Adult Partnerships – Adolescents are often viewed as walking problems: irresponsible, difficult and sometimes violent. But what would happen if they were viewed as walking assets: creative, energetic and enthusiastic? Not only do adolescents have a right to be fully involved in the planning, implementation and evaluation of ASRH programs, but programs in which youth are active participants are also more effective. However, just as youth programs, designed without their involvement, are less effective; programs that are run solely by youth are not likely to succeed either, whether due to lack of skills, experience or economic resources, etc. The most successful ASRH programs are built on the promise of adult/youth partnerships utilizing the assets of adolescents, their parents or guardians, ASRH staff and providers, families, communities and local institutions.

Sustainability – If institutions are to continue to be able to deliver programs that meet the ongoing needs and rights of adolescents, then managers of those programs must, from the onset, plan for financial, institutional and programmatic sustainability. For example, managers must be aware of the financial and institutional resources needed for program implementation and continuation. To ensure programmatic sustainability, mangers need to continuously scan the environment in which they function: are staff, parents, policy makers and/or the community supportive of the program? If not, what strategies can a manager design to garner support? Managers may also want to identify and work with *existing* youth serving organizations that are are already sustainable to incorporate activities.

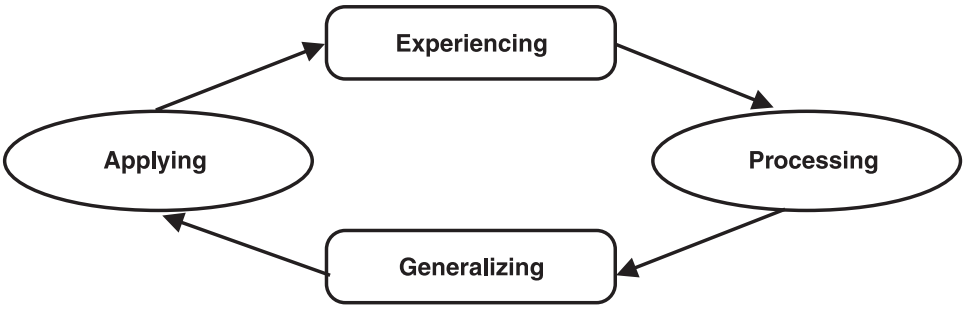
Connecting the Four Cross Cutting Themes

In order for young people to be empowered to act on their ASRH needs, they must know and acknowledge that they have a right to good ASRH and services; that they have the power to make decisions and take action regardless of gender constraints; that they can work in partnership with adults to achieve good sexual and reproductive health; and that both the behavior they desire and the services they require will be sustained. The four cross cutting themes are thoroughly explored during the first few days and addressed throughout the module.

Handout 2C

Experiential Learning Cycle

Experiential learning is conceived as a cycle in which the learner progresses through four phases of the learning process to transform information into useful knowledge. A direct experience becomes the basis for reflection where the experience is processed. Based on this analysis, the learner is able to generalize principles which he must then apply.



Adult and experiential learning experts identify that people retain:

- 20% of what they hear
- 30% of what they see
- 50% of what they hear and see
- 70% of what they see, hear and say (discuss)
- 90% of what they see, hear, say and do

This module is based on this premise and uses the fundamentals of the experiential learning cycle to ensure comprehension, retention and follow through.

The experiential learning cycle includes the following stages:

1. **Experiencing**: Experiencing involves engaging in an exercise or activity together and/or sharing personal experience and feelings. **DO!**
2. **Processing**: Processing involves digesting the exercise, activity and/or sharing from the"experience" stage and sharing comments observations regarding this process. **ANALYZE/THINK!**
3. **Generalizing**: Generalizing involves pulling a meaning from the experience, comparing it to other experiences and identifying general principles or patterns. **CONCLUDE!**
4. **Applying**: Applying involves developing an action or plan for after the training or in the participant's own work environment, using insights gained from the previous stages. **PLAN A CHANGE OR ACTION!**

Source:
CEDPA. 1995. *Training Trainers for Development*. The CEDPA Training Manual Series Volume 1. CEDPA.

Handout 2D

Community Groups

- COMMUNITY TIME: Each morning is committed to Community Time, including a team builder/icebreaker, reporting the evaluation results from the day before and daily announcements by trainers, participants and host organization staff. Two of these tasks are performed by community groups (see description below).
- COMMUNITY GROUPS: The module is enhanced by the involvement of participants in three community groups. Below is a description of the groups:

1. **Environment Group**: This group assists trainers with the logistics of training. This group also moves the nametags around every morning so that participants are seated beside different people each day. The Environment Group helps distribute handouts, sets up equipment and generally keeps the room tidy. This group also reminds fellow participants to be on time and to adhere to other housekeeping details as well as the agenda of the module.
2. **Energy Group**: This group is in charge of keeping the group energized and motivated. This group facilitates a 3-4 minute team builder or icebreaker during morning community time (as well as any other time needed – often after lunch). This group is also responsible for speaking with the Trainers should concerns arise that might affect the group's energy.
3 **Evaluation Group**: This group is in charge of evaluating the day. This group reviews the evaluations completed at the end of each day, tabulates the results and presents the findings to the entire group the next morning during Community Time.

Handout 2E

Participant Presentation Reflection Guide

The following guide is intended to assist the participant in note taking on the participant presentations.

	Name of person presenting	What did you gain from the presentation? Knowledge, Attitudes, Skills	What from this presentation can you adapt or take home?	Comments/Questions for follow-up
PRESENTATION # __				
PRESENTATION # __				
PRESENTATION # __				
PRESENTATION # __				

Other:

Handout 2F

Tips for Participant Presentations

Each participant will have the opportunity to present some aspect of her/his work and organization to the rest of the group, including staff.

Timing

Each individual will have 15 minutes to present and there will be a total of 5 minutes scheduled for Q & A.

Past presenters have shared the following suggestions to help build a strong presentation:

- Approach one of the trainers with at least 24 hours notice to request materials needed (flipchart paper, markers, overhead transparencies, pens, photocopies, power point projector, saving presentation to a disk, etc.).
- Arrive early on the day of your presentation to set up your materials, photos, maps, etc.
- Analyze your audience before developing your presentation. What aspect of your work will be most interesting to your fellow participants? Try to focus on your most innovative program or your greatest programmatic success or challenges.
- Speak loudly and clearly to capture the attention of your audience.
- Speak clearly about the role you play within your organization.
- Discuss your work in adolescent sexuality and reproductive health with engaging examples.
- The audience will be much more interested in programmatic specifics. Limit the information about your country's background or your organization's structure and history.
- Limit the number of your visual aids. Use key words, not sentences. Limit the number of words on each page of flipchart, overhead or PowerPoint.

The training team is available for consultation if you need guidance on planning or organizing your presentation. Please share your outline with the trainers on day 1 or 2 of the training. If you have any audiovisual needs, please inform the trainers immediately.

SESSION 3: BUILDING THE PARTICIPANT PROFILE[17]

OBJECTIVES

- Identify participants' ASRH experiences and interests.
- Enable participants to identify peers who have similar professions and have them form work subgroups accordingly.
- Encourage participants to uncover areas in ASRH where they wish to challenge themselves and explore how the workshop might be useful in this regard.

DAY: 1 – **TIME**: 1 hour and 15 minutes

MATERIALS

- Session #3 objectives printed on flipchart (**FLIPCHART 3A**)
- Index cards and markers (at least one per participant)
- Poster with title and diagram on Group Profile (see categories under Step #1 below)

PREPARATION

Prepare the wall size poster of the Group Profile chart.

NOTE TO THE TRAINER

This session is fundamental for gaining an overall view of the participants. The working subgroups formed through this session will be utilized throughout the module.

[17] This session design is based on a session developed by Kathrin Tegenfeldt for CEDPA's Youth Development and Reproductive Health Workshop, Summer 2002.

FACILITATING SESSION #3

STEP 1 *(30 minutes)*
BUILDING THE PARTICIPANTS' PROFILE

- Review the objectives of Session #3 on flipchart (**FLIPCHART 3A**).
- Explain that while the purpose of the "Appreciative Interview/Icebreaker" was to become familiar with each other, the following activity will delve more into areas of interest, work and experience.
- Prepared Poster. Uncover and bring the participants' attention to the poster of the "Group Profile Chart":

QUESTION	POSSIBLE ANSWERS	CHECK ALL THAT APPLY
I have been working with adolescents for…	1 to 3 years	
	4 to 6 years	
	7 to 10 years	
	More than 10 years	
I have ASRH experience in the areas of…	Rights	
	Gender	
	Advocacy	
	Administration	
	IEC/BCC	
	Life Skills	
	Education	
	Medical services	
	Counseling	
	Training of peer educators	
	Research, Monitoring/Evaluation	
I consider my level of knowledge and skills for working with adolescents…	Inadequate	
	Average	
	Good	
	Excellent	
I would like to strengthen my managerial skills for working with adolescents in…	Rights	
	Gender	
	Advocacy	
	Administration	
	IEC/BCC	
	Life Skills	
	Education	
	Medical services	
	Counseling	
	Training of/peer educators	
	Research, Monitoring/Evaluation	

- Describe the categories. Ask if clarification is needed.
- Explain that this activity is an opportunity to get a profile of the experience and skill base present. This is not an assessment of who has the most experience or the most training. Rather, it is an opportunity to demonstrate and learn from the similarities and differences in the group.
- Give each participant self-adhesive silver stickers (preferably self-adhesive circles) to place in the "Check All That Apply" category. Some questions may have more than one answer. Participants should not write their names. Responses are to be anonymous.
- Allow participants ample time to complete this task.
- After participants have completed the task, process with the full group. Some sample questions: "What category are most of the stickers under?"; "Among the responses, what are some similarities?"; "Among the responses, what are differences?". Ask participants if the responses are in line with what they had expected. Ask participants what they see that they did not expect. The trainer(s) provides participants with a synthesis of the group observations.
- Ask the participants to offer suggestions to the Trainers on the following: What implications do our similarities/differences have on the module/workshop. How should the Trainers use this chart? How should the participants use this chart? What are the implications of this chart?
- Inform the participants that the chart will be posted in the training room during the entire module. Trainer(s) should refer to this chart as future sessions are facilitated. Challenge participants to keep the chart in mind as they experience the module.

STEP 2 *(45 minutes)*
SIMILARITIES AND DIFFERENCES: TRENDS IN THE PARTICIPANT PROFILE

- Using the previous activity as a springboard, introduce the next step. The goal of Step #2 is to explore the backgrounds, talents and interests of the participants.
- Ask the participants to stand, stretch and take a few deep breaths. For fun, lead the group in a few breathing or stretching exercises.
- Explain that the Trainer will ask a series of questions and if this question applies to the participant, remain STANDING. If the question does not apply to the participant, SIT. Provide an example:
  - Who works directly with young people? *(Those who answer yes, please stand)*
- Ask participants to observe who is standing or sitting. Pause for 5 seconds, ask everyone to be seated and move on to the next question. Follow the same procedure for each question:
  - Who supervises people working directly with adolescents/youth?
  - Who is involved with staff development, mentoring and in-service training? (These may be broken into three different questions or participants may stand if they can answer yes to at least one of the questions.)
  - Who works with the government?
  - Who works with an NGO?
  - Who works with the private sector?
  - Who works as a direct service provider?
  - Who is a nurse? Physician? Midwife? Gynecologist? *(4 separate questions)*
  - Who is a health educator?

- Who is a counselor?
- Who is a psychologist? Social worker? *(2 separate questions)*
- Who works in programs for young people of the following ages: 10-24? 10-19? 15-24? *(3 separate questions)*
- Who works with in-school youth? Out-of-school youth? *(2 separate questions)*
- Who works with urban youth? Rural youth? *(2 separate questions)*
- Who works with young people at risk?
- Who works with young married couples?
- Who works with young unmarried couples?
- Who serves young fathers?
- Who serves young mothers?

NOTE TO THE TRAINER

The number of questions may vary based on the information the trainer wishes to highlight or learn about.

- Based on the previous activity, ask participants for their observations. What did they see? How does this apply to the workshop? How does this apply to the sessions? How does this impact participants' time together? How will the diversity of the participants impact the module? How will the diversity of the participants compliment the process of learning?
- Explain that while diversity of the participants will ultimately contribute to the success of the module, there are times when session designs will call for the formation of more focused work subgroups. Work subgroups should typically include participants who are doing similar work and have common areas of expertise; in general, work subgroups should be made up of a more homogenous subgroup of the larger participant pool. Explain that the following stage of this activity will begin to break the larger participant pool into work subgroups that will be used in some of the sessions during the module.
- Ask each participant to write down four or five major characteristics on an index card to help form work subgroups. Examples:
  - Positions
  - Areas of experience
  - Subjects of interest
  - Direct outreach with youth
  - Supervision of personnel who work with youth
  - Project directors or coordinators

- When participants have finished writing, the group places the written cards on the wall. Now have the group organize the cards into three to five work subgroups (the number of groups depends on the number of participants). Participants should discuss and organize the work subgroups, not the trainer(s).
- To demonstrate the importance of all of the subgroups use the analogy of a stool. The seat of a stool cannot stay supported by just one leg. The seat of the stool needs multiple legs to stand. Drawing a picture of a stool, write the names of the work subgroups on the legs of the stools and underscore the importance of all of them in holding up the work of ASRH. (Other analogies that are congruent with local cultures/customs can also be used.)
- Review the objectives for Session #3 to ensure they were met (**FLIPCHART 3A**).

SESSION 4: DEFINING AND EXPLORING THE CONCEPTS OF ADOLESCENCE AND YOUNG ADULTHOOD[18]

OBJECTIVES

- Explore the definitions of adolescence.
- Identify the developmental stages of adolescence.
- Identify adolescent development factors and their impact on reproductive health.
- Identify characteristics and critical issues facing adolescents in our society.

DAY: 2 – **TIME**: 3 hours

MATERIALS

- Session objectives written on flipchart (**FLIPCHART 4A**)
- Flipchart and markers
- Questions for Step 2, Learning Journal activity, on flipchart (**FLIPCHART 4B**)
- PowerPoint presentation on adolescence and stages of development (**APPENDIX 4A**)
- "What Factors Influence Adolescent Development and Reproductive Health?" **(HANDOUT 4A)**
- Handout on "Developmental Characteristics of Adolescence" (**HANDOUT 4B**)
- Poster board, glue, art supplies, old magazines, etc. for **Group Activity** in Step 2.
- Questions for STEP 3 prepared on flipchart (**FLIPCHART 4C**)
- Handout on "The Sexual and Reproductive Health of Youth: A Global Snapshot" (**HANDOUT 4C**)
- Handout on "Youth and the Global HIV/AIDS Pandemic" (**HANDOUT 4D**)

RESOURCES

- James-Traore, T. A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents*. FOCUS Tool Series 4. FOCUS on Young Adults (**WEB SITE 4A**).
- Salgado, A.M., and N. Cheetham. 2003. The Sexual and Reproductive Health of Youth: A Global Snapshot. *Transitions* 15(2). Advocates for Youth (**WEB SITE 4B**).
- Cheetham, N. 2003. Youth and the Global HIV/AIDS Pandemic. *Transitions* 15(2). Advocates for Youth *(***WEB SITE 4C***)*.
- JHUCCP. 1995. *Meeting the Needs of Young Adults.* Population Report XXIII(3) (**WEB SITE 4D**).

PREPARATION

Review the PowerPoint presentation. Review the statistics and facts from the handout on critical ASRH issues. Be prepared to discuss statistics and facts specific to one's geographical region or country. Place instructions for the Step 2 Group Activity on PowerPoint.

[18] This session design is based on a session developed by Judy L. Palmore for CEDPA's Youth Development and Reproductive Health Workshop, Summer 2001.

FACILITATING SESSION #4

PART I

STEP 1 *(30 minutes)*
DEFINING ADOLESCENCE/YOUTH/YOUNG PEOPLE

- Review the objectives of Session #4 with the participants (**FLIPCHART 4A**).
- Have the group brainstorm (trainers record on flipchart) the definitions of youth from their perspective. How is youth defined in their respective countries, regions, organizations, etc.?
- Now ask the group to brainstorm (trainers record on flipchart) other characteristics besides age that define "youth".
- Ask the participants to discuss their observations. What are some similarities in how the participants define youth? What are some differences?
- Explain that since this module focuses on ASRH, it is important that the group establish a working definition of adolescence that will be used for the remainder of the workshop.
- Present PowerPoint slide show. Start by offering the definition of adolescence from the World Health Organization (WHO) (**APPENDIX 4A**).
- Ask the participants to give feedback on the WHO definition.
- Add that while most organizations base their definition of adolescence and youth on the WHO version, others may use it as a foundation and modify it.
- Using the WHO definition as a basis, ask the participants to collectively create their own working definition of adolescence, youth, or young people to be used for the remainder of the module. Record this definition and post prominently in the classroom for the rest of the training.
- Ask participants to identify the purpose of developing and coming to a consensus on their own working definition of adolescence, youth, or young people prior to proceeding with the module.

STEP 2 *(1 hour 30 minutes)*
DEVELOPMENTAL STAGES OF ADOLESCENCE

- Continue PowerPoint slide show (**APPENDIX 4A**). Explain the four stages of adolescence, using (**WEB SITE 4A**) as a reference.[19]
  1. Pre-Puberty (under age 10)
  2. Early Adolescence (10-14)
  3. Middle Adolescence (15-19)
  4. Young Adulthood (20-24)
- Explain that during each of these four stages, certain variables or factors (i.e. family, society, emotions, religion) will impact how one's adolescent development progresses.

[19] James-Traore, T. A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents*. FOCUS Tool Series 4. FOCUS on Young Adults.

- Ask participants to brainstorm as many of these variables/factors as possible. Record participant responses on flipchart.
- Continue PowerPoint slide show (**APPENDIX 4A**). Present the slide listing the factors outlined in "Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents": biological, emotions, cognition, identity, family, sexuality, society, ethics and morality (**WEB SITE 4A**). In addition, provide each participant with the handout: "*What Factors Influence Adolescent Developmental and Reproductive Health?*" based on the document mentioned above. (**HANDOUT 4A**) Solicit questions and/or comments from participants on the PowerPoint slide and handout.

Learning Journal (Note: the learning journal activity should not exceed 10 minutes – this is included in the one hour and 30 minutes)

- Instruct the group to record a specific memorable event from their own adolescent development in their Learning Journals. The event may be related to sexual health or another topic.
- Once participants decide on the event they would like to write about, have them respond to the following questions (**FLIPCHART 4B**):
  - How old were you when the event occurred?
  - Address how each of the following factors influenced this memorable event:
    1. Biological
    2. Emotions
    3. Cognition
    4. Identity
    5. Family
    6. Sexuality
    7. Society
    8. Ethics and Morality
- Inform participants that their Learning Journal entry should be a stream of consciousness, writing the first words/feelings that come to mind.
- Once participants have completed their writing, ask if there are any volunteers willing to share their experiences with the group.

Group Activity

- Divide participants into four groups and assign each group one of the following stages:
  1. Pre-Puberty (under age 10)
  2. Early Adolescence (10-14)
  3. Middle Adolescence (15-19)
  4. Young Adulthood (20-24)
- Distribute handout on *"Key Developmental Characteristics During the Stages of Adolecence"* (**Handout 4B**) *found in "Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents"* (**WEB SITE 4A**).

- Continue PowerPoint slide show (**APPENDIX 4A**). Instruct each group to do the following:
  1. Create an imaginary young person for their respective group.
  2. Give a name to the imaginary young person and designate his/her sex.
  3. Describe some of the key developmental characteristics for this imaginary person's age group within each of the following variables/factors: biological, emotional, cognitive, identity, family, sexuality, social and ethics/morality. Use **HANDOUT 4B** as reference.
  4. What specific ASRH needs does the imaginary young person have in this age group?
  5. Based on this, what does the imaginary young person need from ASRH providers?
  6. Create a collage of the imaginary young person that addresses these questions. Each group will present their imaginary young person to the entire group. For this activity, the Trainer(s) provides: poster board, glue, art supplies, old magazines, etc.
- Once the groups have completed their task and created their collage, instruct each of the four groups to walk their peers through their assigned stage of development, using their imaginary young person as a guide. The Trainer(s) should have the groups present the four stages of development in chronological order.
- Hang the collages in the classroom in chronological order and ask the participants to comment on the differences within each stage.
- The Trainer(s) should underscore some of the clear differences that are occurring developmentally within each stage.
- Now ask the four groups to discuss amongst themselves how an ASRH approach for their imaginary person may differ from an older or younger individual in another developmental stage. For example, choose a specific issue (i.e. reducing teen pregnancy) and talk about how the programming approach would be different depending on the age group.
- Allow each small group to briefly share its discussion with the entire group.
- Ask the group to identify how this journey and the factors that impact the journey may differ for males and females.

TALKING POINTS FOR THE TRAINER

1. Females often have more shame and guilt around physical/biological development due to the stigmatization of having a menstrual cycle; developing too fast; not fast enough; expectations that come along with development and sexual activity.
2. As indicated under the influencing factor "identity", it is typical for girls to tend to focus on relationships, while boys focus on achievement and competition. Are there rituals in your culture that foster this?
3. Gender roles assume that males typically express their "emotions" through anger and violence. This expectation may result in acting out or violent behavior by boys.
4. Cognitive development is impacted by whether or not one is encouraged to learn, attend school and share one's opinion. These are often not encouraged in adolescent girls.

- Ask for examples of how adults can partner with adolescents to help them with this journey.

TALKING POINTS FOR THE TRAINER

1. Develop programs that coach parents on how to talk with their children about the stages, what to expect and how to nurture their children through these stages.
2. Develop an understanding of gender role expectations and how these societal laws and rules inhibit a young person's natural development and increase his/her risk for STI/HIV transmission.

- The trainer closes Step 2 by asking participants to write in their Learning Journal about one age-appropriate idea they would like to implement based on the presentations they just observed. Ask participants to consider the influence of gender and youth/adult partnerships as they think of an idea.

End of Day I

Beginning of Day 2

PART II

STEP 3 *(1 hour)*
ADOLESCENT ISSUES IN REPRODUCTIVE HEALTH

- Bridge from Day I, Session #4, Defining and Understanding Adolescents and Young People Part I. Remind participants of the objectives pursued in Part I. Have all flipchart related to Part I posted in the room to remind participants of the work they accomplished the day before.
- Break the large group into small groups of five to six people. Once groups have been formed, ask each to identify critical issues facing adolescents or young people in their communities and prepare to present a role-play expressing these issues to the rest of the group. Each role-play should last 5-8 minutes. When designing the role-play groups should attempt to address the following: (**FLIPCHART 4C**)
    1. What expectations do young people have regarding sexual and reproductive health?
    2. What information do young people possess about reproductive health?
    3. What are the ASRH critical issues and problems faced by youth?
    4. What are the obvious needs that young people have regarding ASRH programs and services?
- Allow the groups 20 minutes to prepare and 10 minutes to present and answer questions.
- After the role-plays ask for overall observations. Ask participants to list the top four critical issues and the top four needs in ASRH. Ask the participants to record these four critical issues in their journals with a resolution beside each. Participants may choose to use this format:
    - As a result of this critical issue I will…

    Or

    - As a result of this ASRH need for adolescents I will…
- Ask participants to share their responses with the group.
- Distribute handouts on "The Sexual and Reproductive Health of Youth: A Global Snapshot" (**HANDOUT 4C**) and"Youth and the Global HIV/AIDS Pandemic" (**HANDOUT 4D**) as additional resources.

On a positive note…

- Explain that as a result of these critical ASRH issues, managers, providers and clinicians as well as parents often view youth as inherently vulnerable and a walking problem waiting to happen. While there are specific health care needs and critical issues that impact adolescents and young adults, there are also key assets and attributes youth possess that keep them healthy and safe. Trainers now ask participants to find a partner and have each person identify several triumphs and joys of adolescence and youth. Ask each pair to recall their own adolescent experiences. Next ask each pair to identify how youth workers, clinicians and providers can utilize these wonderful assets as part of the ASRH process in programming and outreach.
- Read Session #4 objectives to ensure that they were met (**FLIPCHART 4A**).

What is Adolescence

WORLD HEALTH ORGANIZATION[20]

- The World Health Organization (WHO) defines "adolescence" as 10-19 and "young people" as ages of 10-24.
- WHO further breaks down the evolving nature of adolescence:

  Progression from the appearance of secondary sex characteristics (puberty) to sexual and reproductive maturity;

  Development of adult mental processes and adult identity;

  Transition from total socioeconomic dependence to relative independence.

Stages of Adolescence

FOCUS on Young Adults[21]

Pre-Puberty (Under age 10)

Early Adolescence (10 – 14)

Middle Adolescence (15 – 19)

Young Adulthood (20 – 24)

Factors which influence development and RH

FOCUS on Young Adults[22]

- Biological – physiological changes
- Emotions – feelings, self, mood, others, conflict
- Cognition – thinking/ processing skills, digestion of ideas,
- Identity – who am I? What do I stand for?
- Family – stability, relationships w/ family
- Sexuality – sexual thoughts, expressions, ideas, beliefs, etc.
- Society – community messages and support
- Ethics and morality – values, beliefs, right/wrong

[21] WHO. 1997. *Young People and Sexually Transmitted Diseases.* [Fact Sheet #186]. Geneva: WHO.

[21] James-Traore, T. A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents*. [FOCUS Tool Series 4]. FOCUS on Young Adults.

[22] James-Traore, T. A. 2001.

Group Activity

Group 1 – Pre-Puberty

Group 2 – Early Adolescence

Group 3 – Middle Adolescence

Group 4 – Young Adulthood

- Create an imaginary young person for each stage.
- Name that young person and identify his/her sex.
- Select a situation of risk/temptation that this young person is in.
- According to the factors of development what supports/inhibits this young person's ability to make healthy decisions?
- Based on this, what does this young person need from us?
- Create a collage of this young person and present it to the group.

Handout 4A

What Factors Influence Adolescent Developmental and Reproductive Health?

Several factors that influence adolescent developmental and reproductive health are identified below. Although their degree of influence may vary at different points, they all shape how young people experience the transition from childhood to adulthood.

Biological – Biological and physiological changes, such as physical growth, the development of secondary sex characteristics and menarche, occur during puberty and early adolescence. They, in turn, can influence an adolescent's psychological development, self-image and peer and other relationships, plus the social expectations placed on adolescents.

Emotions – The emotional aspects of a young person's development include the role feelings play in motivating behavior, how youth feel about themselves in relation to their peers and others, how they view their bodies and what their interpersonal relationships are. These emotions can manifest as excitement, optimism, change and growth from the perspective of adolescents; however, circumstances can sometimes defeat those very positive emotional characteristics.

Cognition – As development progresses, enhanced thinking skills enable an adolescent to move from concrete to abstract thought. This process has an impact on the way information is perceived and understood. Consequently, it has implications for how information, education and communication (IEC) materials and counseling and reproductive health services should be designed and delivered.

Identity – Above all, adolescence is a time for discovering "Who am I?" The development of identity – largely determined by culture and tradition – is also linked to family and peer relationships, values and the meaning of being male or female in a given society. Girls are particularly vulnerable to negative reproductive health outcomes because they are often assigned roles that limit and constrain their independence and decision making, placing them at greater reproductive health risk. Although attitudes vary, most cultures expect young women to abstain from premarital sex while tolerating, or sometimes even encouraging, it for males.

Family – In most cases, adolescent development takes place within the context of the nuclear or extended family. The degree to which this developmental period results in family tension and conflict rather than support and celebration will vary. Societal and familial expectations and the nature of family relationships, as well as significant events such as births, deaths and separation, all affect how young people develop. Family stability can be especially critical and disruptions, including death, divorce, or separation, can have a lasting effect on adolescent behavior and development. In addition, some adolescents are institutionalized, are fighting wars, are living on the streets, are orphaned, or have married or formed other partnerships.

Source:
James-Traore, T. A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents*. [FOCUS Tool Series 4]. FOCUS on Young Adults.

Sexuality – Sexuality includes a range of emotions, thoughts and behaviors and is not limited to sexual intercourse. It involves the individual's physiological, psychological and emotional state; sexual expression and gender roles; and expectations.

Society – Adolescent development also takes place within the context of the adolescent's social environment. The healthy development of social skills is reflected in interpersonal and group relationships and in the balance between healthy group interaction, individuality and independence.

Ethics and Morality – A sense of ethical standards and morality, or values, helps an individual distinguish between right and wrong and shapes decisions about individual behavior. That sense is evident in an awareness of broader issues affecting not only the individual, but also the family, the community and the society.

Because of these factors, adolescence, especially in its early stages, is an optimal time to influence the development of healthy gender roles as well as positive and productive goal setting. Data confirm that adolescents do listen to adults and that positive relationships with adults can reduce some of the potential hazards associated with adolescence and can increase positive behaviors. Outlined in this tool are intervention strategies that focus on prevention. These strategies hold special promise for younger adolescents.

Handout 4B

Key Developmental Characteristics During the Stages of Adolescence

Pre-Puberty (under age 10)

Biological

- Has immature reproductive organs.
- May begin to develop signs of puberty such as budding breasts and pubic hair.

Emotional

- Can be impulsive.
- May have difficulty expressing feelings.

Cognitive

- Is learning to master skills.
- Finds that play is an essential way of learning.
- Has limited language skills (difficulty putting feelings into words).
- Is curious.
- Has difficulty distinguishing fantasy from reality.
- Is creative.
- Has unrestrained imagination.
- Is oriented to the moment.
- Is receptive to new ideas.
- Has very concrete thinking.
- Sees behavior in terms of right and wrong.

Identity

- Is sensitive to gender differences.
- Distinguishes gender roles based on observations and societal norms.
- Copies adult behavior.

Family

- Has values determined by family and society.
- Spends the majority of time with family.
- Is dependent on parents and extended family caretakers.
- Has parents or relatives who make all decisions.

Sexuality

- Is exploratory, particularly in relation to body parts.
- Is curious about opposite sex.

Social

- Is competitive (especially among boys).
- Shows tendency toward aggressive behavior (also more often among boys).
- Has strong desire to please (especially among girls).
- Is rules oriented.
- Is physically active.

Ethics/Morality

- Values and beliefs determined by family.
- Adheres to values with little questioning.

Source:

James-Traore, T. A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents*. [FOCUS Tool Series 4]. FOCUS on Young Adults.

Early Adolescence (ages 10 – 14)

Biological
- Puberty begins and body changes; growth spurts occur.
- Ovaries mature in girls in preparation for menstruation.
- Menstruation begins in most girls.
- Breasts enlarge in girls.
- Hips widen in girls.
- Girls are able to get pregnant.
- Boys can produce sperm.
- Genitals enlarge.
- Acne develops.
- Boys experience nocturnal emissions ("wet dreams").
- Muscles enlarge in boys.

Emotional
- Exhibits behavior driven by feelings.
- Has frequent mood swings.
- Is confused about emotional and physical changes.

Cognitive
- Is learning to master skills.
- Sees behavior in terms of right and wrong.
- Responds best to rewards and punishment.
- Has thinking that becomes more abstract and less concrete.
- Tends to suppress feelings.
- Is receptive to new ideas.
- Questions conflicting messages.
- Feels invincible or fatalistic.
- Is fearful of the future.
- Lacks control over life or feels that he or she lacks control.
- Seeks to make more decisions.

Identity
- Models same-sex behavior.
- Learns gender roles and differences.
- Tends to associate with members of the same sex.
- Girls tend to focus on relationships and nurturing, while boys focus on achievement and competition.
- Has self-esteem that is primarily influenced by others.
- Is preoccupied with physical appearance.

Family
- Spends majority of time with family but is beginning to move away from family toward peers.
- Generally has close relationship with parents or extended family, caretakers and advisors.

Sexuality
- Begins to develop interest in opposite sex.
- Is interested in own physical development, particularly in relation to peers.
- May begin to masturbate.
- May begin to experiment with sex play.
- May have sexual intercourse.

Social
- Increasingly transfers interest from family to friends and others as central focus.
- Recognizes wider social spectrum outside the family.
- Is concerned with social and sexual behavior and acceptance by peers and adults.
- Begins to interact with opposite sex.
- May be socially recognized as an adult. May go through pre-marriage or marriage rules or rituals.
- Experiences rites of passage in various forms.
- Seeks acceptance by peers.

Ethics/Morality
- Has values, beliefs and religion primarily determined by family.
- Is aware of different values.

Middle Adolescence (ages 15 – 19)

Biological
- Continues physical growth, development and sexual maturation.
- Pace of physical and emotional development in relation to peers' development is important.

Emotional
- Starts to challenge rules and test limits.
- Feelings contribute to behavior but do not control it.
- Is less impulsive. Begins to respond based on thoughtful analysis of potential consequences.
- Develops more advanced problem-solving skills.
- Concerned with self-image compared with peers.
- May be encouraged to participate in rites of passage.
- Males more likely to engage in sexual activity before marriage, with multiple partners, than females.

Cognitive
- Desires more control over own life.
- Begins to develop own value system.
- Thinks in more abstract terms.

Identity
- Has sense of self that is largely shaped by peers, although becoming less so.
- May be struggling with gender identification.
- May be married and under strong influence of spouse, relatives.

Family
- May become more removed from family and may seek more privacy.
- Moves away from parents toward peers.
- May marry and move away from family of origin.
- May have children.

Sexuality
- Has increased sexual interest.
- May initiate sex within or outside of marriage.
- May struggle with sexual identity.
- May be introduced into the sex industry.

Social
- Peers influence leisure activities, appearance, substance use and initial sexual behaviors.
- Family influences education, career, religious values and beliefs.
- Relationships are developed and are based on mutual expectations and on conformity to group norms regarding time apart from spouse and children, family obligations, hairstyles, dress, music, etc.

Ethics/Morality
- Increases exposure to the values and beliefs of others.
- Starts to question own beliefs, which may lead to conflicts with parents or family.
- Begins to develop own set of values.

Young Adulthood (ages 20 – 24)

Biological
- Has reached sexual and physical maturity.

Emotional
- Is better able to resolve conflicts.
- Develops more stable relationships.
- Is able to recognize and seek help when needed.
- Has developed a stronger sense of self.

Cognitive
- Demonstrates improved problem solving.
- Shows greater understanding of behavioral consequences of actions.
- Has clearer definition of self.

Identity
- Struggles with adult roles and responsibilities.
- Struggles between dependence and independence.
- Struggles with competing demands of spouse, family, community and self.

Family
- Begins to reintegrate into family as a new, emerging adult.
- Begins to create a "fit" between newly defined self and family.
- Is clearer about roles and expectations.
- Is more aware of self in relation to others, including spouse.
- Relates to spouse and family as a fully autonomous adult.
- Is comfortable with role as adult.

Sexuality
- Develops serious intimate relationships that replace group relationships as primary.
- Develops adult social relationships.
- Is ready to enter into a committed relationship.

Social
- Shows that importance of peer interaction for decision making has diminished.
- Has a diminished role of peer relationships as a decisive factor in personal beliefs and actions.
- Makes choices about career or vocation and about roles inside and outside the home.
- Completes education; prepares for employment.
- Prepares for parenthood.
- Can balance the needs of self and others on the basis of healthy interaction.
- Achieves socially recognized status with clear adult rights and responsibilities while showing advanced stages of "social conscience."

Ethics/Morality
- Is often caught between traditional and modern roles and values.
- Balances between own beliefs and those of the family

Handout 4C

The Sexual and Reproductive Health of Youth: A Global Snapshot

At the beginning of the new millennium, about 1.7 billion people -more than a quarter of the world's population-were between the ages of 10 and 24, 86 percent living in less developed countries.[1] Worldwide, many youth have had sexual intercourse and are at risk of sexually transmitted infections (STIs), including HIV, or of involvement in unintended pregnancy. Research based reproductive health programs can provide youth with the information, support and services they need to make responsible decisions about their sexual health.

Sexual Activity among Teens Varies by Region.

- Premarital sexual intercourse is common and appears to be on the rise in all regions of the world.[1] Young people everywhere reach puberty earlier and marry later than in the past. As a result, youth are sexually mature for a longer period of time prior to marriage.[2]
- Youth's degree of sexual experience varies across regions, but is generally consistent within regions. Studies of female youth suggest that two to 11 percent of Asian women have had sexual intercourse by age 18; 12 to 44 percent of Latin American women by age 16; and 45 to 52 percent of sub-Saharan African women by age 19.[3] In developed countries, most young women have had sex prior to age 20-67 percent in France, 79 percent in Great Britain and 71 percent in the United States.[4]
- Among male youth, studies suggest that 24 to 75 percent of Asian men have had sex by age 18; 44 to 66 percent of Latin American men by age 16; and 45 to 73 percent of sub-Saharan African men by age 17.[3] In developed countries, most young men have had sex prior to age 20-83 percent in France, 85 percent in Great Britain and 81 percent in the United States.[4]
- Studies indicate same-sex sexual behavior among males throughout the world-among 13 percent of literate males in Lambayeque, Peru; 10 percent of males attending night school in Lima, Peru; six percent of university males in Dumaguete City, the Philippines; and 10 percent of STI clinic attendees in New Dehli, India.[3] In the United States, between 10 and 14 percent of males report having had sex with another male.[5] Forty percent of these men report the same-sex sexual behavior as occurring before age 18 and not since.[6]
- Youth's sexual activity is not always consensual. Some countries-such as Bangladesh, Brazil and Thailand-report that many children are forced into prostitution.[1] In the United States, studies suggest that about one in three young girls and one in six young boys may have experienced at least one sexually abusive episode before adulthood.[7]

Adolescent Pregnancy and Childbearing Is a Major Concern.

- Adolescent pregnancy and childbearing are associated with a range of outcomes detrimental to teens' health, including complications of pregnancy, illegal or unsafe abortion and death, especially in less developed nations.[8] When compared to women in their mid-twenties, women under age 15 are at 25 times greater risk of dying from complications related to pregnancy or childbirth; 15- to 19-year-old women are at twice the risk.[9]

Reprinted with permission from Advocates for Youth, 2003:
Salgado, A.M., and N. Cheetham. ©2003. The Sexual and Reproductive Health of Youth: A Global Snapshot. *Transitions 15(2).* Advocates for Youth.

- Although rates of adolescent childbearing are declining in many countries, 15 million women ages 15 to 19 give birth every year, 13 million in less developed countries.[1,2] Overall, 33 percent of women from less developed countries give birth before the age of 20-varying from eight percent in East Asia to 55 percent in West Africa.[1]
- In developed countries, up to 10 percent of women give birth by age 20, except in the United States, where up to 19 percent give birth by age 20.[1]
- Worldwide, mostly as a result of unintended pregnancy, nearly four and a half million adolescents undergo abortion each year; 40 percent occur under unsafe conditions.[9]

Contraceptive Knowledge and Use Vary by Region.

- While over 90 percent of teenage women in most countries in Asia, North Africa and the Near East and Latin American and the Caribbean knew at least one contraceptive method, in sub-Saharan Africa knowledge levels were generally lower. Teens who had not yet had sex were the least knowledgeable about contraception in every country except Nigeria.[8]
- While knowledge of contraception may be widespread, relatively few teenage women in most countries use contraceptives. Two percent of sexually active young women in Niger, Rwanda and Senegal reported using contraception; 23 percent in Cameroon; one percent in the Philippines; 34 percent in Indonesia; and less than 11 percent throughout Latin America and the Caribbean.[8] In some developed countries, most sexually experienced teenage women use hormonal contraception and/or condoms: 88 percent in France; 92 percent in Great Britain; and 75 percent in the United States.[4]

Barriers to Adolescent Sexual and Reproductive Health Remain.

- In most countries, adolescents face significant barriers to using contraception. Service-related barriers include incorrect or inadequate information, difficulty in traveling to and obtaining services, cost and fear that their confidentiality will be violated.[1,2,8,10]
- Personal barriers that especially deter young women from accessing and using contraception include fear that their parents will find out, difficulty negotiating condom use with male partners, fear of violence from their partner and concerns about side effects.[1,10,11]
- Social, cultural and economic factors also greatly influence young people's ability to protect themselves from unwanted pregnancy and STIs, including HIV. Mass media, materialism, migration and/or urbanization may increase both the desire and opportunity for sexual activity and many youth feel strong peer group pressure to engage in sexual intercourse.[1] Some cultures may promote early sexual intercourse by expecting women to marry and begin childbearing at an early age.[11]

Effective Programs Include Important Components.

Around the world, effective programs improve sexual health and promote healthy sexual decisions among young people. The following components are often included in effective programs:

- Accurate information and age-appropriate services that focus on behaviors [2,10,12]
- Youth friendly, confidential contraceptive services.[2]

- Culturally appropriate information and services.[2]
- Gender-specific information and services that address young women's needs and pay attention to their less than equal power status in many relationships.[13]
- Services geared specifically to the sexual health needs of young men[2]
- Peer education and outreach.[2]
- Activities to build skills in communication and negotiation.[2,10,12]
- Meaningful involvement by youth in programs' design and operation.[14]
- Involvement of parents and other community members.[14]

Many effective programs also provide integrated services to create an empowering environment for young people and to address their multiple needs.

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Handout 4D

Youth and the Global HIV/AIDS Pandemic

As the HIV/AIDS pandemic enters its third decade, HIV continues to spread rapidly. At least 95 percent of all new infections occur in less developed countries and sub-Saharan Africa is the hardest hit region, followed by the Caribbean.[1] Eastern Europe and central Asia experience the fastest growing HIV prevalence rates, while in eastern and southern Asia, the absolute numbers of infected people are staggering.[1] Finally, experts fear that rising rates of sexually transmitted infections (STIs) in developed nations may signal a rise in unsafe sex, especially among youth.[2] Throughout the world, almost 6,000 youth ages 15 to 24 are infected with HIV each day, accounting for more than half of all *new* HIV infections.[3] As a result, almost 12 million youth are living with HIV or AIDS; 62 percent of infected youth are female.[2,3]

Across the World's Regions, Youth Face Significant Rates of HIV Infection.

- In sub-Saharan Africa, most new HIV infections occur among people ages 15 to 24 and are sexually acquired. Nearly nine million youth are infected with HIV and 67 percent of infections occur in young women.[3] Prevalence rates exceed 20 percent in several countries in southern Africa and experts fear rates will rise in West Africa.[1,2]
- In Latin America and the Caribbean, about 560,000 young people are HIV-infected.[3] In Latin America (especially in Mexico, Brazil and Peru), marginalized populations-such as young men who have sex with men-are most affected.[1] In the Caribbean, infection rates are the second highest in the world and most new infections occur among women ages 15 to 24.[3]
- In southern and southeastern Asia, over one million youth are HIV-infected.[3] Initially fueled in Thailand and Cambodia by the sex trade and injection drug use, the epidemic has been successfully slowed in both countries. Now, India shows alarming increases in HIV/AIDS throughout its diverse population.[1,3]
- In eastern Asia and the South Pacific, nearly three-quarters of a million youth are HIV-infected.[3] Most new cases are in China, home to one-fifth of humanity, where UNAIDS warns of an "unfolding epidemic of proportions beyond belief."[1]
- Eastern Europe and central Asia have nearly half a million HIV-infected youth, mostly as a result of injection drug use. Rates are rising rapidly in Belarus, Kazakhstan, Latvia and Russia, as well as in the Ukraine, where one percent of young women and two percent of young men are now HIV-infected.[1,3]
- Rates remain low, though increasing, in North Africa and the Middle East. Over 160,000 youth in this region are infected.[3] Sexual intercourse and injection drug use are the major routes of transmission; and Djibouti and Sudan have large, widespread epidemics.[1,2]
- In developed nations, nearly a quarter of a million youth are HIV-infected.[3] Higher rates of sexually transmitted infections (STIs) signal a rise in unsafe sex and highlight the need for renewed prevention efforts, especially among youth.[2] Leading factors behind the epidemic vary-from injection drug use in Spain, France and Portugal, to heterosexual transmission in the United Kingdom, heterosexual transmission among disadvantaged women in the United States and sex between males in Japan, Canada, Australia and the United States.[1,2] Nevertheless, each of these factors-heterosexual transmission, injection drug use and sex between males-plays a part in the HIV epidemic in every industrialized nation.

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Young Women and Girls Are Especially Vulnerable in Sub-Saharan Africa and South Asia, but Young Men Are Also at High Risk in Many Regions.

- Of the 11.8 million HIV-infected youth worldwide, over seven million are female.[3] The risk of infection for young women is heightened by their immature vaginal tract and easily torn tissues. Young women are also at heightened risk due to their lower status in society, which decreases their ability to negotiate condom use and to cultural practices that encourage unions between younger women and older men, who are more likely to be HIV-infected.[1,3]
- In sub-Saharan Africa, female children and young women are especially vulnerable due to cultural practices, such as the "sugar daddy," and to a myth that an infected man can "cure" himself by having sex with a virgin. In Ethiopia, Malawi, Tanzania, Zambia and Zimbabwe, for every infected male, ages 15 to 19, there are five to six infected females the same age.[3]
- In some cities in India, there has been a worrisome increase in HIV infection among pregnant women.[1]
- HIV infection remains more common among young men than young women in industrialized nations, Latin America, Eastern Europe and central Asia and the Middle East and North Africa. In industrialized nations and in parts of Latin America and Asia, cases occur mostly among young men who have sex with men; in the other regions, cases occur mostly among young men who use injection drugs.[3]

Youth's Lack of Information, Skills and Access to Services Fuel the Epidemic.

- Around the world, the vast majority of youth have little understanding of HIV transmission or how to protect against it.[3] For example, in 2001 only 10 percent of 15- to 19-year-old females in Tajikistan and less than 60 percent in Azerbaijan and Uzbekistan, had ever heard of HIV/AIDS while as many as 98 percent harbored misconceptions about it.[2] In studies, 95 percent of female Nigerian teens and 93 percent of Haitian adolescents perceived their risk of HIV infection to be minimal or non-existent.[3]
- Some teens are unable to protect themselves because they lack the skills and power to negotiate abstinence or condom use. In some countries, young brides of older husbands may be even more vulnerable to HIV than are unmarried women. For example, in a study in India, 14 percent of young married women at one clinic were HIV-positive; 91 percent of them had sex only with their husband.[3]
- Finally, young people face serious obstacles to accessing medical care, including fear their privacy will not be respected, embarrassment, distance to services and health providers who are reluctant to serve adolescents.[3] In Dakar, Senegal, for example, young people visiting family planning clinics were told they were "too young" to receive contraception.[4]

Programs and Policies Can Help Young People Protect Themselves.

- In Brazil, concentrated campaigns led to increased condom use among young men having sex for the first time (up from less than five percent in 1986 to 50 percent in 1999).[3]
- In Kampala, Uganda, HIV prevalence among pregnant teens fell from 22 percent in 1990 to seven percent in 2000, mostly due to delayed first sex, fewer partners and increased condom use.[3]
- In Thailand, HIV incidence among young military recruits declined by 90 percent between 1991 and 1995, after the government adopted a comprehensive HIV/AIDS prevention campaign.[5]

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SESSION 5: HUMAN RIGHTS IN PROGRAMS AND SERVICES FOR ADOLESCENTS

OBJECTIVES

- Explore the human rights of adolescents.
- Identify the link between human rights and ASRH.
- Identify problems and solutions in ASRH human rights.
- Develop one strategy to address the human rights of adolescents.

DAY: 2 – **TIME**: 2 hours

MATERIALS

- Session objectives on flipchart (**FLIPCHART 5A**)
- Flipchart with the four cross cutting themes written on it (**FLIPCHART 5B**)
- List of questions from end of Step 1 written on flipchart (**FLIPCHART 5C**)
- Chart from Step 2 drawn on flipchart (**FLIPCHART 5D**)
- "Human Rights" written at the top of a large piece of flipchart and posted on the wall (**FLIPCHART 5E**)
- Flipchart and different color markers
- Sticky notes
- Masking tape

RESOURCES

- Cook, R. and B.M. Dickens. 2000. Recognizing Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Health Care. *International Journal of Gynecology and Obstetrics 70*:13-21. (**HANDOUT 14B**)
- Center for Reproductive Rights: Human Rights publications (**WEB SITE 5A**)
- Center for Reproductive Rights: The Reproductive Health and Rights of Adolescents (**WEB SITE 5B**)
- UN Convention on Eliminating all Forms of Discrimination against Women. (**WEB SITE 5C**)
- Convention on the Rights of the Child. (**WEB SITE 5D**)
- Summary of United Nation Agreements on Human Rights. (Including links to the documents) (**WEB SITE 5E**)
- Human Rights Web. (Listings and links to human rights organizations) (**WEB SITE 5F**)

PREPARATION

Become familiar with websites and print relevant material (optional). Most of these documents are free of charge and can be ordered weeks in advance of the training, so that all participants may have their own copy.

FACILITATING SESSION #5

STEP 1 *(1 Hour)*
DEFINING AND PERSONALIZING HUMAN RIGHTS

- Review the objectives of Session #5 on flipchart (**FLIPCHART 5A**).
- Remind participants that in this module, there are four cross cutting themes that will serve as the thread to weave all of the individual sessions together (**FLIPCHART 5B** & **HANDOUT 2D**). These themes are also identified as being the four keys to successful, thorough adolescent sexuality and reproductive health programs and services. The four themes are as follows:
  1. Human Rights
  2. Gender
  3. Adult/Youth Partnerships
  4. Sustainability
- Further explain that throughout the training participants will be asked to express the link between these four themes and ASRH. For example *How are youth/adult partnerships linked to sustainability? How is a human rights-based approach linked to gender equity?* (**HANDOUT 2D**)
- Explain that the first of the four themes to be unpacked and pursued is "Human Rights."
- Ask participants to close their eyes and think about the following questions. Be sure to ask slowly with a pause in between each question.
  1. What are human rights? What do rights or human rights mean to you? What do human rights mean to your family?
  2. Have your human rights ever been denied? When and how?
  3. Have you ever denied the human rights of others? When and how?
  4. Have you ever seen the human rights of a family member or loved one denied or abused? When and how?
  5. Do you remember the first time you exercised your human rights? When and how?
  6. Were your human rights ever denied as an adolescent or young person? When and how?
  7. Are the human rights of males and females different in your society? Why and how?
  8. Do adolescents have human rights? What are these human rights?
  9. Are there human rights that adults have that adolescents do not? What are they?
- Ask participants to open their eyes. Ask participants for the first thing that came to their mind when they thought of question #1, "What do human rights mean to you?". After a brief discussion, have participants develop a general working definition of human rights.

TALKING POINTS FOR THE TRAINER

Human Rights Background

The contemporary notion of human rights has its foundations in the 1945 United Nations' Universal Declaration of Human Rights. The UN declaration, written on the heels of two World Wars that saw violence against fellow human beings intensify on a global scale to new and unprecedented heights, established a conceptual framework for a global set of basic principles to which each and every person was entitled.

Although this landmark document has achieved wide acceptance of the principle that everyone is obligated to respect the rights of others, there is not universal agreement as to how those rights should be specified.

Traditionally, groups monitoring human rights violations worldwide (Amnesty International, Human Rights Watch, International Human Rights Law Group, Human Rights Network, etc.) have focused on incidents or policies needlessly causing loss of life, or serious harm to or disenfranchisement of citizens. Increasingly, though, other social, civil and economic rights are being articulated as human rights. Some of these include the right to literacy and an education, labor rights, reproductive rights, welfare rights and rights of access to the social system.

Working Definition of Human Rights

Some Examples of Human Rights Definitions

- "The basic rights and freedoms to which all human beings are entitled, often held to include the right to life and liberty, freedom of thought and expression and equality before the law." (American Heritage Dictionary)
- "Rights (as freedom from unlawful imprisonment, torture and execution) regarded as belonging fundamentally to all persons." (Meriam Webster Dictionary)
- "Rights that belong to an individual as a consequence of being human. They refer to a wide continuum of values that are universal in character and in some sense equally claimed for all human beings." (Encycolpedia Britannica)

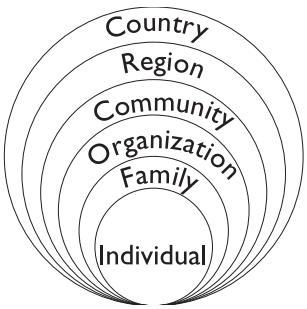
- Now ask the participants to stand and answer questions 2-9 again, this time with their feet. Participants will move far away from the Trainer if they answer YES to the question and close to the Trainer if they answer NO. The closer to the trainer the stronger the NO, the farther away from the trainer the stronger the YES. In between, is maybe. Now the Trainer asks questions 2-9, pausing after each question to ask the *when and how*.

- Now ask participants to form work subgroups, as were identified during Day 1 of the module. Ask each subgroup to respond to and discuss the following questions (**FLIPCHART 5C**):
  1. What basic human rights do adolescents/young people have? Do these differ according to age or marital status?
  2. How are these human rights denied at health clinics, community organizations, schools and homes?
  3. What are adolescents' sexual and reproductive rights?
  4. What is a human rights-based approach to ASRH?
  5. Does your organization utilize a human rights-based approach? How?
  6. What is your (individual and organizational) role in ensuring that adolescents are able to exercise their human rights?
  7. What decisions are adolescents empowered to make regarding their human rights? What decisions are adolescents denied regarding their human rights?
  8. What is the role of parents/guardians in relation to adolescents' human rights?

Step 2 *(1 Hour)*
FROM PROBLEM, TO SOLUTION, TO ACTION: ASRH RIGHTS

Concentric Circles

- The trainer asks the subgroups to report back to the large group regarding their responses to the first three questions. After each subgroup has had a chance to respond ask the large group to identify the most common human rights that are consistently denied to youth that are also related to ASRH. Assign each subgroup an example of a human rights denial to discuss. Each subgroup should address the following in their discussion:
  1. Instruct each subgroup to draw six concentric circles; one circle per topic {individual (these are the participants); family; organization (these are the participant organizations); community; region; country}
  2. Inside each circle the subgroup should write, in one color, how their assigned denial of a human right is influenced at the respective level. For example, how do the participants as individuals influence this denial; how does the family influence this denial, etc.? The first step and color represent the "problem". In a different color the subgroup will write a proposal as to how the assigned denial of a human right can be improved at each respective level The second step and color represent the "solution."
  3. Each group will present its concentric circle diagram to the entire group.



4. Post all of the concentric circle diagrams on the wall. Once all the groups have presented their diagrams, ask participants to walk around and review each one. While reviewing the problems and solutions of each group, ask participants to record in their learning journal one solution they feel could be implemented at one of the following levels: individual, family, organization, community, region, or country. Allow participants to write about their solution and to create a draft outline of how this change can be actualized. The following chart may assist them in their planning (**FLIPCHART 5D**):

Level on which I propose to act?	Problem	What is currently being done to address this area?	What needs to be done…	How do I propose to act?

5. Ask for volunteers to report on the problem/solution they identified and their draft outline for actualization.
6. Ask participants to summarize what was gained as a result of this session and how this links to ASRH.
7. Remind participants of a question that the trainer asked at the very beginning of the session: Are the rights of men/boys and women/girls different in your society? Why and how? This is one of many examples of how the cross cutting themes connect. (i.e. gender, human rights)
8. State the cross cutting themes again (**FLIPCHART 5B**):
   a. Human Rights
   b. Gender
   c. Adult/Youth Partnerships
   d. Sustainability

- Further explain that throughout the training participants will be asked to express the link between these four themes and ASRH. At this point a piece of flipchart will be posted on the wall with the word "Human Rights" across the top (**FLIPCHART 5E**). This flipchart will stay up during the entire training. As participants think of linkages between ASRH and human rights or linkages between human rights and other topics discussed s/he should jot them down on a sticky note and post it on the "Human Rights" flipchart.
- At this point the trainer explains to the participants the manner in which the four cross cutting theme flipcharts will be used. The following examples represent what might be appropriate to document on the four cross cutting themes flipchart as they are presented and throughout the training:
  1. A new idea gained. What have I learned about a specific cross cutting theme?
  2. What are my struggles and challenges within a specific cross cutting theme? (Something within this theme that the participant questions or struggles with).

3. What ideas do I have? Give examples of strategies, ideas and skills to offer in order to adequately and successfully address a theme as it relates to ASRH.
4. Participants will record connections between two or more cross cutting themes. For example, the appointment of youth to a health center Board of Directors is a strategy that links Youth/Adult Partnerships with Sustainability.

- Optional: Distribute relevant handouts from these web sites, or if ordered in advance distribute the actual documents (**WEB SITES 5A, 5B, 5C and 5D**).
- Review Session #5 objectives to ensure they were met (**FLIPCHART 5A**).

NOTE TO THE TRAINER

The discussion on human rights and ASRH rights will vary depending on the country or region where this module is implemented. The trainer will decide whether to facilitate this session as an activity that addresses general human rights of adolescents or sexuality and reproductive health rights of adolescents.

The trainer can also determine which government conventions or treaties the countries of the participants have signed/ratified. If a country has ratified CEDAW or CRC, for example, that can be a strong advocacy tool.

SESSION 6: YOUTH/ADULT PARTNERSHIPS

OBJECTIVES

- Define youth involvement and youth/adult partnerships.
- Identify youth as assets to ASRH programs.
- Identify how young people enhance efforts in ASRH programming.
- Identify strategies for promoting the partnering of young people and adults in ASRH programs and services.

DAY: 2 – **TIME**: 1 hour 50 minutes

MATERIALS

- Session objectives on flipchart (**FLIPCHART 6A**)
- Flipchart and markers
- "Youth/Adult Partnerships" written at the top of a large piece of flipchart and posted on the wall (**FLIPCHART 6B**)
- Index cards and markers
- Masking tape
- Handout on Discrimination of Youth (**HANDOUT 6A**)
- Handout on Hart's Level's of Participation (**HANDOUT 6B**)
- Handout on Assets/Obstacles of Involving Youth (**HANDOUT 6C**)
- Handout: "Youth Involvement in Prevention Programming" (**HANDOUT 6E**)
- Handout: "Youth-Adult Partnerships Show Promise" (**HANDOUT 6F**)

RESOURCES

- UNICEF. *The Participation Rights of Adolescents: A Strategic Approach*. Working Paper Series. UNICEF (**WEB SITE 6A**).
- Senderowitz, J. 1998. *Involving Youth in Reproductive Health Projects*. FOCUS on Young Adults (**WEB SITE 6B**).
- Klindera, K. and J. Menderweld. 2001. *Youth Involvement in Prevention Programming.* Issues at a Glance. Advocates for Youth (**WEB SITE 6C**).
- Sonti, S. and W. Finger. 2003. Youth-Adult Partnerships Show Promise. *YouthLens* 4. YouthNet (**WEB SITE 6D**).
- Norman, J. and K. Klindera. *Youth as Assets: Building Effective Youth-Adult Partnerships.* YARH Brief 3. FOCUS on Young Adults (**WEB SITE 6E**).
- YouthNet. *Youth Involvement Web sites* (**WEB SITE 6F**).

PREPARATION

Review the resource websites. Make copies of the appropriate handouts. Prepare materials. Invite and brief youth panelists (optional). Prepare a wall-sized version of Hart's ladder (see **HANDOUT 6B**).

FACILITATING SESSION #6

STEP 1 *(30 minutes)*
RAISING AWARENESS

- Review the objectives of Session #6 (**FLIPCHART 6A**).
- **FLIPCHART 6B**. Inform participants that Youth/Adult Partnerships is yet another cross cutting theme. Draw attention to the flipchart with "Youth/Adult Partnerships" written across the top.
- Begin the session by asking participants to remember a time in their adolescence when they wanted to participate in an activity and/or program but did not.
- Ask three or four participants to share their experiences regarding why they did not participate. Write down and classify the causes that limited their participation (values, attitudes of adults, the conditions of adolescents themselves, standards, etc.).
- Ask participants if they can think of further reasons why youth often do not engage in ASRH programs and services. Strongly emphasize that even when programs and services partner with youth, only certain types of young people are encouraged to participate while others remain on the sidelines. Ask the group for examples of this type of inequity. Record participants' responses on flipchart. Add the following list to the examples of inequity already mentioned by participants. Distribute handout on discrimination of youth to provide further examples (**HANDOUT 6A**).
    - Gender
    - Class
    - Age
    - Size
    - Ethnicity
    - Race
    - Nationality
    - Religion
    - Education
    - Language
    - Beliefs
    - Sexual orientation
    - Past history of trouble
    - Personal choices
    - Family
    - Ability
- Link these inequities to a young person's right to be involved. How might these be a violation of that right?
- Ask participants how ASRH providers can address these inequities and ensure that all youth are involved. Facilitate a discussion amongst the participants and have them identify one tangible strategy that has not already been discussed and can be taken away by participants to use within their own organizations (e.g. recruit youth who are not in school to be peer health educators). Give participants an opportunity to record this strategy in their learning journals.

STEP 2 *(30 minutes)*
WHAT IS INVOLVEMENT?

- Ask participants to write on index cards the various ways in which they involve youth in their organization. Each type of involvement should be written on a different index card.
- After participants have recorded the way in which they involve youth in their organizations, collect the index cards and have the participants sort them into similar categories (i.e. peer educators; board of directors; committee members; employees, etc.). Have participants code the index cards by placing a mark on the top right corner for each category (i.e. peer health educator is "P"; employee is "E"; Board Member is "B"; Committee work is "C", etc.). Have the groups make observations about the most common type of involvement. Collect the index cards and put aside for later.
- Post the prepared wall-sized illustration of the "Levels of Youth Participation" ladder on the wall. Reference this illustration while going over the steps of involvement in the continuum (ladder). These are: manipulation; decoration; tokenism; assigned but informed; consulted and informed; adult-initiated (shared decisions with youth); youth-initiated and directed; youth-initiated (shared decisions with adults). Distribute **HANDOUT 6B** for further clarification.
- Give the index cards back to the group. Allow participants to take the index cards that they created. Now ask participants to tape each index card on the illustration of the continuum where they feel it best fits. Explain that this is not a test or an assessment; this activity is simply to demonstrate the different ways youth are involved.
- After everyone has placed his or her individual index cards on the illustration of the continuum, discuss. Ask for observations. Return to the categories in which youth are involved (i.e. peer educators, board of directors, committee members, employees). For example, does the group see "P" cards all over the continuum, or just on one level? Based on where the index cards fall, ask questions such as: "Are all peer health education programs youth-initiated?" "Do all youth board members have equal decision making power as adults?"
- Emphasize that the continuum indicates that youth function at different levels and that not all youth will desire or have the skills to function at all levels. Some will be more successful when assigned to a task while others are able to initiate activities. The use of the continuum is to increase provider awareness of the extent to which youth are actually involved, versus tokenism or decoration. The goal is to move from "Non-participation" (manipulation, decoration, tokenism) to "Degrees of Participation".
- Have participants go to their learning journals and challenge themselves to pick one activity (one index card) to move up one rung. Have each participant pick one-activity card that they previously recorded and think of strategies as to how this card can be moved from a lower level on the continuum to a higher level of participation. Allow five minutes for this writing activity and then ask if anyone wants to share what he or she wrote.

STEP 3 *(30 minutes)*
ASSETS AND OBSTACLES

- Introduce the notion of **young people as active**. Ask the question: "Why do we want young people to participate in activities, interventions and strategies in ASRH programs and services?"
- What's in it for us (participants)? Why do we want to form partnerships with youth?

- Remind participants that at the conclusion of the activity on *Defining and Exploring the Concepts of Adolescence and Youth Adulthood* the trainers led a brief brainstorm on assets of youth.

TALKING POINTS FOR THE TRAINER

On a positive note…

Explain that in the field of ASRH, providers and clinicians sometimes view young people as walking problems and vulnerabilities. While there are specific health care needs and critical issues that impact adolescents and young adults, there are also key assets and attributes that youth have that keep them healthy and safe. Ask participants to turn to the person to their right and together identify all the triumphs and joys of adolescence and young adulthood. Ask the participants to think of as many examples as they can, perhaps recalling their own experience during this time of development. Then ask each pair to identify how youth workers, clinicians and providers can use these wonderful assets of youth as part of the process of ASRH programming and outreach.

- Ask participants to recall this conversation with their neighbor and to list some of the assets. Record on flipchart.
- Continue to expand on this list until ideas have been exhausted. Distribute **HANDOUT 6C** and add ideas from this handout to the generated list.
- Now that participants have identified a list of assets, distribute the worksheet "Guide to Identifying Assets/Obstacles of Youth/Adult Partnerships" (**HANDOUT 6D**).
- Ask participants to complete the worksheet. Allow 10 minutes for this process.
- Next, have the participants discuss their entries in small groups.
- Following the small group discussions, ask participants to share their ideas with the entire group. Record the obstacles on the board as they are mentioned.
- Ask participants if they can think of obstacles that have not been mentioned. Complete the exercise by listing obstacles that the participants did not mention, using **HANDOUT 6C** to augment the list.
- Ask the group to share ideas and strategies regarding how these obstacles have been confronted in their organization.

NOTE TO THE TRAINER

Trainers may choose to organize a panel discussion of youth involved in ASRH programs to talk about their experiences. This panel can include youth workers, peer health educators, youth board members, etc. Allow each panelist to give a brief five minute talk about what s/he does with the organization, how s/he got involved and how it has enriched and challenged his/her life. After each panelist has presented, allow the participants to ask questions. The panel should be moderated by a Trainer. The inclusion of a panel would fall in between Steps 3 and 4 and would add approximately 45 minutes to the session design.

STEP 4 *(20 minutes)*
ACTION

- Summarize all that has been covered thus far in Session #6. Ask participants to share successful experiences where youth and adults have partnered to deliver ASRH programs and services. Encourage the exchange of successful strategies, topics and curricula.
- Post the "Youth/Adult Partnerships" flipchart on the wall (**FLIPCHART 6B**). This flipchart will stay up during the entire training. As participants think of linkages between ASRH and "Youth/Adult Partnerships" or linkages between "Youth/Adult Partnerships" and other topics discussed s/he should write them down on a sticky note and post it on the "Youth/Adult Partnerships" flipchart.
- The following examples represent what might be appropriate to document on the four cross cutting themes flipchart as they are presented and throughout the training:
  1. A new idea gained. What have I learned about a specific cross cutting theme?
  2. What are my struggles and challenges within a specific cross cutting theme? (Something within this theme that the participant questions or struggles with).
  3. What ideas do I have? Give examples of strategies, ideas and skills to offer in order to adequately and successfully address a theme as it relates to ASRH.
  4. Participants will record connections between two or more cross cutting themes. For example, the appointment of young person to a health center Board of Directors is a strategy that links Youth/Adult Partnerships with Sustainability.
- Ask for volunteers to write down a number of strategies just shared by the group to be placed on the Youth/Adult Partnerships flipchart.
- Now ask if anyone is willing to jot down ideas regarding the connection between Human Rights and Youth/Adult Partnerships? Ask the volunteers to write down their ideas and place on the Youth/Adult Partnerships and/or Human Rights flipchart. The process of connecting the four cross cutting themes to ASRH and to each other has begun!
- Distribute other relevant handouts (**HANDOUTS 6E & 6F, WEB SITES 6E & 6F**) .
- Review Session #6 objectives to ensure they were met (**FLIPCHART 6A**).

Handout 6A

THE BASES ON WHICH YOUTH ARE DISCRIMINATED

sex (male or female)	education	disability
class (income and wealth)	language	amount of experience
past history of trouble	age	body size
looks	ethnicity	race
nationality	religion	being an orphan
political beliefs/affiliation	rural-urban	being new in the area
where you live	who you know	sexual orientation
previous pregnancies	wars/refugee status	occupation
family occupation	athletic ability	intellectual ability
disposition (quiet/shy)	illness (e.g. HIV+)	personal choices
gender	marital status	sexually active (or not)

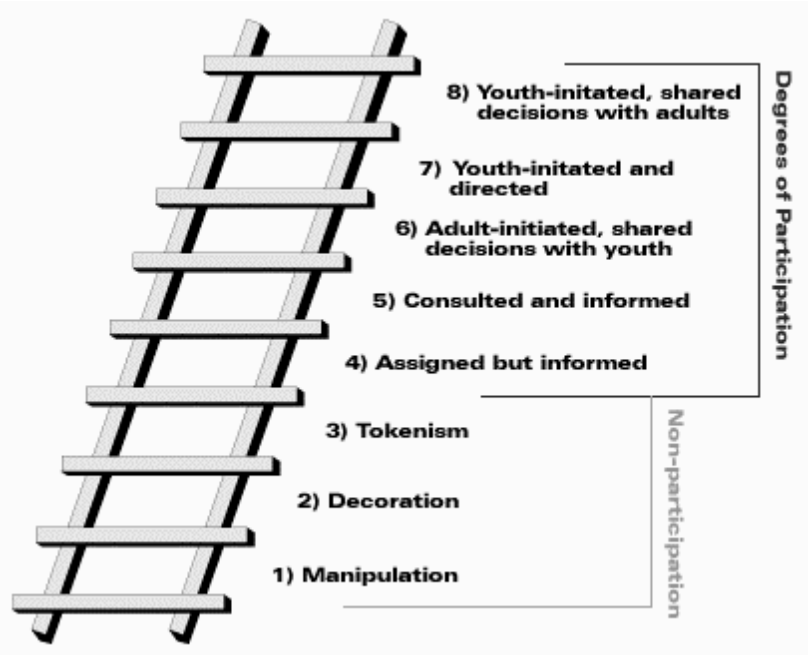
ADAPTED FROM:

UNICEF. *The Participation Rights of Adolescents: A Strategic Approach*. Working Paper Series. UNICEF.

Handout 6B

Levels of Youth Participation

A number of researchers and theorists have proposed models that describe levels of youth participation and involvement. For example, Roger Hart's Ladder of Participation (1992) describes eight degrees of youth participation, summarized below:



8. Youth-initiated, shared decision making with adults: Young people initiate and manage projects at the same level as the adults; shared decision making and shared program planning, adults serve as mentors;
7. Youth-initiated and directed: Young people design, implement and manage their own programs with limited or no adult involvement; adults serve as mentors;
6. Adult-initiated, shared decision making with youth: Adults initiate a project but share decision making equally with young people. Young people are considered key stakeholders in the project;
5. Youth consulted and informed: Projects are designed and run by adults, but young people understand the process, are consulted and their opinions are considered;
4. Youth assigned but informed: Projects are adult-initiated and run, but young people understand intentions, know who makes decisions and why, may have a meaningful role and participate in the project after they understand it;
3. Tokenism: Projects are adult initiated and run. Young people may be consulted, but are not provided opportunities for feedback or to shape agenda. Young people may not feel treated as stakeholders;
2. Decoration: Projects are adult initiated and run. Young people may have a limited understanding about events or activities but have no say in organizing, they may be present as front desk staff or their pictures appear on PR materials;
1. Manipulation: Projects are adult initiated and run. Young people have no understanding of issues behind actions, activities or events. Adults use young people, but do not consider them key stakeholders.

Source:
UNICEF. *The Participation Rights of Adolescents: A Strategic Approach*. Working Paper Series. UNICEF.

Handout 6C

Advantages and Obstacles to Involving Youth

1. ADVANTAGES TO PROGRAMS THAT PARTNER WITH YOUTH

- **Involving youth from the start can enhance a sense of ownership in the project.**
  If young people are brought into program design and decisions at the formation stage of a project, they feel more strongly that the project belongs to them.

- **Youth input can help ensure that programs are relevant to their needs.**
  Assessing the needs of the target audience is basic to the development of any project. It is perhaps more essential with programs for young people because of the importance of generational differences in styles, language, values and popular culture.

- **Youth can help identify messages, communication channels and activities popular in their subculture.**
  Language, slang and key messages change with the times, young people can help craft messages that will be age specific to the current moment. The age-sensitive and age-appropriate approach will lead to higher sustainability of programs, because youth will come to a program that speaks to them, in their language (youth cultural and age appropriate).

- **Youth can bring new and vital ideas to programs, along with high energy to carry out tasks.**
  Young people have great ideas and a lot of energy, especially when a safe place is created as not to inhibit their creativity.

- **Young people can effectively publicize program activities and help interest their peers in becoming program participants.**
  One of the best methods of publicity among young people is word of mouth, especially if the mouth giving the message is a young person, well respected among other youth.

- **Youth spokespersons can give credibility to the program and serve as an outreach link to the community.**
  Youth will often ask their peers if a program is credible, youth friendly, or age appropriate before checking it out. If youth have buy-in, feel involved, think the program is effective, they will tell their friends. This also assures sustainability. If you build an effective youth program, youth will spread the word and more youth will come.

- **Training and experience as peer educators enhance skills, self-esteem and leadership potential among those involved youth.**
  While behavior change of the group of young people targeted to receive peer education is usually the indicator sought by project managers, the much smaller group trained as peer educators appears to reap significant benefits. Remember the youth in our programs (our youth partners) are also benefiting.

- **Involving youth in present activities is an investment in the future**
  Assisting young people in their personal and professional development is useful for a society in general and it can also be viewed as a practical strategy within an organization. The young peer health educators or youth partners of today are the managers and directors of reproductive health programs, tomorrow.

Adapted from:
Senderowitz, J. 1998. *Involving Youth in Reproductive Health Projects*. FOCUS on Young Adults.

2. OBSTACLES AND ISSUES RELATED TO INVOLVING YOUTH

- **Youth involved in program decision making runs counter to most professional experience.**
  Adults have many biases and fears about working with young people. Some cultures or age groups are not accustomed to working with young people and may feel threatened by youth involvement or think that youth involvement takes away from the credibility of a program. They have doubts about successful outcomes. Their fears include that youth will find their work boring or they cannot master the needed skills.

- **Involving youth in programs requires additional training, staff time and costs.**
  Yes, additional resources will be needed to support youth involvement efforts, but the advantages and increase in sustainability will make the additional training pay off. Additional training is needed of managers and program coordinators who will work with youth. Additional training is needed of youth who will work with adults. This thorough training will yield positive outcomes and set all involved up for success.

- **Involving youth requires adjusting schedules to meet young people's needs.**
  Most young people are in school or at work during the day and are thus unable to participate in projects during typical working hours. As a consequence, preparation, monitoring, mentoring and implementation must take place at hours when young people can be available. Since the target group of young people has similar hours of availability, special scheduling would be required in any case.

- **High turnover of young people causes discontinuities and added costs.**
  Some turnover is an inevitable consequence of age. Young people involved in programs for youth eventually grow out of the appropriate age range. It is important for the organization to think of future opportunities (and training) for the youth once they work their way out of a job (age out).

Handout 6D

Guide to Identifying Assets/Obstacles of Youth Adult Partnerships

The purpose of this guide is to answer the following questions:

1. What assets do adults possess that would enhance ASRH programs and services?
2. What assets do young people possess that would enhance ASRH programs and services?
3. What keeps adults from pursuing a partnership with young people?
4. What keeps young people from pursuing a partnership with adults?
5. What will adults gain from a partnership with young people?
6. What will young people gain from a partnership with adults?
7. What institutional policies will encourage the partnering of youth with adults?

WHO	ASSETS	WHAT KEEPS THIS GROUP FROM PARTNERING WITH THE OTHER?	WHAT WILL THIS GROUP GAIN FROM PARTNERING?
Young People			
Adults			
Other			

Notes:

Handout 6E

Youth Involvement in Prevention Programming

That *young people gain more from an experience when they are actively involved* is a core premise of youth development/sexual health programming.[1] Research also suggests that programs for youth which are developed through a partnership of youth and adults may be highly effective in building young people's skills and reducing their sexual risk-taking behaviors. Such programs benefit the youth who help to develop them and also have a greater impact on the young people served.[2]

Too often, however, the attitudes of well-intentioned adults undermine effective youth involvement. Programs may involve young people merely as *token* representatives. Programs may involve youth without sufficient preparation of either staff or youth. Tokenism and insufficient preparation are both recipes for failure. Both youth and adults may have high expectations about successful cooperation. However, when planners put little time and effort into building the skills of both adults and youth to work in partnership or attempt to use young people in meaningless ways, efforts to involve youth will seldom succeed.

Genuine and effective youth involvement requires a serious commitment by an organization and all staff members. Adults who intend to involve and integrate youth meaningfully into prevention programs will need to examine the organizational structure and culture in which they work in order to identify and dismantle barriers to youth involvement. Moreover, staff must understand and accept that effective youth involvement in prevention programming often means changing rules and practices. For example, when government funding does not cover expenses for meals, young people are often unable to participate. Programs will then need to identify other funding sources to cover youth's expenses. Other typical changes might include redefining business hours, modifying meeting spaces and/or altering communication styles of involved adults and youth.

Benefits of Youth Involvement

Direct youth involvement offers potential benefits both to youth and to the organizations that serve them. To name but a few – youth gain experience and confidence; organizations gain a fresh perspective on youth culture; and organizations develop more effective outreach. However, organizations must clearly identify and articulate these benefits if youth and adults are to embrace the concept of youth involvement.[3]

Involving young people may provide an organization with the following benefits:

- Fresh ideas, unshackled by *the way things have always been done*
- New perspectives on decision making, including more relevant information about young people's needs and interests
- Candid responses about existing services

Reprinted with permission from Advocates for Youth, 2001:
Klindera, K., and J. Menderweld. ©2001. *Youth Involvement in Prevention Programming*. Issues at a Glance. Advocates for Youth.

- Additional data for analysis and planning that may be available only to youth
- More effective outreach that provides important information peer to peer
- Additional human resources as youth and adults share responsibility
- Greater acceptance of messages, services and decisions because youth were involved in shaping them
- Increased synergy from partnering youth's energy and enthusiasm with adults' professional skills and experience
- Enhanced credibility of the organization to both youth and advocates

Involving young people may benefit the young people themselves in these ways:

- Increased status and stature in the community
- Improved competencies and increased self-esteem
- Stronger skills and experience as leaders
- Greater knowledge and understanding of other cultures
- Increased self-discipline and schedule management
- Greater appreciation of the multiple roles of adults
- Broader career choices[4]

Involving young people can make a difference in program success. One example is the Project Northland Peer Participation Program, implemented in several school districts and adjacent communities in northeastern Minnesota. The program involved students in the planning and promotion of alcohol-free social activities in order to determine whether such participation is associated with reduced alcohol use among students. Evaluation demonstrated a positive correlation between student involvement in planning the activities and a lower rate of alcohol use among involved students as compared with uninvolved students. In addition, evaluation showed increased acceptance of alcohol-free events by the student population as a whole. This study suggests that involving teens in planning their own activities may be effective both in preventing or reducing alcohol use among involved youth and in changing attitudes among noninvolved youth.

Youth-Adult Partnerships

The essence of youth involvement is a *partnership* between adults and young people. Effective youth/adult partnerships work toward solving community problems. Working partnerships also acknowledge the contributions of all participants – youth and adults. In theory, creating such partnerships sounds good and makes a lot of sense, but putting such partnerships into practice is not always easy.

Power dynamics, usually rooted in cultural norms, may make it difficult for young people and adults to feel comfortable working together. Years of formal instruction in school often teach young people to expect answers from adults. Some youth expect their own ideas to be largely ignored, derided, or vetoed. Adults frequently underestimate the knowledge and creativity of young people. Adults are also accustomed to making decisions without input from youth, even when youth are directly affected by those decisions. Therefore, joint efforts toward solving problems can be difficult, requiring deliberate effort on the part of both adults and young people.

One researcher developed the 'Spectrum of Attitudes' theory and identified three different attitudes that adults hold toward young people.[4] These attitudes affect adults' ability to believe that young people can make good decisions. These attitudes also determine the extent to which adults may be willing to involve young people as significant partners in decisions about program design, development, implementation and evaluation. The three attitudes represent seeing 1) youth as objects, 2) youth as recipients, or 3) youth as partners.

Youth as Objects – Adults who have this attitude subscribe to the myth of adult wisdom. They believe adults know what is best for young people. They attempt to control situations in which young people are involved. They believe that young people have little to contribute. Further, they may feel the need, based on their own prior experiences, to protect young people from suffering the potential consequences of mistakes. Adults who see youth as objects seldom permit more than token youth involvement and usually have no intention of meaningfully involving youth. One example might be an adult writing a letter to an elected official about an issue pertinent to youth and using a young person's name and signature for impact.

Youth as Recipients – Adults who have this attitude believe that adults must assist youth to adapt to adult society. They permit young people to take part in making decisions because they think the experience will be good for them and assume that youth are not yet "real people" and need practice to learn to "think like adults." These adults usually delegate to young people trivial responsibilities and tasks that the adults do not want to undertake. Adults who see youth as recipients usually dictate the terms of youth's involvement and expect young people to adhere to those terms. One example might be adults extending an invitation to one young person to join a board of directors otherwise comprised solely of adults. In such a milieu, a young person's voice is seldom raised and little heard. Adults do not expect the young person to contribute and the young person knows that adults deliberately retain all power and control.

Youth as Partners – Adults who have this attitude respect young people and believe that young people have significant contributions to make now. These adults encourage youth to become involved and firmly believe that youth involvement is critical to a program's success. These adults accept youths having an equal voice in decisions. They recognize that youth and adults both have abilities, strengths and experience to contribute. Adults who have this attitude will be as comfortable working with youth as with adults and enjoy an environment with both youth and adults. Adults who see youth as partners believe that genuine participation by young people enriches adults just as adult participation enriches youth and that a mutually respectful relationship recognizes the strengths that each offers. One example might be hiring a young person to participate from the beginning in developing a proposal to be submitted to a funding institution.

An excellent example of youth being viewed as partners is the Pennsylvania Youth Adult Roundtable implemented by the HIV Prevention Community Planning Group in Pennsylvania. This program, sponsored by the Department of Health, encourages youths' input into a statewide planning process that prioritizes programs for HIV prevention funding. Throughout the state, seven groups of youth in high risk situations meet quarterly to discuss current prevention efforts targeted at young people and to offer ideas for future prevention efforts. Participants receive both a stipend and a free meal. At each roundtable, adult and youth facilitators set agendas, lead meetings and promote dialogue among those attending. Clearly, the role of young people is equal to that of adults in this process. Adults and youth are working in partnership to develop the statewide plan.

Making Youth Involvement Work

To make youth involvement work, good intentions are not enough. Adults who endorse the concept of youth/adult partnerships must be willing to identify and alter the organizational environment where institutional barriers can be especially significant. Institutional barriers that make genuine youth involvement difficult include:

- **Hours for Meetings and Work** – An agency's hours of operation usually coincide with times when young people are at school or work. To engage youth, program planners must find nontraditional times at which to hold important meetings. Often, the conflict between adults' and youths' schedules can be difficult to overcome. However, compromise is necessary if an organization is to enjoy genuine youth involvement. For adults, this may mean holding meetings in the late afternoon or evening or on weekends. For youth, this may mean using the school community service hours to attend daytime meetings.
- **Transportation** – Many young people do not have personal vehicles. Program planners should schedule meetings in easily accessible locations and should provide travel vouchers or promptly reimburse youth for transportation costs.
- **Food** – Few young people have the income to purchase meals in business districts or dinners in restaurants. When meetings occur at meal times, organizations should provide young people either with food or with sufficient funds to pay for meals.
- **Agency Staff and Policies** – In agencies that have always operated from an exclusively adult perspective, staff usually needs cultural competency training prior to involving youth meaningfully. Staff must accept young people's perspectives and ideas and be willing to change rules to meet the needs of youth. Agencies should provide young people, even those who are part-time, with the same equipment provided to other employees, such as computer work station, mailbox, voice mail, E-mail and business cards. Each organization and its staff must make determined efforts to let each young person know he/she is a valued, contributing member of the organization. Finally, with input from both youth and adults, organizations should develop policies on youth/adult interactions. For example, if a program involves overnight travel, youth and adults should be clear about their roles and responsibilities in traveling together. Policies must respect youth and their desire for independence and, at the same time, address parental concerns about security as well as the legal liability of the organization.

Elements of Effective Youth Involvement Programs

Research suggests successful youth involvement programs share important elements that include the following:

- Young people make significant decisions. They identify issues of importance, develop plans of action and write proposals to fund and implement those plans.
- Young people have opportunities to gain knowledge and develop new skills as a result of their involvement.
- The organization undertakes meaningful activities to address the issues and needs of young people in the community and does not contrive activities to give youth practice at being adults.
- Youth and adults have opportunities to explore what each brings to the table. They also have opportunities to express what they need and expect from the other. In this way, each begins to recognize and value the positive contributions of the other.

- Young people and adults have collegial relationships, partnerships focused on common goals. Neither young person nor adult is necessarily subordinate to the other.
- The organization allocates resources to involving youth.
- Young people experience opportunities to achieve successes and to know that they make a difference. Young people develop feelings of self-efficacy.
- Equal numbers of young people and adults comprise advisory boards, councils and committees.
- Young people and adults experience synergy and believe that they can accomplish more together than they could alone.
- Activities occur in a genuine community rather than in an artificial one created for practice. Activities focus neither on the individual nor on the organization.
- Young people have regular opportunities to reflect on their work.

It is work to achieve meaningful youth involvement in programs that target youth and it is not easy work. However, the benefits are enormous for young people and for organizations that care about young people. When youth and adults keep the potential benefits in mind, they will find that the work is worthwhile and it may be easier than they thought it would be.

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[3] Centers for Disease Control and Prevention. *The Prevention Marketing Initiative: Youth Involvement.* Washington, DC: U.S. Dept. of Health & Human Services, 1997.

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YOUTH-ADULT PARTNERSHIPS SHOW PROMISE

While youth are increasingly included in the design and implementation of interventions targeted at them, adults in youth-serving organizations have made fewer efforts to involve youth in policy, management and evaluation issues. Anecdotal evidence on the value of including youth perspectives in these more challenging areas is beginning to emerge.

For example, at the XIV International AIDS Conference in Barcelona, Spain, in July 2002, the Barcelona YouthForce showed how a youth-adult partnership could help affect policy, making youth a higher international priority in HIV prevention efforts. The alliance of some 150 youth and 50 adults from around the world sponsored press conferences and a satellite session, hosted networking sessions for youth, published an on-site newsletter and led public awareness efforts with stickers and t-shirts.

"For the first time at an international HIV/AIDS conference, young people are raising their voices and demanding to be heard as key participants in the fight against HIV/AIDS," reported the official conference newsletter, AIDS 2002 Today, in regard to the YouthForce. And, at the closing conference plenary, in a speech reported widely around the world, former U.S. President Bill Clinton said, "The YouthForce… [is an example] of what we have to have more of if citizens will take ownership of this fight."

Coordinating the project were YouthNet and Advocates for Youth (adult-led groups) and the Student Global AIDS Campaign and Youth Against AIDS (youth-run projects), with funding from the U.S. Agency for International Development and the U.S. Centers for Disease Control and Prevention.

Why create youth-adult partnerships?

Increasingly, donors and nongovernmental organizations involved in HIV prevention and reproductive health issues are attempting to make young people a more prominent part of programming. Youth "should be involved from the start as full and active partners in all stages from conceptualization, design, implementation, feedback and follow-up," advises the World Health Organization.[1]

In the reproductive health and HIV/AIDS fields, information about the impact of youth-adult partnerships is limited. But literature from related fields indicates that involving young people in programs helps them form higher aspirations, gain confidence, attain resources, improve skills and involvement can also foster resilience by giving youth opportunities to contribute to family or community.[3] It can enhance their social competence, problem-solving skills, autonomy and a sense of purpose.[4] It can also help young people be more open to learning, engage in critical dialogue, exercise creativity and take initiative.[5]

Regarding the impact of these partnerships on adults, a U.S. study examined organizations in which youth had such decision making roles as advisory board members, staff members, peer educators and program planners. Interviews and focus group discussions with young people and adults from 31

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Sonti, S. and W. Finger. 2003. Youth-Adult Partnerships Show Promise. *YouthLens* 4. YouthNet.

organizations showed that adults began to view youth as competent individuals who contributed to the organizations rather than simply as recipients of services. The energy of youth also enhanced adults' commitment to the organizations and ability to work collaboratively.[6]

Tools for partnerships

One widely used conceptual model for youth-adult partnerships is known as the "Ladder of Participation," developed by Roger Hart, where the bottom rung represents the lowest level of partnership, such as having a young person play a token, inconsequential role. The higher rungs represent more substantial partnerships between youth and adults.[7] Programs can use various tools to develop partnerships further up the ladder. Substantial partnerships at the local programming level include peer education projects, youth-led clubs and sports teams and youth-run newspapers. Little research exists on the impact of such efforts, with the exception of peer education.

Peer programs recruit and train a core group of youth to serve as role models and to provide information, referrals to services and contraceptives to their peers. Adults provide training, supervision and, ideally, mentoring and support.[8] In Peru, a peer program in six cities resulted in improved knowledge and attitudes, a reduction in the proportion of sexually active males and increased contraceptive use at most recent intercourse.[9] A peer program in Cameroon called Entre Nous Jeunes resulted in improved knowledge about contraception and symptoms of sexually transmitted infection and increased condom use.[10]

In a program in Nigeria and Ghana called the West African Youth Initiative, youth worked as reproductive health peer educators and in other related activities such as program planning, design, implementation and evaluation. The proportion of sexually active youth reporting use of a modern contraceptive increased significantly in the intervention area (from 47 percent to 56 percent) during two years between baseline and follow-up data collection, compared to a slight decrease in the control area (3,500 youth surveyed). The intervention also had a marked impact on youths' reproductive health knowledge, willingness to buy contraceptives and ability to use contraceptives. The changes were most pronounced among in-school youth, with weaker findings for those out of school.[11]

Other studies report that peer programs tend to benefit primarily the peer educators themselves, not their peer contacts. An FHI study of 21 peer programs found that most peer educators reported changes in their own behaviors as a result of their involvement. Thirty-one percent said they were practicing safer sex, including using condoms and 20 percent said they had reduced the number of partners.[12] While such findings are encouraging, "interventions that influence only the behaviors of small numbers of peer educators are not sufficiently cost-effective to justify carrying them out on a large scale," reports the FOCUS on Young Adults Program.[13]

Anecdotal evidence suggests that youth-led clubs, sports teams and newspapers can be effective in reaching youth and in achieving changes in youth and adults involved. The Mathare Youth Sports Association (MYSA) in a slum area of Nairobi, Kenya, offers reproductive health education while operating football teams, garbage collection and other community projects. "Founded on principles that were carefully formulated by the youth themselves, the office uses the skills of [youth] members to carry

out management duties and utilizes a bottom-up structure for decision making," explains a report on MYSA, which summarizes its successes in athletics, environmental improvement, health and education. "One of the keys to MYSA's success is that it treats the skills and ideas of youth as its strongest resource."[14] A youth-run newspaper in Kenya called *Straight Talk* also shows how a youth-led editorial board can respond to questions from youth with a candor and connection that makes the paper widely popular in school clubs throughout the country. Adult partners work with these projects, allowing youth to make decisions and providing assistance where needed.

Youth involvement at the management level has begun to move beyond local projects such as those in Kenya to a broader institutional level. The International Planned Parenthood Federation now has a substantial number of youth on its board of directors, for example. A growing number of organizations working globally, such as YouthNet and Advocates for Youth, have made a commitment to having young people on their permanent staff and linking interns in a two-way mentoring program. Groups such as the Women's Commission for Refugee Women and Children are also incorporating youth into evaluations of projects. "The full participation of young people in our program has definitely enhanced the quality and relevance of our work," says Hally Mahler, youth participation coordinator for YouthNet.

Involving youth in reproductive health and HIV programs can assist the programs themselves, increasing credibility, visibility and publicity, according to several studies.[15] Also, youth can be visible ambassadors for programs and organizations, making presentations before national legislative bodies and working with policy makers, as in the case of the Barcelona YouthForce.

As youth-adult partnerships gain more attention and support, more rigorous research and conceptual models will evolve. YouthNet is developing several tools to assist organizations in building such partnerships, including a youth involvement institutional assessment tool and a curriculum on training staff in youth-adult partnerships. For guidance on thinking about youth-adult models, see "Elements of Effective Youth-Adult Partnerships".

Elements of Effective Youth-Adult Partnerships

Organizational Capacity

- Establish clear goals, expectations and responsibilities for youth and adults.
- Ensure commitment to youth-adult partnerships from all levels of organization.
- Provide support for youth through mentorship and skills-building opportunities.
- Ensure that mentors have time, energy and resources to supervise youth adequately.
- Ensure flexible meeting times for youth and provide free food or transportation if necessary.
- Monitor needs of youth and adults regularly.

Attitude Shift

- Address misconceptions and biases that youth and adults have about each other.
- Be open to changing attitudes and building skills in working with youth and adults.
- Be aware of different styles of communication.
- Value the skills and experiences of both youth and adults.

- Use training to diminish stereotypes and facilitate collaboration.

Selection, Recruitment and Retention of Youth

- Recognize differences among youth (i.e., age, gender, education, ethnicity) and how these issues affect one's contribution.
- Clarify which types of youth are needed and how they will be involved.
- Make an effort to include youth in special circumstances (i.e., younger youth, those living with HIV/AIDS).
- Support youth in balancing school, work and family commitments.
- Recognize that youth "age out" and develop an ongoing system for recruiting younger participants as well as roles for older youth as allies.

Level of Participation

- Assess the current level of youth participation in the organization.
- Determine ways that youth can be involved meaningfully and integrally.
- Ensure that youth are involved in all stages and levels of an organization.
- Avoid tokenism.
- Ensure that youth have ownership and influence in decision making.

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SESSION 7: GENDER[23]

OBJECTIVES

- Define gender and gender role expectations.
- Identify ways in which gender affects the sexual and reproductive health of adolescents.
- Develop one strategy to incorporate gender into ASRH programs and services.

DAY: 2 – **TIME**: 2 hours

MATERIALS

- Session objectives on flipchart (**FLIPCHART 7A**)
- Flipchart with the word "Gender" written at the top for definition exercise (**FLIPCHART 7B**)
- Definition of sex (STEP 1) on flipchart (**FLIPCHART 7C**)
- Definition of gender (STEP 1) on flipchart (**FLIPCHART 7D**)
- STEP 2 "incomplete sentences " on flipchart (**FLIPCHART 7E**)
- "ASRH" written on flipchart and circled (STEP 3) (**FLIPCHART 7F**)
- "Gender" written at the top of a large piece of flipchart and posted on the wall for cross cutting theme exercise (**FLIPCHART 7G**)
- Handout on Gender Definitions (**HANDOUT 7A**)

RESOURCES

- Canadian International Development Agency (CIDA). 1999. *CIDA's Policy on Gender Equality*. Quebec: CIDA (**WEB SITE 7A**).
- Organization for Economic Cooperation and Development (OECD). 1998. *DAC Guidelines for Gender Equality and Women's Empowerment in Development Co-operation*. Paris: OECD (**WEB SITE 7B**).
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PREPARATION

Prepare flipcharts and handouts.

[23] This session is based on materials from: CEDPA. 2000. *Gender, Reproductive Health and Advocacy, A Trainer's Manual*. The CEDPA Training Manual Series. CEDPA

FACILITATING SESSION #7

STEP 1 *(30 minutes)*
DEFINING SEX & GENDER

- Review the objectives of the session on flipchart (**FLIPCHART 7A**).
- Post a piece of flipchart with the word "gender" written at the top (**FLIPCHART 7B**).
- Invite the group to come up and decorate the flipchart, by writing words, definitions and pictures that define the word "gender".
- Ask the group to comment on themes, definitions, etc. Ask the group for clarification on terms, pictures, etc.
- Ask the group to identify the difference between the terms sex and gender.
- Offer definitions of gender and sex (see below):

  SEX (**FLIPCHART 7C**):

  What? Biological (penis, vagina, breasts, testes, ovaries, etc.)

  Who defines sex? Universal – sex (male or female) is defined the same throughout the world.

  When? Something one is born with. Can it be changed? Generally unchanged, except for in the case of male-to-female or female-to-male surgery.

  Generally, **does not vary**.

GENDER (**FLIPCHART 7D**):

What? Socially constructed roles, responsibilities and behaviors and the power associated with these roles. Culturally defined notions of "maleness" and "femaleness".

Who Defines Gender? Elements related to gender vary within and between cultures.

When? Gender roles, expectations and gender identity are learned behaviors starting at birth.

Can it be changed? Gender constructed roles, responsibilities and behaviors can change over time.

Varies within and between cultures.

STEP 2 *(30 minutes)*
EXPLORING GENDER ROLES AND EXPECTATIONS

- Display the following incomplete questions on a flipchart: (**FLIPCHART 7E**)

  In my culture
  - Men are expected to…
  - Men are discouraged from…
  - Women are expected to…
  - Women are discouraged from…
- Ask the group to respond to these questions in their learning journals. Give participants time to complete this task. Now bring participants back to analyze and process the activity. Record the responses to the four questions above on four separate pieces of flipchart.
- Ask the participants for their observations.

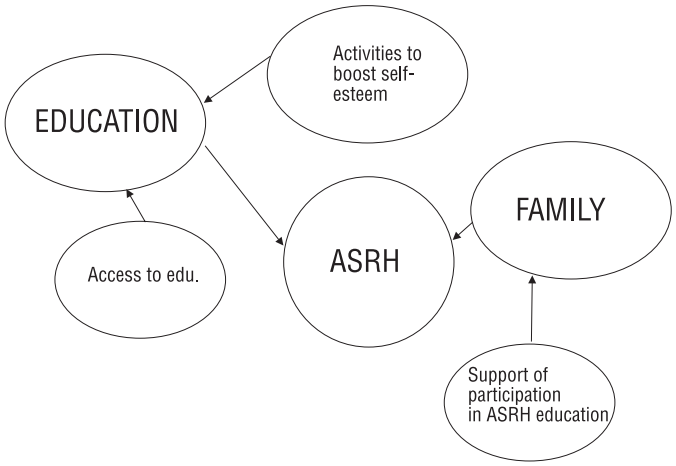
- Ask the participants to identify how these expectations relate to power and how they may affect future opportunities for men and women. Circle in RED responses GIVING power, expectations that reflect power or expectations that might improve future opportunities for that individual. Circle in YELLOW responses INHIBITING power, expectations that reflect an absence of power, submissiveness or expectations that might inhibit future opportunities. Now take a look at where the red and yellow circles are. Use the example of power imbalances (red vs. yellow) to discuss gender inequity.
- Ask participants: "Based on these roles and expectations, who (males or females) seems to have greater potential to achieve sufficient power and control over their own life and their own sexual and reproductive health?"
- Discuss the implications of these inequities for ASRH.

TALKING POINTS FOR THE TRAINER

1. For example, if girls are expected to dress sexy but discouraged from learning about sex, they may find themselves in sexual situations where thay are unsure of what to do or unable to control the outcome of the situation.
2. If boys are expected to be macho but discouraged from showing their feelings, they may find violence to be the only acceptable way to express their emotions. Also, because of this macho gender role they may feel pressured into early sexual onset in order to prove their manhood.
3. If girls are taught to be passive and submissive, while boys are taught to be aggressive, girls are less likely to negotiate no sex or safer sex so as not to "offend" or upset their partners.

STEP 3 *(1 hour)*
GENDER AND HOW IT RELATES TO ASRH SERVICES

- Write "ASRH" in the center of a blank flipchart and circle (**FLIPCHART 7F**).
- Ask the group to identify factors that impact or affect ASRH. Urge participants to be specific. If, for example, a participant says "family" ask for the specific family issues that impact ASRH.
- Record participants' feedback by drawing new circles and then draw a connecting line from these circles to the middle circle, ASRH.



- Encourage as many factors and links as the group can generate.
- Ask participants to think of gender inequities, whether in terms of opportunities or impact (see Step #2) and to identify which circles or factors are impacted by gender and equity. Ask participants to offer specific examples and record them next to the circles.
- For example, beside "access to education" might be a gender inequity showing that often boys are given preferential treatment in schools. An example beside "support of participation in ASRH education" might show that in some cultures the parents place the burden of reproduction solely on the girl, leaving males ignorant of these issues and therefore at risk for reproductive health problems.
- Ask if there are circles that participants wish to add that have not been previously mentioned. It is suggested that the trainer add the circle "Gender Based Violence (GBV)." (This can include sex trafficking, rape, incest, domestic violence, pornography, transactional sex, child brides, etc.) Ask participants where this circle (GBV) should go? Is GBV encouraged by family? Culture? Education? Religion? It is likely that GBV is impacted, at least partially, by all the circles. Ask participants to help the trainer(s) identify how GBV impacts ASRH? For example, victims of incest and child sexual abuse may be more likely to engage in risky behavior in their subsequent sexual relationships. Girls may refuse to question boyfriends about condom use or other sexual partners if they fear violence will be the response.
- Next ask the participants to form groups of three to four people each. Ask these small groups to pick an area of GBV (sex trafficking, domestic violence, transactional sex, child brides, etc.) they wish to tackle. Then choose a factor that impacts ASRH (one of the circles) previously identified by the group. For example, a group may pick child brides and family. Next the small group identifies an intervention, strategy, or program that would address their GBV topic (child brides), within the area (family) they picked as having an influence on GBV. For example, the village chief or influential leader could take a stance on disapproving of child brides and charge a high tax to fathers who sell their girls off into marriage before a certain age.
- Allow small groups to present their strategies.
- Link the session to human rights.

TALKING POINTS FOR THE TRAINER

Many of the issues discussed in this session are not only gender issues but are also violations of rights guaranteed in numerous international conventions and agreements.

- Explain that "Gender" is one of the four cross cutting themes and participants will be encouraged to draw a correlation between gender and other areas of ASRH. Inform participants that the first link to be posted on the Gender poster will be the circle activity they just completed.
- Distribute list of gender terms (**HANDOUT 7A**).
- Review Session #7 objectives to ensure they were met (**FLIPCHART 7A**).

Trainer remember: Each evening ends with 15 minutes of Community Time (Evening Announcements & Evaluation).

Handout 7A

Gender Definitions

Gender: Gender refers to the economic, social, political and cultural attributes and opportunities associated with being male or female…. The nature of gender definitions (what it means to be male or female) and patterns of inequality vary among cultures and change over time. (OECD, 1998)

Gender refers to the socially constructed roles and responsibilities of women and men. The concept of gender also includes the expectation held about the characteristics, aptitudes and likely behaviours of women and men (femininity and masculinity). These roles and expectations are learned, changeable over time and variable within and between cultures. (CIDA, 1999)

Gender Perspective: A gender perspective is a theoretical and methodological approach that permits us to recognize and analyze the identities, viewpoints and relations, especially power relations influenced by gender systems. A gender perspective allows providers to go beyond focusing on women to view reproductive health as family health and as a social issue. It addresses the dynamics of knowledge, power and decision making in sexual relationships, between providers and clients and between community or political leaders and citizens. (Paulson, et al., 1999) (Paulson, 1998)

Gender Equity: Gender equity is the process of being fair to women and men. To ensure fairness, measures must often be available to compensate for historical and social disadvantages that prevent women and men from otherwise operating on a level playing field. Equity leads to equality. (CIDA, 1999)

Gender Equality: Gender equality requires equal enjoyment by women and men of socially-valued goods, opportunities, resources and rewards. (OECD, 1998)

Sources:

Canadian International Development Agency (CIDA). 1999. *CIDA's Policy on Gender Equality*. Quebec: CIDA.
Organization for Economic Cooperation and Development (OECD). 1998. *DAC Guidelines for Gender Equality and Women's Empowerment in Development Co-operation*. Paris: OECD.
Paulson, S. 1998. Opinion: Gender Insights Can Improve Services. *Network* 18(4). FHI.
Paulson, S., Gisbert, M. and M. Quinton. 2000. *Rethinking Differences and Rights in Sexual and Reproductive Health: A Training Manual for Health Care Providers*. FHI.

SESSION 8: SUSTAINABILITY

OBJECTIVES

- Define sustainability.
- Identify sustainability as an essential component of ASRH programs and services.
- Develop strategies for sustainable development of ASRH programs and services.

DAY: 2 – **TIME**: 2 hours

MATERIALS

- Session objectives written on flipchart (**FLIPCHART 8A**)
- Flipchart with "Sustainability" written across the top (**FLIPCHART 8B**)
- Handout on definitions of sustainability (**HANDOUT 8A**)
- Handout of the PROFAMILIA/Colombia case study on sustainability (**HANDOUT 8B**)
- Handout with examples of sustainability (**HANDOUT 8C**)

PREPARATION

Optional: Invite and prepare guest presenters for Step #4.

FACILITATING SESSION #8

STEP 1 *(30 minutes)*
RAISING AWARENESS

- Review Session #8 objectives (**FLIPCHART 8A**).
- Post a piece of flipchart with the word "Sustainability" written at the top (**FLIPCHART 8B**).
- Invite participants to add to the flipchart by writing words associated with their understanding of "Sustainability".
- Ask the group to comment on the words associated with sustainability.
- Offer a definition of sustainability (**HANDOUT 8A**).
- Ask the group to distinguish between institutional, financial and programmatic sustainability:
  1. What characteristics make an organization sustainable?
  2. What characteristics and conditions make an activity financially sustainable?
  3. What characteristics make an activity programmatically sustainable?

STEP 2 *(20 minutes)*
EXPLORING SUSTAINABILITY

- Form three groups based on institutional, programmatic and financial sustainability of ASRH programs and services.
- Have them discuss ideas on sustainability for ASRH that have been or could be developed based on the participants' experiences with programs and services.

STEP 3 *(30 minutes)*
SUSTAINABILITY AMONG MULTIPLE SETTINGS

- Ask the groups to share the ideas they developed in Step 2. Provide feedback to the participants and ask questions to supplement the discussion.
- Emphasize strategies that address sustainability among a variety of cultural contexts, organizations (public, private and NGOs), participants, programs, services and management styles.
- Emphasize that increasing sustainability is critical in any environment or context.

STEP 4 *(30 minutes)*
PROPOSALS

- Ask participants to discuss their personal experiences with sustainability.
- Based on the participants' responses, identify and make specific suggestions to help ASRH program managers address sustainability more effectively.

NOTE TO THE TRAINER

To complement this activity, trainers can invite guests to discuss programs and services that successfully incorporate sustainability strategies. (This may include expertise from one or more of the participants.)

Another option is to have a panel discussion on institutional, programmatic and financial sustainability.

- Introduce the idea of establishing partnerships within private and public sectors, as well as with NGOs as a way to share costs, generate income and obtain discounts and products.
- Focus the discussion on the various types of sustainability and their impact on quality in the delivery of sexual and reproductive health programs and services.
- Present various options and suggestions to improve the sustainability of ASRH programs and services, including payment for services and donations.
- Recognize challenges for ASRH sustainability.
- Use the Profamilia/Colombia example as the basis for further discussion of payment for services and products (**HANDOUT 8B**).

STEP 5 *(10 minutes)*
CLOSING ACTIVITY

- To close Session #8, briefly discuss that the issue of sustainability is a critical component of the module, which will be explored further in subsequent sessions.
- Remind participants that sustainability is one of the four cross cutting themes. Display the sustainability cross cutting theme flipchart and encourage participants to link sustainability to other topics covered in the module thus far (**FLIPCHART 8B**).

TALKING POINTS FOR THE TRAINER

1. Link to gender: Gender differences in access to economic resources will enhance or limit access to services. If a young woman does not have access to financial resources she may not have money for transportation to the clinic, to pay for the services or to purchase contraceptives.
2. Link to rights: Sexually active adolescents wishing to exercise their right to contraception will not be able to do so in the absence of a sustained, low-cost or no-cost contraceptive supply.
3. Link to youth participation: Adolescents are more likely to use services when they have participated in designing, implementing and evaluating the programs and services. This also enhances programmatic sustainability.

- Review Session #8 objectives to ensure they were met. (**FLIPCHART 8A**)

Handout 8A

SUSTAINABILTY

Definition of Sustainability

The ability of an institution to continue to provide quality services and products, even when donors phase out. Any reproductive health program must concern itself with being sustainable. A sustainable program is able to continue with its activities and meet its objectives year after year, to make plans for the future and carry them out despite changes in the external context. It may also obtain financing from various sources so that its existence is not threatened by the loss of a single source of income.

Characteristics of Sustainable Organizations

Although different organizations gain sustainability through different means and routes, sustainable organizations have some characteristics in common. They offer quality services both to users who can pay for services and to those who cannot. This means that such organizations have developed mechanisms to subsidize the cost of the services they offer to low-income clients. These organizations are able to adapt to changing environments and to the needs of their users. For example, a program that has traditionally operated as an urban clinic caring for married women or women with partners may adjust its services to cover the needs of other potential users such as adolescents. Finally, sustainable organizations strive to develop independent, diversified and reliable sources of income so that they will be less dependent on external funds. Having a diversified and reliable source of income gives them greater control over their programs and greater flexibility and freedom to choose their own path.

Reproductive health programs operate in an ever-changing environment. Administrators must develop effective strategies to handle demographic changes as well as changes in the source and level of financing and in consumers' demands. In order to operate effectively in this complex setting, administrators must demonstrate ongoing leadership, must be flexible in their approach to service delivery, must respond to the changing needs of the population and must find new ways to increase income and reduce costs.

Three Components of Sustainability

Sustainability has become one of the priorities of governmental agencies, private organizations and donor agencies that seek to establish a solid foundation for their future. Sustainability can be further broken down into three components:

- Institutional sustainability
- Financial sustainability
- Programmatic sustainability

Institutional Sustainability

Institutional sustainability is the ability of an organization to obtain and manage resources to fulfill its mission and objectives. This is a characteristic of institutions that have matured and are very likely to survive and provide services over time regardless of changes in the external context. In the private sector, institutional sustainability means survival and even though political support is important, it is not as crucial. Typically institutional sustainability involves leadership, effective board and management. In the public sector, institutional sustainability is achieved when there is sufficient political commitment, support and resources to ensure that services will continue to be offered to clients. Despite this difference, the path to achieving institutional stability is similar. In both sectors, family planning programs must be well managed, stable and demonstrate continuous leadership.

In addition, institutional sustainability is concerned with the existence and use of systems that support the design and implementation of strategies, for example, a planning system to program and budget for activities both in the short term and in the long term, a human resources system to recruit, supervise, evaluate, train and compensate staff, a logistics system to provide the inputs needed for programs and a management information system to monitor the performance of programs.

Financial Sustainability

Financial sustainability is the organization's ability to generate income in excess of expenses, to meet its financial obligations (to have sufficient cash to pay its bills) and to be solvent (to have more assets than liabilities). Clearly, a financially sustainable organization has control over resources. In the private sector, organizations must determine the real cost of services in order to establish real prices for specific services, to diversify income and to make decisions based on financial and service information. These organizations must work to reduce (or maintain their costs) as well as their dependence on donors, diversify their income and increase their levels of self-financing. Typically, organizations that have achieved a high level of financial sustainability have a financial management system (budgeting and cash management) and a cost accounting system in place used to monitor expenses and income for better decision making. Organizations in the public sector must develop ways to increase revenues through innovative mechanisms for collaboration with the private sector.

Programmatic Sustainability

Programmatic sustainability is the ability to create a demand for the programs and services offered by providing quality services and by ensuring that support exists for these programs. For example, this can be achieved by involving the community in the design, implementation and evaluation of programs. At the national level, programmatic sustainability is enhanced by the existence of policies supporting the provision of services for youth. Public sector organizations work to increase the general demand for services. Private sector organizations concentrate their efforts on identifying demand within specific markets and determining how best to satisfy that demand. In both public and private programs, ensuring client satisfaction is important for increasing the demand for services.

Potential Obstacles to Sustainability

The following questions need to be asked in order to determine whether an organization is facing obstacles that will keep it from becoming sustainable:

- Does the organization have a strategic plan that defines a clear mission and includes a strategy for responding to future changes in the environment and new user needs?
- Does a culture of sustainability exist in the organization?
- Can the organization hire and retain highly motivated staff?
- Are high-quality services offered to a broad segment of the population, including low-income users and users with limited access to services?
- Does the organization receive financing from more than one donor?
- Can information be obtained on the cost of services and on income?
- Does the organization have a system to generate income from the services it offers?
- Is there a mechanism in the organization for investing at the local level the income that is generated locally?

What Can You Do to Make Your Organization Sustainable?

Develop institutional sustainability

- Define a clear mission.
- Develop strong and innovative leadership.
- Hire, evaluate, train and compensate staff.
- Strengthen administrative systems at all levels.
- Respond to external changes (in the environment) and to user needs.
- Make long-term investments.

Increase financial sustainability

- Expand/diversify the resource base.
- Find ways to reduce/contain costs.
- Implement a cost accounting system that provides information on program costs.
- Plan and monitor expenses.
- Base decisions on the program's actual results.
- Decentralize administration and finances.

Increase programmatic sustainability

- Understand user needs and satisfy them.
- Provide high-quality services.
- Effectively promote services.
- Involve the community.

Handout 8B

Example From Colombia

Diversification Strategy for Achieving PROFAMILIA's Self-sufficiency

PROFAMILIA/Colombia is a Colombian family planning (FP) organization whose mission is to provide services to low-income groups. In order to increase contraceptive use among these groups to that of users with better access to PROFAMILIA's services, mechanisms have been created by PROFAMILIA/Colombia to subsidize certain FP services.

PROFAMILIA/Colombia has diversified the services it provides to include other (non-FP) medical and surgical services related to reproductive health. PROFAMILIA/Colombia has developed services for infertility, testing and treatment for cervical and uterine cancer, pregnancy tests, gynecology and urology consultations, detection of sexually transmitted infections (including HIV/AIDS), sonograms, clinical laboratory services and ambulatory surgical services. By offering these services, PROFAMILIA/Colombia has been able to obtain profits that it uses to subsidize the delivery of FP services.

As of 2001, PROFAMILIA/Colombia is 85% financially self-sufficient – nearly 47% of this amount comes from income generated from providing diversified services. Other resources (e.g., donations) account for the remaining 15%.

Handout 8C

EXAMPLES FROM AROUND THE WORLD

Ideas for Creating Sustainability in FP Programs

Strategies used in the public and private sectors in various countries

Components of sustainability	Governmental and non-governmental organizations in:			
	NGO: CEMOPLAF[1]	**NGO (FPAK[2], CHAK[3]) and Public Sector (NCPD[4])**	**Public Sector**	**Private Sector PROFAMILIA/ Columbia[5]**
Organizational stability	Analyze new and potential markets to identify who needs services, the volume of services required, potential for income-generation and subsidies for users with low incomes and limited access to services.	Define clear missions and motivate staff to achieve the organization's mission.	Develop policies and mechanisms for effective decentralization that motivates staff and members of the community to make the objectives of the national family planning program their own.	Analyze market needs and reorganize services so they are better suited to the needs of the public. This may mean improvements will be needed in the physical plant of the clinic and keeping hours that are different from the customary ones.
Response to all user needs	Indicate the needs and interests of users in specific geographic areas. Establish clinics based on user characteristics. Emphasize control and improved quality, security and rules for all clinic services.	Develop strategies to extend services in NGOs, including effective decentralization and integration of management information systems for all CBD programs.	Develop local administrative systems for FP programs that assign responsibility for the use of FP to volunteers, technical staff and public servants.	Expand the supply of services to generate the resources needed to cover FP and program administration costs.
Greater control over resources	Consider new potential markets for both services and products, by establishing real costs and pricing policies based on costs, competition and user incomes. Establish subsidy systems.	Increase self-financing through costs and fees for services and develop a fee for service structure throughout the institution.	Promote increased local government financial participation in FP, through allocation of a higher percentage of readily available funds for developing FP services.	Study the various activities carried out within the organization in order to cut expenses without affecting the quality of services.

[1] **CEMOPLAF**: Centro Medico de Orientacion y Planificacion Familiar (Medical Center for Counselling and Family Planning)

[2] **FPAK**: Family Planning Association of Kenya

[3] **CHAK**: Christian Health Association of Kenya

[4] **NCPD**: National Council for Population and Development

[5] **PROFAMILIA/Colombia**: Asociacion Pro-Bienestar de la Familia Colombiana (Association for the Wellbeing of the Colombian Family)

SESSION 9: BEHAVIOR CHANGE[24]

OBJECTIVES

- Define risk and risky behavior.
- Identify the factors related to risk-taking behavior.
- Define and identify protective factors and risk factors.
- Create and present behavioral change strategies.
- Explore behavioral change as a multi-layered dynamic that goes beyond information, education and communication.

DAY: 3 – **TIME**: 2 hours and 30 minutes

MATERIALS

- Session objectives written on flipchart (**FLIPCHART 9A**)
- Flipchart and markers
- Flipchart with "Disease Prevention" written across the top (**FLIPCHART 9B**)
- Flipchart with "Health Promotion" written across the top (**FLIPCHART 9C**)
- Flipchart on "Risks involved in using a condom" (**FLIPCHART 9D**)
- Flipchart on "Risks involved in not using a condom" (**FLIPCHART 9E**)
- Flipchart with "Lucy's Risk Factors" written across the top (**FLIPCHART 9F**)
- Flipchart with "Lucy's Protective Factors" written across the top (**FLIPCHART 9G**)
- Sticky notes (with one color being unique from the others)
- Lucy's story (**APPENDIX 9A**)
- Large Concentric Circle Diagram (designed by trainers)

MATERIALS

- Lipovsek, V. et al. 2000. *Risk and Protective Factors for Unplanned Pregnancy among Adolescents in La Paz, Bolivia*. FOCUS on Young Adults (**WEB SITE 9A**).

PREPARATION

Prepare Concentric Circle Diagram and other materials listed above.

[24] This session is based on a session developed by Judy Palmore for CEDPA's 2001 & 2002 Youth Development and Reproductive Health Workshop.

FACILITATING SESSION #9

STEP 1 *(15 minutes)*
PROMOTING HEALTH/PREVENTING DISEASE

- Review Session #9 objectives (**FLIPCHART 9A**).
- Begin with flipchart on which is written "Disease Prevention" and ask participants to brainstorm a list of diseases or consequences that they are trying to prevent through their work in ASRH (**FLIPCHART 9B**).
- Next, post a piece of flipchart on which is written "Health Promotion" and ask participants to brainstorm a list of words and activities that correspond with what they are trying to promote in ASRH (**FLIPCHART 9C**).
- Process the activity. "What is it that we are promoting?" and "What is it that we are preventing?" Identify that there are no right/wrong definitions of health promotion/disease prevention, because the area is so broad. For example, a health promotion activity might entail the creation of a girl's soccer league that will serve as a deterrent to the early onset of sexual activity, unwanted pregnancy and tobacco use.
- Ask participants how health promotion and disease prevention are connected.
- Ask participants why health promotion and disease prevention are not more easily obtained. Looking at the items on the "Health Promotion" and "Disease Prevention" lists (**FLIPCHARTS 9B & 9C**), ask participants to discuss why people do not typically strive to achieve the conditions on the "promotion" list and avoid the consequences on the "prevention" list? Allow participant responses and bridge into Step #2.

STEP 2 *(45 minutes)*
RISK

Ask participants to write in their learning journals about a risky behavior they have changed and/or wanted to change. (To help the group with this process, ask them to think about examples of risky behavior: tobacco use, driving too fast, use of alcohol or drugs, excessive stress, not getting a physical, etc.)

- In their journal participants will write about:
  1. A risky behavior they have changed and/or wanted to change.
  2. An explanation regarding what made them change and/or what kept them from changing.
  3. If the participants changed a behavior, was the change sustained or was there relapse?
- Allow participants to share their learning journal entries, if they so choose.
- Next, lead a discussion on the following:
  - *What is meant by risky behavior?*
  - *Is health promotion or behavioral change risky?*

- To illustrate that health promotion and health behavioral change can also be risky to an individual, list the following on two separate pieces of flipchart (**FLIPCHARTS 9D & 9E**):
  - *Risks involved in using a condom…*
  - *Risks involved in not using a condom…*
- Ask participants to brainstorm all the risks involved in not using a condom (an easy list to generate), then ask them to brainstorm the risks involved in using a condom (a more difficult list to generate for participants). Facilitate a discussion of participants' responses. The purpose of this activity is to begin to explore the difficulties of behavioral change and the sustainability of the changed behavior.
- Ask participants if they have ever considered the risks (as opposed to the benefits) involved in choosing healthy behavior (i.e. using a condom; not using drugs; attending school, postponing sexual activity, etc.). Ask participants to share stories from their professional experiences regarding contact with youth who have expressed the risks involved in choosing a healthy behavior.

STEP 3 *(20 minutes)*
BEYOND KNOWLEDGE

- Read a story about a fictional young female who, despite her knowledge regarding pregnancy prevention, becomes pregnant (**APPENDIX 9A**).
- After reading the story of Lucy, process this activity using the following questions:
  - What were Lucy's risk-taking behaviors?
  - Are these behaviors similar to the risk-taking behavior(s) of youth in your community?
  - What inhibited Lucy from changing?
  - Did she have knowledge about pregnancy prevention? If so, what was the problem?
  - Did she understand the risks involved in her behavior?
  - What risk behaviors can be identified in Lucy's case?
  - What skills/knowledge/opportunities did Lucy lack?
  - What prevented Lucy from changing her behavior?
  - What information and knowledge did she possess?
  - What pressures did Lucy feel and from whom?
  - What could have helped Lucy to be healthier and safer?
  - What were her possible risk factors?
  - Since Lucy was smart and had the knowledge, why did she put herself at risk?
  - Are any of her risk factors related to gender, human rights or sustainability?

TALKING POINTS FOR THE TRAINER

1. **Sustainability**: Did Lucy have money to buy the contraceptives? Did she have money for transportation to go the youth center? Was she dependent on the money of her boyfriend in order to access services?
2. **Gender**: Was there an inequity in power? Who had the power to make decisions, negotiate? Lucy or her boyfriend? Could this have been a case of gender based violence? Did Lucy fear her boyfriend? Did she not negotiate because of the fear of losing him and being judged for being a young woman without a man? Often intelligent girls feel caught in the middle between normal and smart. To avoid being labeled or teased for being intelligent, they conform to the gender role by getting/keeping a boyfriend to appear "normal". Due to financial inequity, Lucy may depend on her boyfriend financially and need his money for school, books, etc. so negotiating is out of the question, as she risks losing her schooling. Clearly it takes two to get pregnant, what gender roles affected the boyfriend's lack of protection?
3. **Rights**: Why should Rita and now Lucy, have to decide between being pregnant and going to school? Should/do pregnant girls still have the right to an education? Is a right to education equally awarded to boys and girls? Perhaps the inequity of this right impacted decisions.

- Pause and define "Protective Factors".

TALKING POINTS FOR THE TRAINER

1. Protective Factors are influences in the community that help one to make healthy decisions.
2. Protective factors may include support from the community; access to services, self-esteem, self-efficacy, skills, etc.

- Continue to process with the group: What were Lucy's protective factors?
- Did her risk factors outweigh her protective factors?
- Record Lucy's risk factors on one piece of flipchart and her protective factors on another piece of flipchart (**FLIPCHARTS 9F & 9G**).

STEP 4 *(40 minutes)*
PROTECTIVE AND RISK FACTORS

- Bridge from Step #3 by asking participants what other protective factors might have kept Lucy safe? List these on **FLIPCHART 9G**. Have participants list as many protective factors as possible (make sure the following are included on the list).
  1. Goals for the future
  2. Opportunities for girls
  3. Self-esteem
  4. Self-efficacy
  5. Negotiation and communication skills
  6. Community support
  7. Positive role modeling
  8. Family support
  9. Understanding susceptibility/severity
  10. Awareness and exploration of costs/benefit
- Ask the group to collectively vote on the one most challenging Protective Factor (from the flipchart).
- Have the participants break into their small working subgroups (as defined on Day 1). Ask the subgroups to develop a specific intervention to address the one challenging Protective Factor. In other words, what does an intervention for this Protective Factor look like for each respective work group (i.e. "medical/clinical" level, "counselor" level, "educator" level, "material development" level, "managerial" level, etc.)?
- Now have each subgroup present their intervention to the entire group.
- Thank the participants for their thoughts and ideas. Ask the participants: Is one intervention adequate? Does one need to address protective factors at many levels? The answers is YES and demonstrate this fact by featuring the interventions that were just created in the classroom, to be carried out on several different levels.

STEP 5 *(20 minutes)*
BEHAVIORAL CHANGE: BEYOND THE INDIVIDUAL

- The trainers bring out a concentric circle design poster, very similar to the one developed by participants during the session on human rights. This design should include the following categories: adolescent, organization, family, community, nation and society.
- In each category, the group will record how behavioral change is enhanced (through protective factors) or inhibited (through risk factors). Ask participants to think of specific protective and risk factors for each level of the concentric circle (e.g. **adolescent** – lack of motivation; **organization** – not marketing to girls; **family** – pulling girls out of school to care for younger siblings; **community** – providing poor role-modeling of healthy behavior; **nation** – few programs to offer emergency contraception; **society** – little value given to youth as contributing members of society). Use **FLIPCHARTS 9F** & **9G** from Steps 3 and 4 to remind participants of risk/protective factors they already brainstormed.

- It is important to note that the risk factors at various levels: can influence whether or not a person seeks services again; can encourage behavioral change; and can influence whether or not the changed behavior is sustained.
- Summarize the many factors and levels at which behavioral change is impacted. Indicate that participants will have an opportunity to work more with this Concentric Circle later in the module.
- Review Session #9 objectives to ensure they were met (**FLIPCHART 9A**).

Appendix 9A

The Case of Lucy[25]

Lucy and Rita are friends; they are both 16 and in high school. Rita recently realized that she is pregnant. For this reason, they have kicked her out of class and are pressuring her to withdraw from school so that she can "take care of her baby," "earn money," and because "it is very tiring to go to school and take care of your pregnancy and your baby."[25]

Rita tells Lucy to be careful, to refrain from having sexual relations or to use a condom. She tells her not to think that if she becomes pregnant, her boyfriend will marry her or assume responsibility for the child. "Lucy, don't make the same mistakes I did." "Forget about those boys until you finish your studies." "Abstaining from sex is the best way to prevent pregnancy and keep from contracting diseases like AIDS."

Rita was distressed because she didn't know whether she wanted to have the baby and she didn't want to withdraw from school. Lucy offered her support to continue her studies until graduation. Nonetheless, Rita withdrew from school.

In one of the their last chats, Rita reminded Lucy of how important it was to be careful in handling sexual relations so as not to ruin your life. The two girls promised to see each other the next week.

A month later Lucy visited Rita. Rita was very happy to see Lucy, as it had been a while since she had seen her friend.

Lucy told her that she was pregnant. The condoms given to her by her friend were not used. She told Rita that she wanted to have the child. Rita and Lucy cried together.

[25] From: U.S. Peace Corps. 2000. *Life Skills Manual*. Washington, D.C.: U.S. Peace Corps.

SESSION 10: LIFE SKILLS

OBJECTIVES

- Define life skills.
- Identify services/programs that build capacity in the area of life skills.
- Create an intervention at various levels that builds capacity in life skills.

DAY: 3 – **TIME**: 1 hours and 30 minutes

MATERIALS

- Session objectives on flipchart (**FLIPCHART 10A**)
- Flipchart and markers
- Index cards with words for Step #2
- Examples of skill-building programs and services
- **FLIPCHART 9G** (from Session #9)

RESOURCES

- UNICEF. *Life Skills-based Education: What Do All These Terms Mean?* (**WEB SITE 10A**)
- World Health Organization. 1998. *Health Promotion Glossary*. Geneva. WHO/HPR/HEP/98.1 (**WEB SITE 10B**)
- Moya, C. 2002. *Life Skills Approaches to Improving Youth's Sexual and Reproductive Health*. Issues at a Glance. Advocates for Youth (**WEB SITE 10C**).
- Moya, C. *Life Skills Approaches to Improve Youth Adult Reproductive Health*. YARH Brief 2. FOCUS on Young Adults (**WEB SITE 10D**).

PREPARATION

Index cards with words for STEP #2.

FACILITATING SESSION #10

STEP 1 *(30 minutes)*
LIFE SKILLS

- Review Session #10 objectives on flipchart (**FLIPCHART 10A**).
- Bridge back to the Protective Factors from Session #9. Ask participants to identify which of the protective factors listed (**FLIPCHART 9G**) are also life skills? What are life skills? What is life skills programming/intervention?

> TALKING POINTS FOR THE TRAINER
>
> 1. **Life skills** refer to a large group of psycho-social and interpersonal skills which can help people make informed decisions, communicate effectively and develop coping and self-management skills that may help them lead a healthy and productive life. Life skills may be directed toward personal actions and actions toward others, as well as actions to change the surrounding environment to make it conducive to health.[26] Examples of life skills include empathy building, active listening, negotiation and conflict management, values clarification, creative and critical thinking, goal setting, self-esteem, coping with peer pressure, identifying personal strengths and weaknesses, interpersonal communication, giving and receiving feedback and analytical skills.[27]
> 2. Capacity Building is the process of enhancing knowledge, skills and attitudes. Knowledge is the mastery of content. Skills are abilities to carry out behavioral tasks at a defined level of competence. Attitudes are values and beliefs that affect the probability of behavior. Capacity building is facilitated through formal and nonformal learning opportunities and the support of technical resources. Capacity building recognizes that all individuals require different levels of skill building and enhancement throughout their lives.

- Ask the group to give examples of skill-building programming and services that their program/organization offers.
- The trainers may choose to have samples in the training room of life-skills interventions including posters, curricula, youth programs (e.g. soccer leagues), commercials. The samples should include more than information, education and communication (IEC) materials.

[26]UNICEF. *Life Skills-based Education: What Do All These Terms Mean?* (**WEB SITE 10A**)
[27]World Health Organization. 1998. *Health Promotion Glossary*. Geneva. WHO/HPR/HEP/98.1 (**WEB SITE 10B**)

STEP 2 *(1 hour)*
GROUP ACTIVITY

Break participants into small groups (not necessarily their work subgroups) and have each group develop one intervention/strategy for the life-skill they have been given (see below).

- Each group chooses an index card from the trainer, without looking. On one side of the card is a level at which an intervention can take place (health care provider, educator, materials developer, counselor, youth director, manager, etc.). On the other side of the card is a life skill (decision making, self-efficacy, refusal skills, problem solving, self-esteem).
- Ask the small groups to create an intervention based on the information on their index card.
- Have each small group presents its intervention strategy.
- Process the sharing of strategies and encourage participants to record, in their learning journals, two points:
  1. List one "intervention" strategy that can be easily implemented in your organization and at your level.
  2. List one "intervention" strategy that can be taken home to share with a colleague at a different level.
- Close this activity by congratulating participants on their work in developing creative interventions that build life skills, yet go beyond IEC. As was discussed with the story of Lucy, behavioral change involves more than knowledge; it also involves life skills and protective factors.
- Ask participants to address the following regarding life skills and risk/protective factors (and behavioral change):
  1. What is one new idea gained about Life Skills and risk/protective factors that relates to the four cross cutting themes? Record this idea on a sticky note and place it on one of the cross cutting theme flipcharts.
  2. What are some connections between Life Skills and risk/protective factors and the four cross cutting themes? Record on a sticky note and place on one of the cross cutting theme flipcharts.
- Review Session #10 objectives to ensure they were met (**FLIPCHART 10A**).

Each evening ends with 15 minutes of Community Time
(Evening Announcements & Evaluation).

SESSION 11: YOUTH FRIENDLY SERVICES

OBJECTIVES

- Identify the basic characteristics of youth friendly ASRH services.
- Identify ways in which participants and their organizations possess (and do not possess) these characteristics.
- Explore ideas of how participants can build the capacity of individuals to provide more youth friendly services.

DAY: 4 – **TIME**: 1 hours and 45 minutes

MATERIALS

- Session #11 objectives on flipchart (**FLIPCHART 11A**)
- Flipchart with "Youth friendly" written across the top (**FLIPCHART 11B**)
- Blank paper for preparing classified ads
- Flipchart and markers
- Handout on youth friendly programs from *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents* (**HANDOUT 11A**)

RESOURCES

- Barnett, B. 2000. Chapter 8: Youth friendly Programs. *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents*. FHI (**WEB SITE 11A**).
- Senderowitz, J., Solter, C. and G. Hainsworth. 2003. *Clinic Assessment of Youth-Friendly Services: A Tool for Improving Reproductive Health Services for Youth*. Pathfinder International (**WEB SITE 11B**).
- Senderowitz, J. 1999. *Making Reproductive Health Services Youth Friendly*. FOCUS on Young Adults (**WEB SITE 11C**).
- Senderowitz, J. Solter, C. and G. Hainsworth. 2002. *Module 16: Reproductive Health Services for Adolescents*. Pathfinder International (**WEB SITE 11D**).

PREPARATION

Prepare flipcharts.

FACILITATING SESSION #11

STEP 1 *(45 minutes)*
YOUTH FRIENDLY PROGRAMS AND SERVICES

- Review Session #11 objectives (**FLIPCHART 11A**).
- Lead a discussion on the characteristics of youth friendly services. Record participant responses on flipchart. Ask participants for youth friendly examples from their own organization. Who from their organization is youth friendly and what are his/her characteristics? What is it that makes their organizations, or the services they provide, youth friendly? What are their organizations' policies and procedures? Are young people involved in planning and implementing the health services? (**FLIPCHART 11B**)
- Break the participants into small groups of four to five persons. Ask each small group to create two five-minute role-plays. One role-play will depict an interaction that is youth friendly. The other will depict an example of an interaction that is not youth friendly. Both role-plays should use the same scenario, but with different approaches: friendly vs. unfriendly. For example: Portray two separate ways a young person might be received at a health clinic or youth center. Participants can also use the settings of the role-plays to depict youth-friendliness and unfriendliness. For example: A clinic scenario where the opening hours are during school or a location that is impractical for young people.
- Process after each group has completed its two role-plays. Ask participants to identify what they observed. What characteristics were youth friendly vs. unfriendly? Did the group observe anything that relates to human rights? Did the adolescent get what he/she came for? Related to gender – Would the youth have been treated differently if s/he was a boy/girl? Related to gender and adult/youth partnerships – Who had the power in the interaction: male/female, adult/youth? Related to sustainability – Is this approach sustainable? What would a young person tell his/her peers about each respective scenario? Ask participants to record their ideas on the cross cutting theme flipcharts.
- Close by asking what staff members were portrayed in these scenarios?
- Ask participants if any of the identified staff members are exempt from being youth friendly? If so, who? Emphasize that all staff members contribute to the friendliness or unfriendliness of a program or service, so it is important that everyone is youth friendly and considerate of the rights of youth. Ask participants if all staff friendliness is linked to sustainability? In what way?

STEP 2 *(1 hour)*
WHO IS YOUTH FRIENDLY?

- Breaking into their work subgroups (identified on Day 1), ask participants to pretend as though they are writing a classified ad for an ASRH staff person. In this ad the subgroup should describe their "ideal" youth friendly ASRH worker for their subgroup's respective area of discipline.
- Ask each group to share its ad. Based on these presentations, start a discussion on the ideal candidate's characteristics: educational background, professional experience, personality, etc. Establish connections between the ideal worker profile and the financial costs (which relate to sustainability) associated with hiring this person, since having "ideal" staff can have financial

implications for the organization. Link to the session (Session #6) on adult/youth partnerships by asking if the ad specifically requested someone who had youth-related experience and was comfortable working with that population.

- Remind participants that the ad said "ideal". What does one do when "ideal" is not possible? How does one build the capacity in individuals to be more youth friendly? Brainstorm some responses to these questions (e.g. offering training, partnering with youth for a day, including youth friendly characteristics in performance appraisals, providing coaching and mentoring from youth friendly staff).
- Ask the participants to form groups of two. Ask each participant to share with his/her partner one youth friendly characteristic s/he possesses and one youth friendly characteristic on which s/he needs to improve. Each participant will then share with his or her partner what s/he plans to do to build his/her capacity in this area which is lacking.
- Distribute the handout on youth friendly programs (**HANDOUT 11A**).
- Review Session #11 objectives to ensure they were met (**FLIPCHART 11A**).

Handout 11A

YOUTH FRIENDLY PROGRAMS

> "With someone your own age, you will be serious. You'll feel at ease. With someone older, you don't want to discuss some things, problems, what's in your heart."
>
> *–Student peer educator in Haiti*

To meet the needs of adolescents, you can consider ways to attract and better serve young people. There are strategies to make services more "youth friendly".

Youth friendly programs:

- Actively involve adolescents in program design and service delivery.
- Consider how adolescents' needs differ from those of adults and provide services that specifically meet the needs of young people.

Providing youth friendly services does not necessarily mean building a new clinic. It can mean adding adolescent-only hours or offering services in places where adolescents congregate, such as youth centers, sporting events or work sites. For community-based workers, it can mean including young people in home visits. And for all health workers, it means establishing or working within a *referral network*. While family planning/reproductive health programs may not be able to offer all methods and services to young people, they can link with other organizations that offer services to young people, including educational and social service programs.

What you can do: youth friendly programs

How far you can go to meet the needs of adolescents depends on your resources, interest and motivation.

1. At a minimum, you can and should do the following:
   - Involve young people in planning and implementing health services.
   - Make all staff – receptionists, nurses, physicians – aware that they should treat adolescents with respect and dignity.
   - Revise clinic policies and procedures that prevent youth from getting services and information. For example, revise age requirements for contraceptive use or requirements that clients must be married.
   - Ensure that young clients have privacy and that clinic policies emphasize confidentiality.
   - Train staff in counseling techniques and make sure they have the most current information on contraceptives.
   - Allow enough time for counseling.
   - Develop referral systems. Find out about other services in your community for adolescents. Keep a list of these services readily available.

2. If you have some resources for improving adolescent services, you can also add these components:

   - Offer separate services for adolescents and adults.
   - Offer services at hours that are convenient for adolescents, such as after school or on weekends.
   - Make the clinic attractive to adolescents (bright colors, posters, popular music).
   - Offer information and education to young clients, both at the clinic and as part of community outreach. For example, hold education sessions at your clinic at times convenient for adolescents, such as after school, or meet with adolescents at local youth clubs to answer their questions about reproductive health.
   - Reduce prices for young clients. Provide services free or based on a sliding scale.
   - Involve young people by creating a youth advisory board.

3. Programs with more resources can do more. Possibilities include:

   - Advocate to improve national policies and service delivery guidelines for adolescents.
   - Develop community outreach programs and off-site clinics held at schools, in factories or on the streets.
   - Reach adolescents through educational talks before they need reproductive health services. Target parents, too.
   - Train peer educators to provide information, education and certain methods to youth.
   - Use mass media to communicate reproductive health messages. Use billboards, soap operas, videos, radio dramas, comic books, popular songs or plays.
   - Create or work with "youth development programs" – programs that improve socioeconomic status, such as literacy programs or job training.
   - Evaluate your program. Examine quality, gender equity and respect for adolescent rights. Evaluations may include:
     - Simple observations.
     - Review of clinic statistics to determine if more young people are attending clinics and returning for follow-up visits.
     - Collection of data to compare services before and after youth friendly services are implemented.
     - Outcome evaluations to assess whether the project met its goals.

General guidelines for all adolescent programs

If you decide to offer services to adolescents, you can take several steps to ensure that programs are effective:

- Identify which specific target groups will be served. The group can be defined by age, school status, marital status or place of residence (urban versus rural).
- Establish specific objectives and indicators to measure whether these objectives were achieved. For example, an objective might be to increase awareness about STIs. An indicator might be that 10 peer educators were trained and then they reached 100 young people with safer sex messages.
- Involve young people in program planning, implementation and evaluation.

- Consider the potential effects of gender, culture and tradition on service delivery.
- Offer short waiting times and welcome drop-in clients.
- Welcome boys and develop programs targeting them.

To be successful, you also may need to consider approaches to service delivery that involve the community, such as:

- Peer motivators and educators.
- Contraceptive information at schools, sports events, youth clubs, concerts or other places where young people congregate.
- A parents' day at the clinic to provide information to adults about adolescents' reproductive health needs.
- A young people's day at the clinic to provide information about good health. Children of all ages, not just adolescents, could be invited.
- Community feedback sessions to solicit ideas from young people about the types of health services they want, their satisfaction with current services and their ideas for changes and improvements.

The key to providing quality services for adolescents is to treat clients with courtesy and dignity. Above all, young people who seek reproductive health information and services deserve respect.

Questions for Providers and Program Managers about Youth friendly Programs

? What can you do to make reproductive health information and services more accessible, attractive or convenient to youth? How can you make your clinic or program more youth friendly?

? Among the three levels of improvements outlined in this section, which can your clinic or program undertake now?

? Which specific activities in this section can you implement to improve adolescent services?

? What creative activities can you undertake to ensure that services and information reach more young people?

? How can you work with parents and other adults in your community to help them understand the unique reproductive health needs of adolescents?

? How will you evaluate your clinic or program to determine whether it is meeting the needs of adolescents?

REPRINTED WITH PERMISSION FROM FAMILY HEALTH INTERNATIONAL, 2000:
Barnett, B. 2000. Chapter 8: Youth friendly Programs. M*eeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents*. FHI.

SESSION 12: MONITORING AND EVALUATION OF ASRH PROGRAMS AND SERVICES

OBJECTIVES

- Define monitoring and evaluation (M&E) in ASRH.
- Identify the need and importance of M&E for program managers.
- Develop strategies to perform M&E.

DAY: 4 – **TIME**: 1 hours and 10 minutes

MATERIALS

- Session #12 objectives written on flipchart (**FLIPCHART 12A**)
- Flipchart with "Monitoring" written across the top (**FLIPCHART 12B**)
- Flipchart with "Evaluation" written across the top (**FLIPCHART 12C**)
- Flipchart with definition of Monitoring (**FLIPCHART 12D**)
- Flipchart with definition of Evaluation (**FLIPCHART 12E**)
- Flipchart with definition of Indicator (**FLIPCHART 12F**)
- Questions for Step #2 activity written on flipchart (**FLIPCHART 12G**)

RESOURCES

- Adamchak, S. et al. 2000. *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs*. Tool Series 5. FOCUS on Young Adults (**WEB SITE 12A**).

PREPARATION

Ask the participants to bring their learning journals.

FACILITATING SESSION #12

STEP 1 *(30 minutes)*
DEFINING M&E

- Review objectives for Session #12 on flipchart (**FLIPCHART 12A**).
- Post the two prepared flipcharts in the front of the room. On one is written, "Monitoring" and on the other "Evaluation". Ask participants to define the two terms and summarize their comments on the flipchart (**FLIPCHARTS 12B & 12C**).
- Ask participants to explain the differences and similarities between Monitoring and Evaluation.
- Give the formal definition of each (see below) and note the similarities/conflicts between the actual definitions and the perception of what the participants described. Correct any discrepancies between the two.

  Monitoring –An assessment of what is being done (**FLIPCHART 12D**).
  Monitoring involves and is performed on organizational processes. Monitoring is separate from evaluation. Monitoring explores whether defined and desired strategies and procedures are being used to implement the selected ASRH program or project.

  Evaluation –An assessment of the ef fectiveness of what is being done (**FLIPCHART 12E**).
  Evaluation should not be an isolated act but rather an ongoing and systematic process for an entire program or project. Evaluation is meant to measure the achievement of objectives and goals. Evaluation works best when programmers and evaluators work collaboratively. Often the person delivering the program or project is also the evaluation coordinator, so it is imperative that staff possess evaluation skills.

> NOTE TO THE TRAINER
>
> It might be useful to provide the participants with additional clarification on the differences between *process, outcome* and *impact* evaluation. See introduction of: *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs*.

- Explain to participants that Monitoring and Evaluation are interdependent.
- Ask participants to identify how they currently conduct M&E in their programs and services. Allow ample discussion and sharing of ideas.
- Next, ask the group to list the advantages of M&E and the disadvantages. The trainer(s) should record on the flipchart and underscore the most common "excuses/disadvantages" to not doing M&E and the most common "reasons/advantages" to doing M&E.
- In discussing advantages/disadvantages, *bridge back to the session on Sustainability* (Session #8) and ask if participants would like to draw links between M&E and sustainability. Ask participants to record these links on sticky notes and post them on the Sustainability flipchart.

TALKING POINTS FOR THE TRAINER

Advantages:

- Evaluation statistics can also be very useful in the managerial decision making process; to have the programmatic information linked to financial information and supported, ideally, by a management information system. For example, how many clients were served and at what cost?

Disadvantages:

- Financial cost
- Human resources required

- Next ask the group to identify at what stage M&E should be performed – beginning of the project, middle, end, when the grant report is due? (Link back to the different types of evaluation – *process, outcome and impact* – to reiterate how M&E is crucial throughout the project cycle.)
- Review the definition of "indicator" with the participants in preparation for Step 2.

  Indicator – a measurable statement of program objectives and activities (**FLIPCHART 12F**).
  Some programs have single indicators, others have multiple indicators. Generally it is preferable to have several indicators to capture the multiple dimensions of the program. A manageable number of indicators should be selected to accurately reflect the program objectives, activities and evaluation priorities. Indicators can be expressed in different forms. Numeric indicators are generally expressed as counts, percentages, ratios, proportions, rates or averages. Nonnumeric indicators (also referred to as qualitative or categorical) are expressed in words and usually denote the presence or absence of an event or criteria.

NOTE TO THE TRAINER

Depending on the participants' level of M&E experience, additional time may be spent on explaining what indicators are and how to select and modify them to match the program's objectives and activities.

Chapter 4 of *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs* provides some useful guidance and examples. Chapter 7 discusses data collection and Chapter 8 explains data processing, analysis and interpretation.

STEP 2 *(30 minutes)*
LIFE SKILLS INTERVENTION EVALUATION

- Ask participants to find in their learning journals the "intervention/strategy" they developed during Step #2 of Session 10 (Life Skills).
- Explain that the next Step of this session will explore the evaluation of their proposed life skills "intervention/strategy" from Session #10.
- Ask participants to answer the questions below regarding their individual life skills intervention/strategy (**FLIPCHART 12G**).
  1. What are the goals of your intervention/strategy?
  2. What behaviors are you seeking to modify/change through your intervention?
  3. What life skills are you seeking to develop through your intervention?
  4. What protective factors/risk factors are you addressing through your intervention?
  5. Based on your answers to the first four questions, develop three to four evaluation indicators that you wish to measure. For example, if you are trying to measure changes in gender equity/power relations, you might look at percentages of sexually active girls who are able to negotiate condom usage with their partners.
  6. How will you measure the effectiveness of these indicators?
  7. At what stage will evaluation occur in this process?
- Ask participants to record their answers in their learning journals.
- Ask the participants to share their responses with everyone.
- Respond to participants that this is simply practice, as many participants will feel intimidated by this process; there will likely be a significant amount of professional diversity in the room, from evaluation experts to novices.
- Ask the full group to choose the three or four best "model" indicators identified by their peers and discuss why they are effective indicators. Trainer(s) should record these model indicators on flipchart.

STEP 3 *(10 minutes)*
CLOSING ACTIVITY

- Ask participants to compare the top four model indicators just selected with the three to four evaluation indicators they previously created (from question #5, Step #2). Ask participants to take this opportunity to adjust, edit and rewrite any of their indicators in their learning journals.
- Review Session #12 objectives to ensure they were met (**FLIPCHART 12A**).

SESSION 13: ADVOCACY[28]

OBJECTIVES

- Define advocacy.
- Identify and practice using the steps of advocacy.
- Explore the importance of advocacy in ASRH.
- Develop one advocacy strategy.

DAY: 4 – **TIME**: 1 hours and 45 minutes

MATERIALS

- Session #13 objectives on flipchart (**FLIPCHART 13A**)
- Definition of advocacy written on flipchart (**FLIPCHART 13B**)
- Flipcharts and markers
- Index cards
- Steps of advocacy written on individual pieces of construction paper. (See Step 2)

RESOURCES

- International Planned Parenthood Federation (IPPF). 2001. *Advocacy Guide for Sexual and Reproductive Health & Rights*. IPPF (**WEB SITE 13A**).
- Rosen, J. 2000. *Advocating for Adolescent Reproductive Health: Addressing Cultural Sensitivities*. In FOCUS. FOCUS on Young Adults (**WEB SITE 13B**).
- Advocates for Youth. 1996. Advocacy Kit. Advocates for Youth (**WEB SITE 13C**).

PREPARATION

Prepare the steps of advocacy on individual pieces of construction paper: Identifying the Issue; Developing Goals and Objectives; Identifying a Target Audience; Developing the Message; Identifying Channels of Communication; Building Support; and Implementing.

[28] Based on a session in: CEDPA. 2000. *Gender, Reproductive Health and Advocacy, A Trainer's Manual*. The CEDPA Training Manual Series. CEDPA.

FACILITATING SESSION #13

STEP 1 *(30 minutes)*
DEFINING ADVOCACY

- Review Session #13 objectives on flipchart (**FLIPCHART 13A**).
- Give each participant three index cards. On each card, have each participant write a word they associate with the term "Advocacy". Ask participants to form small groups of three persons. Each group should compare the various words they have written. When finished, each group of three should merge with another group, forming a larger group of six. Follow this process until the entire group of participants has merged back into one group. Ask participants to identify and agree upon the five words that they feel best describe "Advocacy". Post these five words on the wall.
- Offer definitions of advocacy (see below for examples). Ask participants to read the definitions aloud (**FLIPCHART 13B**).

  "Advocacy is the act or process of supporting a cause or issue. An advocacy campaign is a set of targeted actions in support of a cause or issue. We advocate for a cause or issue because we want to:

  1. Build support for that cause or issue;
  2. Influence others to support it; or
  3. Try to influence or change legislation that affects it."[29]

  "Advocacy is defined as the promotion of a cause or the influencing of policy, funding streams or other politically determined activity."[30]

  "Advocacy is speaking up, drawing a community's attention to an important issue and directing decision-makers toward a solution. Advocacy is working with other people and organizations to make a difference."[31]
- Ask the group to identify the similarities between the definitions provided and the five words they feel best describe "advocacy".

STEP 2 *(1 hour and 15 minutes)*
STEPS IN ADVOCACY

- Ask participants to break into their work subgroups (identified on Day 1). Ask each subgroup to identify an issue for which it wants to advocate. The issues should come from either the "circle activity" performed in the Gender session (Session #7, Step #3) or the "concentric circle activity" performed in the Human Rights session (Session #5, Step #2). Prepare the steps of advocacy on individual pieces of construction paper. Post the first step, "Identifying the Issue", on the wall. Draw participants' attention to the name of this step.

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[29] International Planned Parenthood Federation(IPPF).2001. *Advocacy Guide for Sexual and Reproductive Health & Rights*. IPPF. (**WEB SITE 13A**)

[30] Advocates for Youth. Advocacy 101. Training course.

[31] CEDPA. 1995. *Cairo, Beijing and Beyond: A Handbook on Advocacy for Women Leaders*. CEDPA.

- Post the second step, "Developing Goals and Objectives", on the wall. Draw participants' attention to the name of this step and explain. Ask participants to develop goals and objectives for their advocacy efforts; what do they wish to accomplish by taking on this particular issue?
- Post the third step, "Identifying a Target Audience", on the wall. Draw participants' attention to the name of this step and explain. Ask participants to identify the target audience they are trying to influence. Are they targeting consumers? policy makers? parents? community leaders? clergy?
- Post the fourth step, "Developing the Message", on the wall. Draw participants' attention to the name of this step and explain. Now ask the work subgroups to develop their advocacy message. What kind of terminology and argument will the subgroup use in its advocacy message? What is the intended message? Why should the target audience be receptive to this message? Will the advocacy message be directed to or received by other groups besides the target audience?
- Post the fifth step, "Identifying Channels of Communication", on the wall. Draw participants' attention to the name of this step and explain. How do the work subgroups plan to disseminate their advocacy message? Through what communication medium(s) will the advocacy message be delivered?
- Post the sixth step, "Building Support", on the wall. Draw participants' attention to the name of this step and explain. How do the work subgroups intend to identify allies who will help support their issue and deliver their message? Which specific individual, groups, organizations, etc. will support their advocacy efforts? Will any of this support entail funding? If funding is needed for the advocacy project, where will the resources come from?
- Post the seventh step, "Implementing", on the wall. Draw participants' attention to the name of this step and explain. Finally, what steps need to be taken to develop an advocacy project/plan?
- As the trainer was describing the steps he/she was posting the steps, in order, in the training room. Therefore, at the conclusion of this activity, all the steps are on the training wall: Identifying the Issue; Developing Goals and Objectives; Identifying a Target Audience; Developing the Message; Identifying Channels of Communication; Building Support; and Implementing.
- Give each subgroup an opportunity to present their advocacy steps. Using the steps already posted on the wall, ask them to clearly identify their group's response to each step.

TALKING POINTS FOR THE TRAINER

1. How does advocacy relate to adult/youth partnerships? Where on Hart's ladder of participation does most advocacy fall? Are we involving youth in advocacy? Referring back to **HANDOUT 6C**, what are some advantages of involving youth in advocacy?
2. Is advocacy linked in any way to sustainability? For example, a change in policy may create a more supportive environment for the provision of ASRH services, thus enhancing programmatic sustainability.

- End Session #13 by asking participants: Why advocate? Why do we not just leave behavioral change and gender equity up to individuals? Why is advocacy particularly important in working with youth? Why is it important to involve youth in advocacy?
- Share answers, process and bridge back to the session on Human Rights (Session #5).
- Review Session #13 objectives to ensure they were met (**FLIPCHART 13A**).

SESSION 14: VALUES, ATTITUDES AND BELIEFS

OBJECTIVES

- Explore and reflect on participants' individual ASRH values, attitudes and beliefs.
- Identify strategies to deal with ethical dilemmas faced by providers of adolescent sexual and reproductive health services.

DAY: 4 – **TIME**: 1 hour and 30 minutes

MATERIALS

- Session #14 objectives on flipchart (**FLIPCHART 14A**)
- Posters with titles: "Agree", "Disagree", "Strongly Agree", "Strongly Disagree"
- Values, Attitudes and Beliefs Questionnaire (**HANDOUT 14A**)
- Case studies (**APPENDIX 14A**)
- Optional handout on "Recognizing Adolescents' Evolving Capacities to Exercise Choice in Reproductive Health Care" (**HANDOUT 14B**)

PREPARATION

Make appropriate copies and prepare materials.

FACILITATING SESSION #14

STEP 1 *(45 minutes)*
PURSUING OUR VALUES, ATTITUDES AND BELIEFS

- Review Session #14 objectives (**FLIPCHART 14A**).
- To begin this exploration of ASRH values, attitudes and beliefs, participants are going to take a quiz to see where they stand on certain issues.
- Distribute the questionnaire on values, attitudes and beliefs and ask the participants to complete the questionnaire, but NOT to put their name on the sheet or in any way identify themselves on this sheet of paper (**HANDOUT 14A**).
- After participants have completed the questionnaire, ask them to crumple their sheets of paper into tight balls.
- Then ask the participants to engage in a bit of "football" and kick, head-butt and toss their balls of paper to another side of the room. Ask participants to pick up pieces of paper and continue to kick, head-butt and toss the balls until the trainer(s) calls time (approximately 15 seconds).
- Ask the participants to pick up the ball of paper closest to them. Then ask the participants to open the piece of paper and to make sure it is not their own.
- Next post the following signs in four separate corners of the room: Disagree, Agree, Strongly Disagree and Strongly Agree.
- Read the sentences, one-by-one on the questionnaire and ask the participant to go to the sign that corresponds with the response on the paper they now have; not necessarily their own responses.
- Inform the participants there are no middle positions and that they must now vigorously defend the response that is on the sheet of paper that they have.
- Conduct the exercise, stopping to ask 3-4 participants to defend their opinion. Encourage discussion, reminding the participants that there are no right or wrong answers.
- Process as a group after all questions have been addressed:
  - What was it like to defend an opinion or value that you may not have agreed with?
  - What was it like to have someone disagree with you?
  - Did anyone feel uncomfortable or judged during this activity? How?
  - Talk about the body language of persons as they were disagreeing; disagreement can be subtle and expressed through body language (posture, crossed arms, facial expressions, for example).
  - Ask the participants if they can identify the purpose of this activity.
- Review the lessons learned.
- Emphasize that the important lesson about the exercise is that each person who works in ASRH is encouraged to identify his/her own values, attitudes and beliefs (VABs) so that they do not inhibit his/her ability to work effectively with adolescents and young people.
- Remind the participants that one is not being asked to be stripped of one's VABs, but rather to know one's personal VAB "buttons", so that they do not impede one's work in ASRH. If one is unable to keep personal VABs separate from his/her ASRH responsibilities, one should be sure to refer the young person to someone else who can help him/her.

TALKING POINTS FOR THE TRAINER

1. How do VABs relate to gender? Do some participants feel their responses would be different for males than females?
2. How do VABs relate to rights? Do adolescents have rights regardless of providers' VABs? If provider VABs are negative, can he/she be respectful of the adolescent that comes to him/her? What should he/she do?
3. How can VABs affect adult/youth partnerships? In most clinic settings, the provider has the power. If his/her VABs are that STIs are the fault of the youth, then will the youth feel empowered to ask about protection? About treatment?
4. How does this link to Sustainability? Will youth come back for services if the VABs of the staff are negative?

NOTE TO THE TRAINER

Trainer(s) should edit the Questionnaire (**HANDOUT 14B**) and add statements that are consistent with local/national ASRH ethical issues.

STEP 2 *(45 minutes)*
CASE STUDY

- Ask participants to organize into their work subgroups (as identified on Day 1).
- Give each work subgroup a case that corresponds with its area of work (**HANDOUT 14A**). Ask the subgroups to read their cases then answer the following:
  - What is the ethical issue?
  - Who is involved?
  - What is the position/opinion of each party involved?
  - What does your work subgroup propose to do about the ethical dilemma?
  - Why has your group chosen this course of action?
  - What are the potential consequences of your proposed action?
- Have the work subgroups report back to their peers and process.
- Ask the participants to summarize the leading "ethical issues" identified by the work subgroups. Do any of these issues involve gender? human rights? Emphasize the case studies that involve gender and human rights.
- Ask the group to return to their learning journals and the "intervention/strategy" they developed during Step #2 of Session 10 (Life Skills). Is it possible that your intervention/strategy could be scrutinized or impacted negatively based on colleagues' values, attitudes and/or ethics? How could

this scrutiny impact the delivery of the program? How would this scrutiny impact young people? How would the participant deal with this scrutiny and ensuing challenge?

> NOTE TO THE TRAINER
>
> The case studies (**HANDOUT 14A**) are examples of what has been used previously in this activity by PROFAMILIA/Colombia. The trainer(s) should ensure that the case studies examples to be used in this module are adapted to the cultural context in which the training is being delivered.

- Review Session #14 objectives to ensure they were met (**FLIPCHART 14A**).

Each evening ends with 15 minutes of Community Time (Evening Announcements & Evaluation).

Appendix 14A

Case Studies

CASE No. 1

Martha is a 16-year-old adolescent who has come into the clinic for emergency contraception for the second time in the past six months. She is asking that she be prescribed an emergency contraceoption method because she is afraid of getting pregnant. She has had unprotected sex with a new boyfriend she began sleeping with a month ago.

The first time she came in, Martha was attended by the program counselor as well as the physician. The professionals gave her a prescription and provided guidance on the emergency method (requirements for its use, correct way to use it, contraindications and possible side effects). They also gave her information on other temporary methods, including double protection.

The doctor and the counselor have now come to you, the coordinator and head of the adolescent program, for guidance on how to act ethically and according to the institution's standards in treating this adolescent girl who has come in for the emergency method for the second time and hasn't followed the instructions she was given.

The guidance counselor says she has given Martha all the information on the correct use of the method as well as on other temporary methods, including where to buy them.

The doctor, somewhat irritated, is refusing to attend Martha and prescribe the method for a second time, since he has already informed her about the risks of using emergency contraception routinely.

CASE No. 2

Alfonso and Margarita are the parents of 17-year-old Maria. They have brought her to the medical service and asked for a consultation because they want to know whether their daughter is a virgin or not. Margarita says she surprised her daughter with her boyfriend in the living room. Although she didn't see them having sex, they were in a compromising position. Their reaction upon being discovered confirmed her suspicions that her daughter was having sexual relations with her boyfriend. Apparently this has been happening for some months.

Margarita and Alfonso say they have asked Maria repeatedly whether she has actually had sexual relations and Maria has refused to answer. As the parents of a minor, Margarita and Alfonso say they have a right to know Maria's real situation because they are obliged to take care of her, they love her and they want what's best for her.

Both the doctor and the counselor have explained to Alfonso and Margarita that a physical examination cannot reveal whether or not Maria has had sexual relations. They have told the parents that virginity cannot be measured by whether or not the hymen is intact, as it may or may not break during sex and even during other activities such as sports.

The two professionals come to you, the coordinator and head of the program for adolescents, for some directions on how to act ethically and in accordance with the standards of the institution in light of the

parents' request, since Maria told them in the consultation that she has, in fact, had sexual relations with her current boyfriend.

CASE No. 3

Gonzalo, a young professional who has just joined the adolescent program is facing a dilemma and hopes that you, as coordinator and head of the sexual and reproductive health program for adolescents, can help him.

Gonzalo is now giving out the results of pregnancy tests to adolescent girls. Martha is a girl who has come to the service for the third time. She has been in twice before - Gonzalo remembers her well because he spoke to her on both occasions about the need to protect herself against unwanted pregnancy and sexually transmitted infections. Now Gonzalo is facing the dilemma of what to say to Martha, since her pregnancy test is positive.

Gonzalo is aware that his duty as a health services provider is to be objective and that he must inform Martha of the test result. However, he fears the response the girl might have to her situation.

CASE No. 4

Gustavo, an educator in the sexual and reproductive health program for adolescents, phones you from the school where he is facilitating a workshop on sexuality and pregnancy prevention with secondary students between the ages of 12 and 13.

Gustavo is asking for advice from you, the coordinator and head of the sexual and reproductive health program for adolescents, because you have more experience and knowledge about handling cases like the one he is now facing.

Gonzalo went to facilitate a workshop on sexuality and pregnancy prevention for adolescents, which was coordinated directly by the school guidance counselor. She came to the program because her students spontaneously asked her for information about the subject.

While Gustavo was in the middle of the activity, the principal of the school came to the classroom. In a very irritated tone, he rebuked Gustavo and asked him to leave immediately, since he felt that Gustavo was giving the students information that was inappropriate for their age and developmental stage. Gustavo was talking to the students about how to use a condom, since the students themselves had asked for this information. Gustavo was also planning to work with them on reproduction, decision making and communication in the field of sexuality.

Gustavo knws that he was acting according to the philosophy and standards of the program, but he needs advice so he can make the principal understand that his work has a positive value in the life of the students. He particularly doesn't want to shut off the possibility of working with the students in the future.

Gustavo asks you to give him some suggestions for discussion with the principal, based on ethics and the rights of adolescents. He would like to ask the principal to reconsider continuing with the student workshop in upcoming days.

Handout 14A

Values, Attitudes and Beliefs Questionnaire

(Trainers should develop their own questions based on local/national ethical issues.)

Read the following statements and indicate your feelings about this statement by marking A, D, SA, or SD (see key below).

A D SA SD

1. It is appropriate for a girl younger than 18 to get/choose pregnancy. _____
2. If someone gets an STI, it's his or her own fault. _____
3. If you teach adolescents about sex education, it will encourage them to have sex. _____
4. In discussions about safe sex, an essential topic to talk about is sexual pleasure. _____
5. If an adolescent is under a certain age and has sexual relations, his or her parents should know about it. _____
6. Males and females should abstain from sex until they are married. _____

A = Agree

D = Disagree

SA = Strongly Agree

SD = Strongly Disagree

Handout 14B

Recognizing Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Health Care

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Summary

All countries (with the exception of Somalia and the United States) have signed the United Nations Convention on the Rights of the Child, which generally applies to individuals under the age of 18. The Convention requires that governments respect the obligations, rights and duties of parents [or those acting in lieu thereof] consistent with the evolution of the child's faculties. Many adolescents acquire the ability to make decisions for themselves with respect to reproductive and sexual health services and to make decisions regarding specific matters such as confidentiality.

Immature adolescents should receive the usual protections. The Convention establishes a limitation with respect to the parents' power to deny capable adolescents reproductive and sexual health services. The question of whether an adolescent is a "mature minor" should be decided by health services providers, independently of the parents' judgment. The specific rights of government and of health services providers to put into practice the inherent right of adolescents to have their reproductive and sexual health needs met are examined.

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Key words: Reproductive health of adolescents; Evolving Abilities of Adolescents; Human Rights of the Child; Convention on the Rights of the Child; Parents; Parentalism; Sex education.

Source:
Cook, R. and B.M. Dickens. 2000. Recognizing Adolescents' "Evolving Capacities" to Exercise Choice in Reproductive Health Care. *International Journal of Gynecology and Obstetrics 70*:13-21.

1. INTRODUCTION

The immense challenge that health services providers face internationally is the general failure of national health services to deal with the inherent problems of pregnancy, childbirth and sexually transmitted diseases (STDs) among adolescents. The risks increase as adolescents mature earlier and marry later. The failure results, among other causes, from the fear of health services providers that local laws restrict their ability to provide contraceptives and other services to adolescents who come to them, unless they have the consent of their parents. Another factor is the failure on the part of countries to honor international legal commitments they have made through human rights treaties "to ensure that no child is deprived of his or her right to the enjoyment of health services,"[1] including commitments relating to reproductive health as an aspect of "preventive health care"… and education and services in the area of family planning".[2] Most governments have not adequately faced the need for reproductive health services, under conditions of absolute confidentiality, to which adolescents are entitled.

The purpose of this document is to explain the legal duties that governments have to respect the rights of adolescents to obtain such services and to relate services to the "evolution of the faculties" of adolescents to make crucial decisions for themselves.

In many countries, adolescents represent a significant segment of the population. For example, of Brazil's 163.1 million inhabitants, 34% are under age 15;[3] of India's estimated 929 million inhabitants, 35% are under age 15.[4] In India, approximately 50% of women have their first stable union before the age of 18 and nearly 30% have their first child before the age of 18.[5] In 1988, Brazil established a national health policy for adolescents that, despite its uneven implementation throughout the country, includes some of the best practices. In contrast, the services provided by the government of India barely manage, if they do so at all, to deal with the deficiencies in reproductive health care for adolescents, abortion and STDs.[6]

Myths about conception and infections, which are prevalent among adolescents, as well as existing ignorance, myths and misinformation regarding the sexuality of adolescents and the sexual behavior of adults, make it necessary for health services providers to undertake the education of adolescents with respect to responsible and safe sexual behavior, as well as the education of adults, including those who hold political power, about adolescent sexuality.

Public understanding of and policy regarding the extent of unwanted pregnancies among adolescents, as well as the consequences of childbirth, abortion and STDs, can bring to public light the limits and dysfunctions of repressive laws and moralist rhetoric and focus attention on clinical, public health and legal strategies that can contribute to achieving the reproductive health of adolescents, which both adolescents and their communities desire. A step toward achieving these objectives is to encourage governments to determine whether local laws, as they are being interpreted by their courts, recognize that mature minors may have access to confidential services to protect their reproductive health. If they cannot, the next step is to encourage governments to comply with the international human rights commitments that their countries have made, in order to guarantee that adolescents have access to adequate health services.

2. THE CONVENTION ON THE RIGHTS OF THE CHILD

The Convention on the Rights of the Child, approved by the United Nations General Assembly in November 1989, defines children as:

All human beings under the age of 18, except for those who by virtue of law applicable to them have obtained their majority before this age.[7]

All countries, except the United States and Somalia, have ratified the Convention. In accordance with the above, children under the age of 18 have the right to be protected by the Convention (except if a signatory country establishes a lower age as the majority). Current laws and judicial interpretations of laws recognize more and more forcefully that adolescent minors who have sufficient maturity to assume the inherent responsibilities of their decisions can give their consent to use health services with the same independence that is enjoyed by adults.[8] Laws also tend to accept that adolescents under the age of 18 reach their maturity (or adult age) from the time the marry or, in the case of women, when they become mothers. This latter recognition seeks to overcome the anomaly of a young mother who has to make decisions regarding the care of her child, when her legal capacity to make decisions regarding her own health is at least uncertain. Nonetheless, a major principle of legal thought under international human rights law is that individuals under the age of 18 are entitled to the protections of the Convention in the signatory countries.

An important provision of the Convention is Article 5, which stipulates that:

> The states party [to the Convention] shall respect the responsibilities, rights and duties of parents or, as applicable, the members of the extended family… or other persons legally responsible for the child to give the child, consistent with the evolution of his or her faculties, appropriate direction and guidance so that the child can exercise the rights recognized in this Convention.

The meaning of this provision lies in the recognition that "the child exercises" rights under the Convention and in the repetition of this language in Article 14. This article provides that:

1. The states party [to the Convention] shall respect the right of the child to freedom of thought, conscience and religion.
2. The states party shall respect the rights and duties of parents and, as applicable, of legal representatives, to guide the child in the exercise of his or her rights consistent with the evolution of his or her faculties.

The Convention on the Child recently received strong support from the Committee that monitors the compliance of countries with the Convention on the Elimination of All Types of Discrimination against Women. The committee on the Elimination of Discrimination against Women encourages the states party to the Convention "to concern themselves with questions relating to women's health throughout their lives, recognizing that the term "woman" also includes girls and adolescents."[9] The committee points out, for example, that "Questions relating to HIV/AIDS and other sexually transmitted diseases are

vitally important to women's and adolescent girls' rights to sexual health. Adolescent girls… in many countries lack sufficient access to the information and services necessary to guarantee sexual health… and are often unable to refuse to have sexual relations or to insist on responsible and risk-free sexual practices… The states party must guarantee the rights of adolescents of both sexes to education on sexual and reproductive health… in specially designed programs that respect their rights to intimacy and confidentiality.[10]

Consistent with the above, when the committee examines country compliance with obligations relating to the health of women, it reinforces compliance with respect to adolescent women, as derived from the Convention on the Rights of the Child.

3. LEGAL LIMITS OF PARENTALISM (PATERNALISM)

Paternalism is literally the policy or practice of acting as a parent. So as not to fall into gender inequity based on language and so as to consider mothers and fathers as equal, modern practice is to talk about "parentalism." In the best sense of the word, parentalism is the policy or practice of acting to limit a child's freedom and responsibility based on well-intentioned rules. Children who lack judgment have the right to the protection and guidance that their parents or guardians can give them. Nonetheless, parentalism can become unworthy and insulting when policies are used that treat competent adults as if they were children.

Fortunately, a strong contrast has been established between unjust and unethical parentalism and the appropriate exercise of an authority similar to that exercised by parents.[11] Legitimate parentalism can be exercised over children who require protection in making decisions that could harm them, due to the fact that their own judgment lacks experience and they do not have adequate discernment and foresight. Naturally, those who have experience and foresight can also make poor decisions, but it is to be hoped that adults will take responsibility for their errors. Children are denied the power to make many decisions in order to save them from the practical consequences of and moral responsibility for their errors. However, Articles 5 and 14 of the Convention on the Rights of the Child recognize that even before children reach the age of 18, they are capable of exercising their rights and have their faculties have evolved. The Convention requires that parents and other legal guardians of children act in a manner consistent with the evolution of the faculties of those under the age of 18. Therefore, the Convention limits parental powers when adolescents develop their own faculties not only to make decisions but also to reasonably anticipate and accept responsibility for the consequences of their own decisions.

Adolescence is a stage in the transition from childhood to adult age, a stage in which adolescents believe they have acquired abilities they have not fully acquired, but it is also the stage where adults, particularly the parents who have raised these children since infancy, may deny that their children have acquired the maturity and responsibility that they actually have. Parents' good instincts to protect their children can degenerate into over-protectiveness and denial that their children are no longer children and may deprive adolescents of the chance to experiment with responsibility in order to acquire it and thus reach adulthood. Part of parental denial regarding the growth of their children is often a negation of their children's sexuality and ability to maturely and responsibly choose their sexual behavior. By requiring legal respect for the evolution of adolescents' faculties, the Convention on the Rights of the Child establishes legal standards regarding inappropriate, restrictive and dysfunctional parentalism.

4. DECISIONS REGARDING REPRODUCTIVE HEALTH CARE

Those who make decisions regarding their health care must face the consequences of such decisions. However, decisions on reproductive health can also affect others. Sexual relations between adolescents have a tendency to bring inter-generational consequences because the birth of a child to an adolescent couple, particularly if they are not married, affects the newborn, the adolescent mother and her parents' ability to care for their children and grandchildren. Parents of an unmarried adolescent daughter may also show apprehension regarding their daughter's sexual behavior because her pregnancy may reflect negatively on their child rearing and may imperil the adolescent's chances of continuing her education and achieving the type of married life that her parents hoped she would have. Terminating a pregnancy may also represent shame for the family or spiritual anguish, or parents may consider it unacceptable from a religious or other point of view that their daughter would consider this option. Terminating the pregnancy may put the daughter's life at risk when only unprofessional procedures are available and may distance her from her parents and from the family's religious traditions. Based on the above, parents may be particularly protective of their daughters' virginity and vigilant in controlling their sexual behavior.

Daughters may share their parents' apprehensions about an unwanted pregnancy, but want refuge from the restrictions their parents place on them in their choice of social and sexual behaviors. Nonetheless, they may not want to reveal their intimate sexual lives to their parents and may use contraceptive methods to avoid becoming pregnant. Preferences of this type on the part of adolescent woman present health services providers with problems that are difficult to resolve from an ethical and legal point of view in terms of their professional responsibilities under professional codes of ethics, the provisions of local laws, judicial decisions and both national and international human rights laws to which governments that have jurisdiction over them are legally committed. The concerns of health providers are exacerbated when professional codes and local laws seem to be in conflict with broader, usually more liberal, provisions that countries have adopted legally under local human rights codes and international conventions on human rights.

5. CONFIDENTIALITY OF ADOLESCENT PATIENTS

One basis suggested for the legal incapacity of young people to make some decisions for themselves is their inability to pay for the goods and services they need. The economic dependence of adolescents not only legally obligates their parents to give them the care they need but also gives them the right to receive information about the demand for goods and services, including health care, so that they will know the needs they must satisfy as parents and to distinguish which of these payments are not priorities and which they therefore are not legally obligated to pay. Consistent with the above, health services providers must inform parents regarding the services they provide to children and for which they ask parents to pay the fees.

Health services providers that do not directly bill the parents of adolescent patients do not have a legal obligation to compromise the confidentiality of their patients and, rather, have the legal duty to protect the confidentiality of adolescents. In health plans with services financed through a family account such as in government or private insurance plans, confidentiality should be maintained, with a note on the bill that the service should not be checked with the parents. Government and private health insurance

plans should include provisions that allow fees for services to adolescents in such a way that their confidentiality is preserved. In general, there is no obligation to inform parents without the prior consent of adolescent patients. However, as a rare exception, disclosure may be professionally justified when an adolescent asks for health services due to sexual exploitation or abuse, against which the parents can provide protection.[12] In many laws on this subject, sexual abuse or other types of abuse within or outside the home can be reported to child social welfare agencies or other protective agencies. In those countries where this is still not required, this may be considered legitimate discretion supported by the Convention on the Rights of the Child.[13]

6. REPRODUCTIVE HEALTH SERVICES

The services that adolescents may seek cover a broad spectrum of services for reproductive and sexual health. An exception might be that adolescents may be less inclined to ask for infertility services outside of marriage, although in cultures where the evidence of fertility in young women is a condition for marriagability, women under the age of 18 may seek such services to be sure they are fertile.

As with adults, information on a birth may be unavoidable and sufficient to protect the interest of newborns and mothers themselves. The birth of children to children is a source of concern in all societies and generates unavoidable conflicts of interest between the newborn and its mother, which can ethically be resolved in favor of the former. However, pregnant adolescents may appropriately ask that third parties, including their parents, not be informed of the pregnancy except, perhaps, when the reality is obvious to them. Secrecy serves the interests of adolescents by reducing their level of stress while they are deciding whether to have an abortion or not.

Adolescent girls should not be subject to parental pressure either to have a medically induced abortion or to continue the pregnancy and carry to term. The conservative convictions of devout parents who practice a religious faith and prohibit their daughters from having an abortion have led to legislation, such as laws in many US states that require parental approval to perform an abortion on minors and, although many of these laws have been declared unconstitutional by the courts,[14] require prior notice to the parents.

However, it seems equally possible that many parents will exert their influence and even their legal authority to demand that their daughters have an abortion so that their adolescence will not be disrupted, nor their chances for marriage and timely motherhood compromised by an early birth.

In one case in India, for example, a father sought authorization from the Supreme Court to end the pregnancy of an underage daughter.[15] However, he was unsuccessful and his petition was denied on the basis that the procedure could not be imposed on a capable minor who intended to have her child. Judges usually accept that parents cannot invalidate the decision of a capable adolescent not to have an abortion, although a court may order this as an exception.[16]

Contraceptive services require protecting the confidentiality that adolescent patients consider necessary. Health services providers must be aware that if they do not guarantee confidentiality sexually active adolescents may decide not to use contraceptives and may run the risk of pregnancy and face the

dangers of an unprofessional abortion. It is not an exaggeration to state that, each year, the inability to guarantee confidential contraceptive services costs the lives of thousands of adolescents and deprives many of them of their reproductive and general health. Denying service or confidentiality may literally mean the death of an adolescent girl or serious and permanent damage.

The evolution of adolescent girls' ability to handle their own sexuality and that of their partners is frequently threatened by a lack of information and education on reproduction and sexuality. Girls must receive information, for example, on the fact that contraception does not provide them any protection against STDs (sexually transmitted diseases) and that their partners must use condoms during sex. Men must also be educated on contraception and safe sex. One legal obstacle is that while girls who are below the legal age required for giving valid consent to sexual relations can be legally educated on preventing conception and contracting STDs, since such laws are designed to protect them rather than penalize them, educating boys may be different.

In general, educating boys about caring for their reproductive health and that of their partners is not a problem. However, teaching a boy how to protect himself during sex with a girl, for example his regular girlfriend, who has expressed consent but whose consent to the sexual act is not legally recognized because she is not of legal age, can lead health services providers to become accomplices. The health provider's explanation that it only instructed the boy to do safely what the couple would have done unsafely is probably not a convincing argument when a prosecutor or the girl's angry parent claims that the health providers involvement encouraged the girl to think that the sexual act would not be detected. They can allege that without such involvement the girl would not have consented to the sexual act. The punitive intent of the law can discourage health services providers from offering education on protection. States should remove from their laws legal risks that may dissuade health services providers from educating young couples about prudence and reproductive and sexual safety, since states have accepted the obligation under the Convention on the Rights of the Child to guarantee access to such education.

7. THE STATE'S DUTY TO GUARANTEE THE EXERCISE OF REPRODUCTIVE RIGHTS

Under international human rights conventions,[17] including the Convention on the Rights of the Child, a useful framework has been developed for guiding and evaluating compliance with the commitments that countries have made. Countries are required to guarantee three types of duties in particular

- The duty to *respect* rights, which prohibits countries from interfering with the protection and promotion of reproductive rights;
- The duty to *protect* rights, which requires countries to prevent behaviors on the part of third parties that could result in violations of reproductive rights;
- The duty to *implement* rights, which requires countries to take appropriate legislative, administrative, budgetary, judicial and other types of measures to implement reproductive rights.

These obligations require countries to begin a wide variety of actions to prevent, remedy and punish violations of reproductive rights.

7.1 The duty to respect the rights of adolescents

Respect for the reproductive rights of adolescents is frequently unwittingly negated by countries' laws and practices that have been designed to protect adolescents from premature sexual behaviors and intercourse, including the risks of pregnancy and exposure to STDs. It is acceptable for a country to reinforce parental interests in protecting vulnerable children. However, when the state aligns itself with parental interests it fails to give due respect to adolescents in the conflict between parental protection and the evolution of adolescents' faculties that is frequently a marker of adolescence. Lawmakers often yield to parental requests to strengthen their authority and overlook the interests of adolescents who are too young to vote.

National laws designed to protect adolescents, for example by denying them access to information and contraceptive methods by making reproductive health services contingent upon the consent of parents with whom adolescents may be in conflict regarding sexual issues and by criminalizing their voluntary sexual behavior, not only fail in their protective intent but also may be in violation of the Convention on the Rights of the Child and other Conventions. The belief that parents will educate their children at home about sexuality is very often false, but schools may be inhibited and not set up sex education programs for fear of violating parental interests and laws against children's participation in sexual activities.

Including information in school programs may lead to controversy because biology and sexual behavior may be explained in a way that parents oppose or consider premature at a certain point in time, or may cause children to ask questions at home about which parents may feel uncomfortable. The European Court of Human Rights has respected the sensitivity of parents' opinions, but confirmed the compulsory nature of sex education courses in Danish high schools as follows:

> The school program has as its purpose an objective, a pluralist and critical method… [and does not] pursue an objective of indoctrination that might be disrespectful of the religion and philosophical convictions of parents.[18]

Providing reproductive health services may be useless if it does not incorporate real provisions with respect to violating confidentiality. The legal duty to guarantee confidentiality can be found in various provisions, among them the Convention on the Rights of the Child. Article 16 protects children from inference with their intimate lives and Article 14(2) requires respect for freedom of thought and conscience, respecting parental rights "to guide the child in the exercise of his or her right according to the evolution of his or her faculties." This condition requires that health services providers take into account the evolution of adolescents' faculties with respect to their sexual responsibility.

7.2 The duty to protect the rights of adolescents

This duty requires that state agencies and civil servants prevent violations of adolescents' reproductive health rights on the part of private individuals or organizations that are not themselves directly bound by international human rights laws, although they may be bound by national laws that incorporate international laws. Countries are directly committed to providing protection against such violations in

those cases where, based on economic policies, they transfer state functions to private individuals and entities. Their continued obligation under international human rights law is to:

> Organize the government apparatus and generally all structures through which governmental power is exercised in such a way that they are capable of legally guaranteeing the free and total enjoyment of human rights.[19]

For example, in a case involving the rape of a mentally disabled girl, the Dutch government denied all responsibility in the subsequent physical and mental problems. The European Court of Human Rights maintained, however, that the state has "a certain degree of responsibility" in the child's health problems. The World Health Organization describes health as "a state of… physical, mental and social well-being." The obligation arose because measures were not taken to ensure that the assailant was brought to justice nor to compensate the victim for the damage done to her health. The Court maintained that the state had the obligation to take positive measures regarding events that occur between private individuals when human rights have been violated.[20]

The protection of adolescents requires that they be instructed and informed about all aspects of sexuality. However, those adults who directly influence their lives, such as parents, teachers, religious leaders and health services providers often lack the ability to discuss all sexual subjects or to do so in a language that is familiar to adolescents. Using a language laden with moral judgments that deny adolescents their curiosity regarding sex and sexual experimentation is not appropriate. For example, in 1996 during a discussion of abortion in South Africa, Nomboniso Gasa, a feminist activist, wrote an open letter to the members of Parliament arguing forcefully the benefits of reproductive self-determination. She wrote about when for the first time she heard the word Xhosa for abortion, ukuqhomfa, in her rural village, when she was 7 years old. She asked her parents about the death of a young girl as the result of an abortion. She stated:

> Throughout my childhood and adolescence, we heard about women who had aborted. I saw fetuses and sometimes fully developed babies in the rivers and places where mothers met to gather firewood. Answering my naïve questions, my father shouted and said: "Once and for all let me answer you and then be quiet about it! Abortion is real, unpleasant, terrifying and it happens. But I don't want to talk about it, we don't talk about – people don't talk about it."[21]

Silence about abortion, sexuality and methods for preventing STDs and unwanted pregnancies not only involves parents but also teachers of adolescents, government agencies and agencies responsible for protecting health both nationally and internationally. And unless they decide to work together to break the silence regarding the sexuality of adolescents, their right to have their reproductive health protected will continue to be violated. Governments and the health services providers they use have the duty to guarantee adolescents' access to the information necessary for the protection of their reproductive health and the related duty to eliminate legal, regulatory and social barriers to essential information and health care.

7.3 The duty to respect the rights of adolescents

The duty to respect rights requires that countries take the appropriate legislative, administrative, judicial, economic and budgetary steps as well as other steps to ensure the full realization of adolescents' human rights in a manner consistent with the evolution of their faculties. The failure of government to confront the magnitude of violations of adolescents' reproductive rights puts the state in the position of failing to fulfill this duty. Countries may have laws that prohibit the sexual act with women under a certain "age of consent," but the purpose of these laws is to punish men who take advantage of girls and not to put girls at a disadvantage or deny them the protection of medical services. Countries should not have laws that prevent minor girls from exercising their ability to consent in their healthcare in general and their reproductive healthcare in particular, when they have the maturity to be responsible for their own well being. Many legal traditions recognize that adolescents who are minors may be "less mature" but may still have the ability to make important decisions regarding their lives as if they were adults.

Laws may establish age limits for specific purposes such as marriage without parental consent, marriage subject to parental consent, compulsory attendance at school and obtaining a driver's license. However, it is a violation of the adolescents' human rights to control their access to counseling and health services by making their requests subject to parental veto or notification.

States must guarantee that health services providers recognize their obligation to assess whether adolescents who seek reproductive health care are capable of exercising reasonable judgment and must recognize their duty to attend those who are as capable as adults by providing them treatment and respecting their confidence.[22] One sign of maturity in minors is the understanding that they must protect their reproductive health and seek contraceptive services when they are, or plan to be, sexually active. As a general rule, it can be said that adolescents who are capable of freely making decisions regarding their sexual activity, without the need for parental control, are equally capable of receiving counseling in reproductive health and healthcare without seeking parental control.

8. REPRODUCTIVE HEALTH PROGRAMS FOR ADOLESCENTS – THE PROFAMILIA MODEL

The hope that governments, consistent with their human rights commitments, will undertake or require education in adolescent reproductive and sexual health in programs specially designed for adolescents and that respect their rights to privacy and confidentiality[23] can be frustrated when governments assign these programs to religious authorities that restrict them. However, certain initiatives can be taken by nongovernmental organizations (NGOs) that are capable of meeting this challenge and governmental resistance. The initiatives of NGOs that recognize adolescents' need for reproductive health have been developed in different regions, including Latin America, where it has been internationally recognized that the "indisputable leader" is Profamilia in Colombia,[24] an agency founded in 1965. It works with the Colombian population of more than 36 million inhabitants, 34.3% of whom are under the age of 15.[25] It manages youth centers in 21 cities and provides services to adolescents in another 14 towns.[26]

The challenge of providing sexual and reproductive healthcare to adolescents in Colombia may be comparable to that faced in other countries. Approximately one out of every ten women acknowledges

having her first sexual relationship before the age of 15 and one-third before the age of 18 years.[27] In Colombia, 14% of women between the ages of 14 and 19 are mothers,[28] frequently inside marriage, given that although the minimum legal age for marriage is 18, men older than 14 and women older than 12 can marry with the consent of their parents.[29]

In 1992, the Constitutional Court of Colombia recognized the need for boys and girls to receive sex education as part of modern schooling, the need to provide students with serious, timely and adequate knowledge regarding sexuality in order to encourage self-esteem, respect for the integrity of others and healthy personal and social sensitivity.[30] In 1993, the Ministry of Education ordered the inclusion of sex education programs in the national educational curriculum. Profamilia strengthens the Ministry's National Plan on Sex Education through its youth centers. Thanks to properly trained professionals, these centers provide information and sexual and reproductive health services for adolescents, provide sex education in high schools and train young people so that they will demand/exercise their reproductive rights. Under contract to the national government, Profamilia gives courses and training on subjects such as gender equity, sexuality, adolescent pregnancy and communication between parents and adolescents. The Profamilia model of adapting to the evolution of adolescents' capacities to achieve responsible sexuality and to protect their reproductive and sexual health attracts and ensures international attention.

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SESSION 15: STI/HIV REVIEW

OBJECTIVES

- Receive updated medical information regarding STI/HIV transmission and treatment.
- Link behavioral change and gender to STI/HIV transmission.

DAY: 5 – **TIME**: 1 hour and 30 minutes

MATERIALS

- Objectives for Session #15 written on flipchart (**FLIPCHART 15A**)
- Handshake icebreaker (**APPENDIX 15A**)
- Optional exercise for defining sexual abstinence (**APPENDIX 15B**)
- PowerPoint slide presentation on updated medical issues regarding the transmission and treatment of STIs (prepared by the facilitator).
- Handout on STIs, containing up-to-date information, prepared by the trainer with input from a medical professional. Additional resources listed below may be useful for developing the handout.
- Index cards

RESOURCES

- Advocates For Youth. *Sexually Transmitted Diseases to Know* (**WEB SITE 15A**).
- Barnett, B. 2000. Preventing Sexually Transmitted Infections. *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents*. Family Health International (FHI) (**WEB SITE 15B**).
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PREPARATION

Research and prepare PowerPoint slide presentation. Prepare materials for the Handshake icebreaker. Research and prepare STI handout.

FACILITATING SESSION #15

STEP 1 *(15 minutes)*
"HANDSHAKE"

- Review Session #15 objectives (**FLIPCHART 15A**).
- Facilitate the "Handshake" icebreaker following the directions on the handout (**APPENDIX 15A**).
- Ask participants for some reasons why people put themselves at risk for STIs and HIV. If having anal, oral or vaginal sex is as risky and random as the "Handshake" activity, why do people still put themselves at risk? Remind participants that this is a review from the session on Behavioral Change (Session #9). Link this activity to the lessons learned in Session #9 regarding the transmission of STIs and HIV.
- Ask participants how gender and STI/HIV transmission are linked.
- Bridge back to lessons learned from the session on Gender (Session #7, Steps 2 and 3).
  - Power relations
  - Gender based violence (GBV)
  - Expectations for boys/girls
  - Access/control over services, behaviors, economic resources
- Ask participants how this activity would be different for young people. How could this activity potentially impact adolescents? Would it raise awareness, skills, capacity or knowledge?

> NOTE TO THE TRAINER
>
> It may be useful at this point to spend some time defining the term "abstinence". In the Handshake exercise it is defined as postponing sex; however, it can mean different things to different people. It is particularly important for ASRH service providers to clarify what adolescents believe to be abstinence versus what their own definition is. Studies indicate that young people often define oral or anal sex as "abstinence". Such differences in beliefs and practices can have enormous impact on a program's success.
>
> An optional exercise for defining abstinence can be found in **APPENDIX 15B**. The trainer should adapt the language to the local context.

STEP 2 *(45 minutes)*
THE MEDICAL FACTS

- Acknowledge that while many participants have significant knowledge about STIs and HIV and this session may serve as a review, others may not possess the same level of expertise and this session may serve as an invaluable resource. Regardless of participants' professional roles within ASRH, it is imperative to understand the facts.

- The following session will cover the cutting edge and medical facts regarding STIs and HIV, including transmission, treatment and the specific physiological vulnerability of youth.
- At this point, a health care provider (perhaps the Medical Director of the host organization) presents a 30-minute slide presentation on STIs and HIV. An additional 15 minutes will be set aside for questions and answers. The health care provider should use visual aids and pictures and as many hands-on props as possible.
- Distribute the STI handout prepared by the trainer.

> NOTE TO THE TRAINER
>
> The trainer should work with the professional to ensure that his/her presentation is in line with the goals and objectives of the session.
>
> If a medical professional is not available to deliver the session in the manner in which it is intended, the trainer could instead present an STI/HIV 101 session (using international resources – Advocates for Youth, Pathfinder, UNICEF, WHO).

STEP 3 *(30 minutes)*
BEYOND THE FACTS

- Ask participants to write the letters STI and HIV on the middle of an index card. Next ask them to write, on the right-hand portion of the index card, all of the topics covered so far during the module that influence STI/HIV transmission (e.g. lack of education, lack of skills, poverty).
- Ask participants to read their topics aloud to the group.
- Now ask the participants to write, on the left-hand portion of the index card, a separate list of factors that influence STI/HIV transmission that are directly linked to gender. The factors on the left-hand side can be general or specific (e.g. gender-based violence, homophobia, girl trafficking, policies/laws that do not protect women should they become victims of violence, discrimination in purchasing condoms, child marriage).
- Ask participants to read aloud their factors (from the left-hand side) to the group.
- Finally, ask participants to choose one topic from the right side of their index card and one factor from the left side of their index card that are connected and influence each other.

  In their learning journals, participants should consider this connection and propose strategies (e.g. skill-building training for girls/young women) at the organizational level to reduce the risk of STI and HIV transmission.
- Ask participants to share their ideas with the group.
- Review the Session #15 objectives to ensure that they were met (**FLIPCHART 15A**).

Appendix 15A

HANDSHAKE

Objectives:

- Simulate how unsuspectingly sexually transmitted infections (STIs), including Human Immunodeficiency Virus (HIV), can be transmitted from person to person.
- Internalize the reality of a positive STI test result.
- Underscore abstinence (postponing, or not having, sex) as a 100% effective prevention method.
- Explore barrier methods (e.g. condoms), which greatly reduce one's risk for HIV and other STIs.
- Emphasize that STIs cannot be spread through "casual contact".
- Discuss the importance of testing and identify local testing site information.

Materials:

- Pieces of paper marked on one side only, folded and stapled: (one per student)
  1. "H" for Herpes (on 10% of the cards) – Alternatively "H" could stand for HIV
  2. "Ch" for Chlamydia (on 10% of the cards)
  3. "B" for barrier (latex/plastic condom or dental dam) (on 30% of the cards)
  4. "P" for postponing, or not having, sex (abstinence) (30%)
  5. Blank for anal, oral, or vaginal sex without a barrier (remaining cards)
  6. #1 & 2 can be altered. For example, you may want to do "W" for genital warts.

More simple variations may include a red X for HIV, C for Condom, A for Abstinence, S for STI. You can also attach these symbols (i.e. X, H, A, C, etc.) to a handout, instead of folded paper.

Instructions:

- Instruct participants that you're going to start with an **icebreaker**.
- Hand one folded piece of paper to each participant and instruct him/her **NOT TO OPEN IT**!
- Then have each participant mingle around the room and introduce him/herself to **three people** and have them **initial** their piece of paper. As the facilitator, you should NOT participate.
- After everyone has briefly greeted three people and obtained initials for each, have them return to their seats. If you do not have enough pens/pencils, just ask them to remember whom they greeted.
- Explain that for the purposes of this exercise the greeting or handshake **simulated** anal, oral or vaginal **sex**.
- Ask everyone to **open** his/her piece of paper and ask the person with **"H" to please stand** .
- Explain that for the purposes of this activity this means that this person is infected with **herpes**. Explain a little about herpes. You could do "H" for HIV. It's your choice. Be sure to explain.
- Ask this person to **read the three names** on his/her sheet and then ask those three people **to stand**.
- Explain that since we are pretending that the greetings were anal, oral, or vaginal sex, these persons are **also infected** with herpes, unless they had a "B" or "P". The "**Bs**" and "**Ps**" can sit back down

and you should explain why. Now ask **these "newly infected" people to read the names** of the people on their cards.

- You should continue to facilitate this activity until **everyone in the room is standing**, except for the "Bs" and "Ps".
- You can also do "W" and "C", if time allows.
- Clearly explain that while we were pretending that a greeting was anal, oral or vaginal sex, we know that **casual contact** (e.g. shaking hands) **does not spread STIs/HIV** from person to person.
- Thank everyone for participating and underscore the importance of getting tested and using protection, because like in this activity, people who are infected with STIs don't "look a certain way".
- Identify local HIV and STI testing sites.

Appendix 15B

Defining Sexual Abstinence

Purpose:

To assist individuals to develop individual definitions of abstinence, based on individual, family and community value systems.

Materials:

Flipchart and markers

Time: 50 minutes

Planning notes:

Before the session begins, prepare flipchart listing the behaviors from Defining Sexual Abstinence Leader's Resource. See the additional Leader's Resource, User's Guide to Sexual Abstinence, for ideas that you may want to share with the group after they have done this exercise.

Procedure:

1. On flipchart, write out SEXUAL ABSTINENCE.

2. Brainstorm with the entire group for a definition of sexual abstinence, writing down ideas as they are expressed. Do not attempt to edit or to limit these ideas.

3. Have the group count off to form small groups of three to six people, depending on group size. When the groups are formed, give each group five minutes to come up with its own definition of sexual abstinence.

4. After five minutes, display the list of behaviors.

5. Ask the small groups to work through the list of behaviors and decide (as a group) which behaviors are consistent with their group's definition of sexual abstinence. Say they will have 15 minutes to do this.

6. Have each group report back its definition, what the group discussed and which behaviors are consistent with its definition of abstinence.

7. Facilitate the discussions. Explain that the purpose of the exercise is to help young people develop their own, individual definitions of sexual abstinence and be able to communicate that definition to a romantic or sexual partner. Discuss the points in the User's Guide to Sexual Abstinence.

Leader's Resources:

Defining Sexual Abstinence

This Leader's Resource is not intended for distribution to youth. It is a general guide for the leader as to subjects that youth may raise as being consistent, in their opinion, with abstinence.

- Kissing with mouth closed
- Holding hands
- Hugging with hands on each other's back
- Flirting using the eyes only
- Open mouth kissing (French kissing)
- Touching each other's lower body with clothes on
- Mouth contact with partner's breasts
- Hugging with hands on each other's buttock
- Hands on one another's genitals
- Masturbation
- Mutual masturbation
- Reading/viewing erotica (anything that turns you on)
- Oral intercourse
- Vaginal intercourse
- Anal intercourse
- Cybersex

A User's Guide to Sexual Abstinence

- Sexual abstinence means different things to different people.
- Sexuality and sexual feelings are normal. How we choose to express and not express those feelings is a personal decision. What is right for me may not be right for you.
- Sexual abstinence, like contraception, is only effective when it is used correctly and consistently.
- To be sexually abstinent is a decision that has to be made by each individual. Sexual abstinence cannot effectively be imposed on others.
- To have sexual intercourse or to be sexually abstinent is a decision that each individual makes repeatedly throughout life. In other words, to have sexual intercourse or to be sexually abstinent is not a permanent, one-time decision.
- Sexual abstinence requires planning, commitment and skill in being assertive.
- Sexual abstinence is an option that can be used at any time.
- Knowledge of contraceptive options and how to protect oneself is helpful for when a person decides it is right for her/him to engage in sexual intercourse.
- Sometimes, a person who intends to abstain from sexual intercourse is forced or pressured into unwanted sexual activity.

SESSION 16: ACCESS TO AND USE OF CONTRACEPTIVES BY ADOLESCENTS

OBJECTIVES

- Identify obstacles to adolescents accessing contraception.
- Review myths and facts regarding contraceptive technology.

DAY: 5 – **TIME**: 1 hour and 45 minutes

MATERIALS

- Session #16 objectives written on flipchart (**FLIPCHART 16A**)
- Handout on Reflection Guide on Contraceptive Purchase (**HANDOUT 16A**)
- Relevant flipcharts from Sessions on Gender (Session 7), Youth Friendly Services (Session 11), Behavior Change (Session 9), Human Rights (Session 5) and Life Skills (Session 10).
- True/False quiz on local contraceptive myths/realities
- Flipchart with listing of contraceptive resources (**FLIPCHART 16B**) – The trainer may also develop a handout on adolescents and contraceptives (based on the resources below) or provide the participants with a handout of the listed resources.

RESOURCES

- Center for Communication Programs, Johns Hopkins University. POPLINE (**WEB SITE 16A**).
- Center for Communication Programs, Johns Hopkins University. Population Reports (**WEB SITE 16B**).
- FHI. 1995-2003. *Contraceptive Technology & Reproductive Health Series*. Training modules (**WEB SITE 16C**).
- Pathfinder International. 2003. *Adolescent Cue Cards* (Contraceptive Methods) (**WEB SITE 16D**).
- Advocates for Youth. 2003. *Condom Effectiveness*. The Facts. Advocates for Youth (**WEB SITE 16E**).
- FHI. 2002. Quick Reference Chart for the Medical Eligibility Criteria of the WHO For Initiating the Use of Combined Oral Contraceptives, Noristerat, Depo-Provera and Copper IUDs. *Network* 21(3). FHI (**WEB SITE 16F**).
- Barnett, B. 2000. Preventing Pregnancy. *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents*. FHI (**WEB SITE 16G**).
- Advocates for Youth. *Contraceptives: What Are Your Choices?* (**WEB SITE 16H**).
- FHI. 1997. Contraceptive Methods for Young Adults. *Network* 17(3). FHI (**WEB SITE 16I**).
- Advocates for Youth. *Contraceptive Myths and Facts* (**WEB SITE 16J**).

PREPARATION

One or two days in advance, participants should be instructed to buy contraceptives (condoms, spermicidal jelly/strips, or other in-country available items). Similar to the session on STIs/HIV (Session 15), instruct a health care provider to develop a presentation on current contraceptive technologies. Prepare the True/False quiz on contraceptive myths/realities, based on local beliefs and/or rumors.

FACILITATING SESSION #16

STEP 1 *(15 minutes)*
PARTICIPANTS' EXPERIENCE

- Review Session #16 objectives (**FLIPCHART 16A**).
- Distribute the "Reflection Guide on Purchasing Contraceptives" handout (**HANDOUT 16A**).
- Quickly break participants into small groups of three to four persons.
- Ask the small groups to process and discuss the contraceptive activity using the "Reflection Guide on Purchasing Contraceptives."
- Bring the participants back from their small groups and process together. Be sure to touch on the question from the handout that deals with gender and discuss how this activity would be different for adolescent males vs. females.

STEP 2 *(30 minutes)*
OBSTACLES TO ACCESS OF CONTRACEPTIVES FOR ADOLESCENTS

- Choose relevant flipcharts regarding behavioral change and protective/risk factors (from Sessions 9 and 10; these were also referenced during the preceding session on STIs/HIV).
- Have the group establish obstacles to contraceptive access faced by adolescents that are related to behavioral change. Ask the participants to identify which of the protective/risk factors are also obstacles to contraceptive access. Record participant responses on flipchart.
- Display relevant flipcharts from Session 5 (Human Rights) and ask participants to identify obstacles to contraceptive access faced by adolescents related to human rights. Discuss and record on flipchart.
- Next, display relevant flipcharts or activities from Session 11 (Youth Friendly Services) and have the group establish obstacles to contraceptive access faced by adolescents related to youth friendly issues and values, attitudes and beliefs (VABs) of providers. Discuss and record on flipchart.
- Display relevant flipcharts or activities from the Session 7 (Gender) and have the group establish obstacles to contraceptive access faced by adolescents related to gender inequity and inequality. Be sure to mention examples faced by both males and females. Discuss and record on flipchart.
- Display relevant flipcharts or activities from Session 8 (Sustainability) and have the group establish obstacles to contraceptive access faced by adolescents related to sustainability. Discuss and record on flipchart.
- At the conclusion of Step 2 participants are faced with a very long list of obstacles to contraceptive access that overlap with human rights, gender, behavior change, economics and youth-friendliness. Emphasize that the use of contraceptives is about more than knowledge. Ask participants to share one word that summarizes their feelings as a result of seeing this list.

STEP 3 *(30 minutes)*
HOW TO FACE THE OBSTACLES?

- Ask participants to share successful and creative strategies they have used to break down these obstacles to contraceptive access. Allow participants time to share their ideas with their peers, exchange resources, gain feedback, etc.
- Provide feedback and summarize strategies.

STEP 4 *(30 minutes)*
MYTHS and REALITIES

- This session can be presented by the same health care provider who presented on STIs/HIV (Session 15). This session is a review of current contraceptive technologies.
- The presenter can begin with a true/false quiz about contraceptives in order to spark the curiosity of the participants. Below is a list of sample statements that can be used. Additional examples can be found in **APPENDIX 16A**.

STATEMENTS	Mark "T" for True and "F" for False
Contraceptives make you fat	
Boys should not use contraceptives	
Girls should not use contraceptives	
The availability of contraceptives encourages sexual activity	
Using contraceptives causes infertility	
The IUD causes pelvic infections	
Breastfeeding is a contraceptive	
Repeated use of monthly injections creates a risk of cerebral hemorrhage	
The IUD provides effective protection for more than 5 years	

- After responding to these questions, the guest presenter can ask the group to reveal other local myths and rumors regarding contraceptives.
- The guest presenter will cover a 15-minute slide presentation on the cutting edge and medical facts regarding contraceptives. The health care provider should use visual aids and pictures and as many hands-on props as possible.
- Offer contraceptive resources: (**FLIPCHART 16B**) (Alternatively, you can make a handout from these.)
  - Johns Hopkins University – Center for Communication Programs
    - POPLINE - http://db.jhuccp.org/popinform/basic.html (**WEB SITE 16A**)
    - Population Reports - http://www.jhuccp.org/pr/ (**WEB SITE 16B**)
  - Choose additional sources from the "Resources" list provided (**WEB SITES 16C –16I**).
  - Ask participants for other resources.
- Review the Session #16 objectives to ensure they were met (**FLIPCHART 16A**).

NOTE TO THE TRAINER

Trainer(s) will need to work with the guest presenter to ensure that his/her presentation is creative, informative, contains correct information related to adolescents and contraception (especially in relation to those who only have sex sporadically, as is the case with many adolescents) and takes the Experiential Learning Cycle into consideration. The guest presenter may also decide to use the Learning Journal as part of his/her session.

Appendix 16A

Contraceptive Myths and Facts

There are a lot of young people who have the wrong information about contraceptives and where to get them. Here is a collection of myths and facts about contraceptives from all over the world. Use these to educate your peers.

Myth: *Since they are taken daily, oral contraceptives build up in a woman's body.*

Fact: Pills dissolve in the stomach just like other medicines and do not build up in the body.

Myth: *An IUD can leave the uterus and travel through a woman's body.*

Fact: The device almost always stays in the uterus until it removed by a health worker. If it does come out it will come through the vagina. To be sure the IUD is in place, women are advised to check for their IUD strings following each menstrual cycle.

Myth: *A condom can get lost in a woman's body.*

Fact: Because of its size, a condom is too big to get through the cervix.

Myth: *Condoms take away from pleasure.*

Fact: Using condoms does not reduce enjoyment or either partner's ability to climax. Specialty condoms can even enhance one's experience.

Myth: *Injectable contraceptives cause infertility.*

Fact: Occasionally when a woman uses a progestin injectable, it can take several months to return to regular cycles.

Myth: *Taking birth control pills makes you fat.*

Fact: Some women may experience minor weight gain, depending on the woman and the pill she is taking.

Myth: *A girl that takes the pill must be promiscuous.*

Fact: A young woman who takes the pill is acting responsibly and protecting herself against pregnancy. Additionally, the pill is often prescribed for other medical reasons, such as to make a woman's menstrual cycle more regular or to alleviate the symptoms of premenstrual syndrome.

Myth: *Wearing two condoms will provide extra protection.*

Fact: Using more than one condom creates friction and can cause them to rip.

Advocates for Youth. *Contraceptive Myths and Facts* (**Web Site 16J**).

Handout 16A

Reflection Guide on Purchasing Contraceptives

Participants had the chance to buy contraceptives (condoms, spermicidal cream/strips, etc.) before participating in this session. Participants should discuss the following in small groups:

- What contraceptive did you buy? Why this choice?
- Where did you purchase the item? Why?
- How did you feel before you went?
- Did you go in a group or by yourself? Why?
- How did you feel as you were buying the contraceptive?
- Was there a reaction of the person making the sale? What was his/her reaction?
- Were there reactions on the part of other customers?
- What reflections and lessons did you take from the experience?
- What are some things to consider concerning young people's access to contraceptives?
- Do you think this experience is different for males/females? How would your experience have been different if you were a male/female?
- Other observations:

SESSION 17: YOUNG MARRIED COUPLES

OBJECTIVES

- Identify the ASRH needs of young couples.
- Explore psychosocial norms, values and attitudes that impact the reproductive health of young couples.
- Develop strategies to address the challenges and reproductive health issues of young couples.

DAY: 5 – **TIME**: 1 hour and 30 minutes

MATERIALS

- Session objectives on flipchart (**FLIPCHART 17A**)
- Flipchart with "Expectations of a young wife" written across the top (**FLIPCHART 17B**)
- Flipchart with "Expectations of a young husband" written across the top (**FLIPCHART 17C**)
- Flipchart and markers

RESOURCES

- *Men and Reproductive Health* section of Reproductive Health Outlook (RHO) website (**WEB SITE 17A**).

PREPARATION

Prepare flipchart for Step 1.

FACILITATING SESSION #17

STEP 1 *(45 minutes)*
REPRODUCTIVE EXPECTATIONS OF YOUNG MARRIED COUPLES

- Review Session #17 objectives (**FLIPCHART 17A**).
- Ask participants whether they are familiar with programs and services directed to young couples.
- Ask participants what kinds of services are provided to this population. Summarize.
- Ask participants to think of challenges faced by young couples that are different than those faced by young people who are not married (e.g. non-married youth are discouraged from conceiving and are judged if they do; often young married couples are pressured to conceive as soon as possible and to reproduce as often as possible and are judged if they do not).
- Prepare two pieces of flipchart. On the first flipchart is written "Expectations of the young wife". On the second flipchart is written "Expectations of the young husband" (**FLIPCHARTS 17B & 17C**). Ask the group to think about expectations, values and biases that are placed on the young couple. Ask each of the following questions and record key messages under "young wife" or "young husband", as applies:
  1. What expectations do the families have of the young wife?
  2. What expectations do the families have of the young husband?
  3. What expectations do the friends have of the young wife?
  4. What expectations do the friends have of the young husband?
  5. What expectations does the community have of the young wife?
  6. What expectations does the community have of the young husband?
  7. What expectations does society have of the young wife?
  8. What expectations does society have of the young husband?
  9. What expectations do the young wife and young husband have of each other?
- Based on the responses, summarize key messages. What are the main messages given to a young wife? What are the main messages given to a young husband?
- How do these messages from family, friends, community and society impact the young couples' reproductive health? Which of these expectations are related to reproductive health and sexuality? For example, if both families send the message to reproduce as soon as possible, what will be the repercussion of this expectation?
- Are the expectations placed upon the husband/wife different based on gender? How do gender role expectations negatively impact the reproductive health of the female? Of the male?
- Discuss the role of gender and how it affects expectations surrounding family planning and parenting.
- With all these expectations and biases, is it possible for a young couple to exercise their human rights to family planning decision making?

STEP 2 *(45 minutes)*
PROVIDING SERVICES FOR YOUNG COUPLES

- Ask participants how ASRH providers can better meet the needs of young married couples.
- Ask participants to explore the importance of involving the young husband in sexuality and reproductive health services. Should there be special services and programs provided just to the young husband?

TALKING POINTS FOR THE TRAINER

1. Are there dangers to this approach? For example, if the husband has the information and not his wife, will she be in a better or worse position to make a decision? It may be important to remind participants that gender roles limit not only women and their health but men as well. Men have distinct reproductive health needs of their own. It is important that men have a place with a welcoming atmosphere to discuss sexual and reproductive health issues and receive services. Men also play an important role in the health of women and children, often serving as gatekeepers to women's access to reproductive health services.
2. Men's participation activities should seek to: promote women's equality in RH decision making; to increase men's support of women's sexual and reproductive health and of children's well-being; and to meet the reproductive and sexual needs of men. Men need to have their perspectives used in program design, to feel welcome at clinics, to have a wider range of information and services available. And to be portrayed positively.
3. The challenge is to meet the needs of men to be involved without disempowering women.

See **WEB SITE 17A** for additional information.

- Going back to the session on youth friendly services (Session 11), explain that some sexuality and reproductive health services and programs are oriented towards females, while males may not feel welcome and therefore may not support their wives in making reproductive health decisions. Or perhaps males may distrust a clinic that only provides services to women and excludes husbands.
- Brainstorm ways in which programs and services can be more inclusive of young husbands. How can this be balanced with the needs and rights of the wife?
- Ask participants to develop suggestions that would help their organizations better serve the needs of young couples.
- Looking back at the list of "Expectations of the young wife" and "Expectations of the young husband" what is the greatest challenge that must be addressed by ASRH workers? At what level should this challenge be addressed – parents? husband/wife? friends? community? society?
- Keeping this greatest challenge in mind, ask participants to record ideas in their learning journals that they wish to take home in order to better meet the reproductive health needs of young couples.
- How might this scenario change if we are talking about a young wife and a much older husband?

NOTE TO THE TRAINER

This raises the issue of power imbalances. The assumption is that the older husband has more power and therefore control in the relationship in general and in reproductive health decision making, specifically. The older husband may be ready to have children immediately while his young bride is not. How can the rights of the husband be balanced with the rights and health of the wife? How can youth friendly services help the young wife?

- Ask participants to share their ideas. Trainer(s) summarize.
- Review the Session #17 objectives to ensure they were met (**FLIPCHART 17A**).

Each evening ends with 15 minutes of Community Time (Evening Announcements & Evaluation).

SESSION 18: ACTION PLANNING[30]

OBJECTIVES

- Review key messages learned during the module.
- Determine possible applications of what was learned.
- Develop a specific action plan (application) to implement at participants' own organizations.

DAY: 6 – **TIME**: 2 hours

MATERIALS

- Session #18 objectives written on flipchart (**FLIPCHART 18A**)
- All of the flipcharts from the entire module
- Four cross cutting theme flipcharts
- Various colored sticky note pads
- Green index cards
- Participant Learning Journals
- Action Planning Worksheet (**HANDOUT 18A**)

PREPARATION

Post the flipcharts from the entire module around the room. Do this before the session starts.

[30] Closing session based on CEDPA's YDRH Action Planning II Activity, developed by Judy Palmore, 2002.

FACILITATING SESSION #18

STEP 1 *(30 minutes)*
MODULE REVIEW AND ACTION PLAN

- Review Session #18 objectives (**FLIPCHART 18A**).
- Using the multiple flipcharts and posters hanging on the wall, invite participants to briefly list the key fundamental sessions of the module: **Human Rights**, **Youth/Adult Partnerships**, **Gender**, **Sustainability**, **Behavioral Change**, **Life Skills**, **Youth Friendly Services**, **M&E**, **Advocacy**, **Access to Contraception** and **Young Couples**.
- Congratulate participants for their hard work over the past five days and explain it is now time to summarize what was covered over the course of the module and to commit to a specific Action Plan to take home.
- Using the flipcharts and posters (including the four cross cutting theme flipcharts) mounted on the wall, ask participants to slowly take 10 minutes to walk around the entire room in order to review the work accomplished and the key points covered over the past five days.
- Instruct participants that as they are reviewing the flipcharts and posters, they should place a sticky note beside all of the key points, strategies, interventions, ideas that were particularly useful or eye opening.
- Instruct participants to have a seat and look through their training manuals and learning journals in order to also review the work accomplished and the key points covered over the past five days.
- Instruct participants that as they are reviewing their learning journals, they should place a sticky note beside all of the key points, strategies, interventions and ideas that were particularly useful or eye opening for them.
- Ask participants to return to the flipcharts, posters and learning journals where they placed sticky notes and choose five strategies or interventions they feel committed to start planning. Ask the participants to physically gather these 5 sticky notes, with the intervention/strategy written on each and lay the notes out in front of him/her.
- Next give each participant a green index card. Inform participants that from the collection of five intervention/strategies they liked best, they are to choose the one they most wish to implement back home. The participant should write the one intervention/strategy on the green index card and the other sticky notes can be placed inside the participants' learning journals to be implemented and pursued at a later date.

STEP 2 *(30 minutes)*
ACTION PLAN WORKSHEET

- Distribute the Action Planning Worksheet and give participants the opportunity to work out the details of their selected Action Plan (**HANDOUT 18A**).

STEP 3 *(45 minutes)*
PEER REVIEW

- Once the participants have designed their activities, have them form groups based on their selected Action Plan. Trainer(s) should facilitate the formation of small groups by asking participants to

identify their selected Action Plans. Small groups should then be formed based on similar topics. Within the small groups, participants should present their Action Plans to each other.

- Instruct participants to ask each other questions and make suggestions to their colleagues.
- Thank the group for its participation and end the session. Collect participant action plans and make photocopies (one copy remains with the trainer(s) and the original will be returned to the participant during the graduation ceremony).

STEP 4 *(15 minutes)*
UPDATE PARTICIPANTS' PROFILE

- Bring the group's attention to the participants' profile which they completed on Day 1 (Session 3):

QUESTION	POSSIBLE ANSWERS	CHECK ALL THAT APPLY
I have been working with adolescents for…	1 to 3 years	
	4 to 6 years	
	7 to 10 years	
	More than 10 years	
I have ASRH experience in the areas of…	Rights	
	Gender	
	Advocacy	
	Administration	
	IEC/BCC	
	Medical services	
	Counseling	
	Training of peer educators	
	Research, Monitoring/Evaluation	
I consider my level of knowledge and skills for working with adolescents…	Inadequate	
	Average	
	Good	
	Excellent	
I would like to strengthen my managerial skills for working with adolescents in…	Rights	
	Gender	
	Advocacy	
	Administration	
	IEC/BCC	
	Medical services	
	Counseling	
	Training of/peer educators	
	Research, Monitoring/Evaluation	

- Distribute gold stickers to the participants. Ask participants to place the gold stickers in the columns that apply (as was done with silver stickers on Day 1). Urge participants to see what progress has been made over the past five days. The silver stickers represent the participants' responses before the module; the gold will represent the participants' responses on the final day of the training.
- The trainer(s) should examine the difference in silver and gold stickers and note where the majority of gold stickers are located. For example, is there an increase in the number of participants who want to know more about a specific subject? Was there an increase in the "level of knowledge"? What were the most significant changes?
- Review Session #18 objectives to ensure they were met (**FLIPCHART 18A**).

Handout 18A

ACTION PLANNING WORKSHEET

What is your action plan?

Describe the desired outcome of this plan?

How are the rights of adolescents guaranteed? respected? promoted?

What areas of behavior change are you addressing in this Action Plan?

What types of protective/risk factors do you plan to address in this Action Plan?

How does this Action Plan incorporate gender? How does your Action Plan address gender inequities?

How will this Action Plan make your program more sustainable? How will you ensure institutional support for this action plan?

How will youth be involved in this Action Plan? At what level of the continuum/ladder (discussed in Session #6) will youth be involved?

How will this Action Plan be monitored and evaluated?

Is advocacy needed in this Action Plan? What are the steps? What is the advocacy message?

With whom will you partner to implement this Action Plan?

Briefly develop a timeline for your Action Plan

Action	By when will this step be performed?	Who will help me to perform this step?	Resources needed

The action plan will need a budget. Resources (financial and human) need to be identified for the implementation of the action plan. The costing of the activities does not have to be done at this stage but it is an important step that can be completed in collaboration with the accounting department when you return to your organization.

SESSION 19: EVALUATION AND CLOSE OF THE MODULE

OBJECTIVES

- Evaluate the Module on Adolescent Sexuality and Reproductive Health.

DAY: 6 – **TIME**: 1 hours and 30 minutes

MATERIALS

- Copy of evaluation for each participant (**HANDOUT 19A**)
- Graduation certificates
- List of participants' contact information (addresses, phone numbers, e-mail addresses, etc.) to be distributed.

PREPARATION

Design and prepare the graduation certificates. Create a sheet of participants' contact information.

FACILITATING SESSION #19

STEP 1 *(45 minutes)*
EVALUATION

- Ask each participant to complete the evaluation of the module (**HANDOUT 19A**).
- Distribute the participants' contact information and any other resources.

STEP 2 *(45 minutes)*
GRADUATION/CLOSING

- Formally culminate the event with a graduation ceremony and distribute the graduation certificates. Include a copy of the participant's Action Plan with the certificate.
- Inform participants they will receive a summary of the overall evaluation within the next six months.

Module Evaluation

Overall Module Evaluation

Please take your time and thoroughly evaluate the ASRH Module that you have just completed. Your opinion matters and the trainer(s) will consider your feedback when developing and delivering future modules. Thank you.

E=Excellent G= Good A=Average P=Poor

Item to be Evaluated	Evaluation Criteria	E	G	A	P
CONTENT	Relevant to ASRH				
	Accurate and thorough				
	Applicable to my work				
	New skills				
	Handout, websites, resources				
METHODOLOGIES	Logical flow				
	Participatory				
	Built on participants' knowledge and experiences				
	Met session objectives				
	Linked topics together in a logical manner				
	Use of learning journal				
WHAT YOU LEARNED	Personally				
	Professionally				
	That can be transferred to your work with youth				
	That can transferred to your organization				
QUALITY OF TRAINERS	Facilitation skills				
	Keeping to the agenda and time				
	Offer assistance to participants				
	Linked relevant sessions to each other				
	Knowledge of content and ASRH				
LOGISTICS	Information prior to module				
	Information during the course of the module				
	Guidance of action plans				
	Travel and lodging arrangements				
	Transport from airport to hotel				
	Daily transport				
	Lodging				
	Meals				
	Rooms and equipment				
	Response to personal needs				

Qualitative Evaluation of the Module

How were your expectations met? How were your expectations not met?

What sessions do you think were effective and why?

What sessions do you think were not effective and why?

Do you think there are topics that were not covered that should have been? What are they?

Do you think there are sessions that should be eliminated? If so, which ones?

Module Evaluation (cont.)

Have you had the chance to attend other workshops on ASRH for young people or for adolescents? If so, how did this workshop compare?

Write at least one idea or experience you had during the workshop that you plan to apply in your organization.

What are your recommendations for the next workshop?

Please comment on the benefit of the Action Plan.

Add any additional comments and suggestions on the other side of this page.

OPTIONAL SESSION 1: SEX, SEXUALITY, SEXUAL HEALTH

OBJECTIVES

- Define sex, sexuality and sexual health.
- Explore our own sexuality journey during adolescence and young adulthood.
- Link and apply the exciting, but challenging journey of adolescence to our work with youth.
- Explore the psychosocial components of sexuality and how they impact our work with youth.

DAYS: 3 – **TIME**: 3 hours and 30 minutes

MATERIALS

- Flipchart with session objectives written on it (**FLIPCHART O1A**)
- Flipchart with words "Sex", "Sexuality" and "Sexual Health" written on the top (**FLIPCHARTS O1B, O1C & O1D**)
- Flipchart with definitions of Sex, Sexuality and Sexual Health (**FLIPCHARTS O1E, O1F & O1G**) (**WEB SITE O1A**)
- Flipchart with questions from Step 2 written on it (**FLIPCHART O1H**)
- Flipchart, markers
- Magazines, art supplies

RESOURCES

- The Sexuality Information and Education Council of the U.S. (SIECUS) (**WEB SITE O1A**).
- Advocates for Youth. 2000. *Transitions* 12(2). Advocates for Youth (**WEB SITE O1B**).

PREPARATION

The activity requires arranging the setting. Make the setting as comfortable and confidential as possible. Do not encourage interns or other staff to come in and out of the classroom during this session.

The day before, suggest that participants come the next day dressed in comfortable clothing.

FACILITATING THE SESSION

STEP 1 *(45 minutes)*
DEFINING TERMS

- Go over the session objectives flipchart (**FLIPCHART O1A**).
- Explain that it is time to explore a key word that is part of this workshop: sexuality, the "S" in ASRH. Explain that this activity will begin to explore the terms sex, sexuality and sexual health and how they related to ASRH.
- Break the large group into three small groups, preferably by engaging them in a creative activity.
- Give each group a piece of flipchart with one of the following words written on the top: SEX, SEXUALITY and SEXUAL HEALTH (**FLIPCHARTS O1B, O1C & O1D**).
  1. Ask the groups to write words, definitions, pictures that define the word or words that are written on their piece of flipchart.
  2. Allow five minutes and then rotate, so that group A now has the sheet that group B had and so on.
  3. Allow three minutes to make additions and then rotate again. Each group should have an opportunity to record, make additions to each sheet of flipchart.
  4. Tape each sheet onto the wall and ask the group to comment on themes and definitions used. Ask the group for clarification on terms or pictures that are not understood. Process.
  5. Ask the group to identify common themes or links among the three. Ask if the participants can identify why the facilitator chose these three words to dissect. How does defining these terms impact our work with youth?
- Finally offer definitions of these terms[33] and ask the group to edit accordingly in order to reach definitions on which the entire group can agree (**FLIPCHARTS O1E, O1F & O1G**).
  - Sex – biological male or female or a sexual act.
  - Sexuality – is reflected in the total expression of who we are as human beings. It involves a person's values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, socialization and spiritual selves. It involves sexual expression and relationships, as well as the biology of the sexual response system. Sexuality begins before birth and lasts a lifetime and it is influenced by ethical, spiritual, cultural and moral factors. It involves giving and receiving sexual pleasure, as well as enabling reproduction. Sexuality is a total sensory experience, involving the whole mind and body – not just the genitals.
  - Sexual Health – is the ability to express one's sexuality free from the risk of sexually transmitted infections, unwanted pregnancy, coercion, violence and discrimination. It means being able to have an informed, enjoyable and safe sex life, based on a positive approach to sexual expression and mutual respect in sexual relations. It is positively enriching, includes pleasure and enhances self-determination, communication and relationships.
- Point out that often when we talk about sexuality, we leave out the pursuit of sexual health (the third flipchart). Sexuality is an eclectic phenomenon that is about more than biological development or the act of "sex" (the first flipchart). It involves many components, which we will pursue later.

[33] Siecus (**WEB SITE O1A**).

STEP 2 *(60 minutes)*
PURSUING OUR OWN SEXUALITY:

- Explain that in order to further pursue sexuality, we are going to ask participants to take a look at their own sexuality, their own journey through sexuality.
- Trainers will assist participants in setting ground rules in order to establish a safe climate for this activity. These ground rules will be posted during the entire session on sexuality and gender. Examples of possible ground rules:
  - Confidentiality: What is discussed in the room, remains in the room and is not for discussion outside of the training session.
  - Respect: Respect the opinions being expressed and if one does not agree, be willing to agree to disagree with respect.
  - Right to not participate: Allow participants and colleagues the space to not participate if that is their choice. Silence is allowed and not judged.
  - Avoid making judgments or assumptions about one's sexuality or sexual activities.
- Lead a brief discussion: When does sexuality occur? When does it begin? When does it end? Is it constant? Is it just when we are adolescents or young? Is it when we are babies? Revisit the definition of sexuality that states that it begins before birth and lasts a lifetime.
- Explain that the following activity will allow participants precious time to recall their own sexuality through young adulthood. It is not to say that sexuality ends with young adulthood, as was already stated, but this pursuit through young adulthood may prepare participants to better work with young people. The activity is a meditation. The participants close their eyes and for 10 minutes recall as many memories as they can about their sexuality from birth through young adulthood. Explain that soft music will be playing in the background and participants are encouraged to get comfortable in their chairs or on the floor and to close their eyes. Be sure to add that if anyone feels uncomfortable during the activity he/she should feel free to open his/her eyes, but not to make noise or interrupt the process that others are experiencing.
  1. Allow participants to get comfortable. The instructor may choose to play music, but it should be gentle music with no vocals.
  2. Allow a 10 minute quiet meditation, reminding participants to begin with birth and slowly walk through and recall their sexuality journey through young adulthood.
  3. After slowly bringing the participants back to the present, ask if anyone would like to share part of his/her journey? Allow silence for people to think about responding. This is not a time to process, but to listen. After people have shared, thank the group for participating in this activity.
- Break the large group into small groups of four. Within certain cultures, it may be more appropriate to separate the men and women for both the small group work and the feedback/sharing from the small group work. This will require a male and a female trainer. Explain that the purpose of the next activity is to bridge from their meditation to identifying key memories of their sexuality journey. This activity will also help participants identify what was helpful/not helpful during their journey.

- Explain that in their small groups, they have the right, of course, to not answer or to pass.
  - Post the following questions on a flipchart and ask the small groups to discuss (**FLIPCHART O1H**).
    - What was your first message about sexuality? Was it positive/negative/idealistic/realistic? If it was negative, tell about your first positive message.
    - What was your most positive and negative physical change during adolescence? How did you deal with both the negative and positive?
    - What made you feel ashamed or guilty during adolescence/young adulthood? What made you feel proud and accomplished during adolescence/young adulthood?
    - What was helpful during this transition? What was not helpful? Even though this may be done in groups separated by gender, they should be informed that this section on helpful and not helpful issues will be shared in the entire group.
- Bring the entire group together again and process the activity. The trainer explains the rules for processing this activity: No names should be given; only individual people can speak for themselves, no one has to participate, etc. The trainer should make time to walk through each question and give the group time to respond, all the while writing the "positive/helpful factors" on a "positive/helpful" flipchart and "negative/challenging factors" on a "negative/challenging" flipchart.

STEP 3 *(30 minutes)*
APPLICATION: If the group was separated into same sex small groups, they will come back together in one group for this step.

- Bridge from STEP 2: After all questions of the last activity in Step 2 have been discussed and participants who wish to share have done so, the trainer thanks the participants for their bravery and honesty. The trainer now asks the participants to take a look at the two lists. What do they see? Anything familiar? Anything to add? Anything that makes them feel sad, happy, encouraged?
- Ask how this list and our own experience apply to the work we do with youth? Process: How do the negative/challenging feelings impact behavior? How do the positive feelings and experiences impact behavior? How do they apply to outreach with youth? To programming?
- Ask participants to go to their learning journals and write about one intervention or program that would address both a positive trait of this journey and a negative trait of this journey. In other words what program would optimize the positive/helpful traits of the journey and foster healthy sexuality decision making and what type of program will minimize the negative/challenging traits in order to foster healthy sexuality decision making? (Allow 15 minutes for writing and 5 minutes for sharing with one partner).
- Ask if anyone wants to share. Encourage feedback from most of the group. This activity of application is KEY; the trainer may have to push the participants a bit to share their application strategy. Trainer also gives examples of helpful strategies and explores the importance of being nonjudgmental, not defining normal/abnormal, not describing sexual behavior as normal/abnormal and tolerance, as strategies.
- Emphasize that shame and judgment often lead youth to the most risky behavior.

STEP 4 *(45 minutes)*
COMPONENTS OF SEXUALITY

- Ask participants to look back at the "negative/challenging" flipchart and the "positive/helpful" flipchart. Ask participants to review the list and to think of factors or components that impact how we feel about our sexuality. What makes us feel inclined to feel guilty about one thing or positive about another? What influences sexuality in our culture? What influences how we feel sexually, act sexually, identify sexually, etc?
  - Ask participants to decorate the large flipchart paper on the wall with magazine pictures, words, expressions, drawings, etc. of the different factors and components of sexuality and what influences how we define, express, identify, act out sexuality in our culture. Allow participants 35 minutes to do this.
  - Process the activity by asking participants to explain the symbols, pictures, drawings, words that were expressed. Explain that sexuality is very complicated and briefly add any components or factors that were not expressed by the group (e.g. gender, religion, culture, media, customs, race, family).
  - At this moment the trainer can cover any theory or components of sexuality that he/she wishes to present. Profamilia/Colombia uses a model based on biology, sexual identity, sexual roles and assigned sex. This is an example. Others may use general psychosocial factors that influence sexuality (e.g. culture, social, psychological, biological).
  - Ask participants to identify the link between these theories or components and their work in ASRH.
  - Process by asking participants to identify what is useful from this theory or what they will be able to apply.

STEP 5 *(30 minutes)*
Journal processing/Conclusion:

- Trainers have participants go to respond in their journals to the following:
  - What about this session surprised you?
  - What about this session encouraged you?
  - What about this session kept you questioning?
  - What about this session will impact your work with youth?
- Allow 10 minutes to write
- Allow 10 minutes to share. As many people who want to share should be able to.
- Ask participants to think about the cross cutting themes that have been addressed thus far. Through this session on sexuality can participants identify:
  1. A new idea gained about sexuality that related to Rights, Youth/Adult Partnerships or Gender?
  2. Do I have struggles and challenges with sexuality and Rights, Youth/Adult Partnerships or Gender?
  3. What ideas do I have regarding sexuality and Rights, Youth/Adult Partnerships or Gender?
  4. Examples of strategies, ideas and skills to adequately and successfully address sexuality within Rights, Youth/Adults Partnerships or Gender?
- Finally, ask the participants to record connections between sexuality and rights; sexuality and youth/adult partnerships; and sexuality and gender.
- Review the session objectives to ensure they were met (**FLIPCHART O1A**).

OPTIONAL SESSION 2: FIELD VISIT – PREPARATION FOR FIELD VISIT

OBJECTIVES

- Identify the specific site to be visited by the participants.
- Develop a list of goals and objectives for the field visit.

TIME: 1 hour

MATERIALS

- Session objectives on flipchart (**FLIPCHART O2A**)
- Travel instructions (if necessary)
- Per diem (if necessary)
- Observation guide for participants (**HANDOUT O2A**)

PREPARATION

Thoroughly prepare all logistics related to the visit. This preparatory session should be held the afternoon prior to the field visit.

FACILITATING THE SESSION

STEP 1 *(30 minutes)*
GOALS AND OBJECTIVES

- Review session objectives (**FLIPCHART O2A**).
- Briefly cover information pertaining to the Field Visit. The location of the site, potential travel, logistics, per diem, times of departure, etc. Specific logistics will be covered under Step 2.
- Ask the participants to brainstorm a list of goals and objectives for the field visit. What do the participants hope to gain from these visits? Record responses on flipchart.
- Now ask the participants how they plan to achieve these goals and objectives. Encourage participants to be actively involved in the visits and ask questions of staff and the host.

STEP 2 *(30 minutes)*
LOGISTICS AND QUESTIONS

- Provide participants with all relevant information regarding their trip.
- Provide specific instructions as to where participants should meet for their departure.
- Assign a team leader for each group.
- Answer participants' questions.
- Remind participants of the goals and objectives of the visit.
- Destribute observation guide handout to participants (**HANDOUT O2A**).

OPTIONAL SESSION 2: FIELD VISIT – CONDUCTING THE FIELD VISIT

OBJECTIVES

- Learn more about ASRH services offered in the field.
- Identify new ideas for ASRH delivery of programs and services.

TIME: 1 Day *(5-8 Hours)*

MATERIALS

- Observation guide for participants (**HANDOUT O2A**)

CONDUCTING THE SESSION

- During the visit:
  - Representatives of the institution in each location welcome the group, show the facilities, lead a tour and present the infrastructure and services of the site.
  - The participants have interviews with directors; staff that handle programs and services, and young people.
  - They may have the chance to observe treatment procedures (depending on the planning and coordination of the activity).
  - The tour allows them to define the context, policy and substance of programs and services.
  - The coordinator of the program presents the objectives, activities, strategies and goals of the site. S/he gives examples with cases, shares materials and discusses management structures.
  - Plenty of time is left to allow participants the opportunity to ask questions.
- The participants use the observation guide for participants (**HANDOUT O2A**) to make sure their goals and objectives of the visit (as identified in the previous session) are met.

OPTIONAL SESSION 2: FIELD VISIT – EXCHANGING EXPERIENCES FOLLOWING THE FIELD VISIT

OBJECTIVES

- Reflect on lessons learned from site visits.
- Critique services provided at the site.
- Choose one strategy that can be implemented in participants' organization.

TIME: 1 hour and 30 minutes

MATERIALS

- Observation guide for participants (**HANDOUT O2A**)
- Participants' learning journals

CONDUCTING THE SESSION

STEP 1 *(1 hour)*
SUMMARY OF VISIT: LESSONS LEARNED

- Using the observation guide for participants (**HANDOUT O2A**), facilitate a discussion on the participants' observations during the site visit.
- Go through each question and lead a discussion on the services and programs observed.
- Explore lessons learned and observations for improvement.
- Revisit the goals and objectives of the field visits that the participants developed in the session "Preparation for Field Visit".
- Discuss ideas and strategies observed that participants could possibly implement or adapt in their home locations.
- Review the ideas and concepts that have been presented by the participant.
- Ask participants to offer criticism and suggestions for making the programs and services of the organization they observed more effective.

STEP 2 *(30 minutes)*
CLOSING

- Close the session by asking participants to record one strategy in their learning journals gained from their visit that they wish to implement in their organization.
- Next ask the participants to write a pretend letter in their journals to the coordinator of the site they visited. In this letter they should offer a suggestion that the coordinator could implement to improve his/her ASRH programs and services. This suggestion should cite knowledge gained through a session or sessions in the module.
- Have participants share their letters with each other.

Handout O2A

Guide For Participants

Field visits represent a chance to show how ASRH programs and services for adolescents are carried out in a specific setting. Summarize what you gathered from your visit to the center.

Name of center: _____

Programs and services: _____

Key characteristics: _____

_____

Strengths:

Weaknesses:

Obstacles and challenges:

What is your general view of this service?

How are youth involved? To what extent?

Are the four crosscutting themes woven into the programs and services? How?

What do you suggest to this program or services for improvement?

How do they manage M&E?

Does the site have an advocacy component?

How does this site ensure sustainability?

General observations?

Comments?

WEB SITE RESOURCES USED THROUGHOUT THE MODULE

WEB SITE 4A.

James-Traore, T. A. 2001. *Developmentally Based Interventions and Strategies: Promoting Reproductive Health and Reducing Risk among Adolescents.* [FOCUS Tool Series 4]. FOCUS on Young Adults.
http://www.pathfind.org/pf/pubs/focus/guidesandtools/PDF/Focus_tool4.pdf

WEB SITE 4B

Salgado, A.M., and N. Cheetham. 2003. The Sexual and Reproductive Health of Youth: A Global Snapshot. *Transitions* 15(2). Advocates for Youth.
http://www.advocatesforyouth.org/publications/factsheet/fsglobal.htm

WEB SITE 4C

Cheetham, N. 2003. Youth and the Global HIV/AIDS Pandemic. *Transitions* 15(2). Advocates for Youth.
http://www.advocatesforyouth.org/publications/factsheet/fsglobalHIV.htm

WEB SITE 4D

JHUCCP. 1995. Meeting the Needs of Young Adults. Population Report XXIII(3).
http://www.jhuccp.org/pr/j41edsum.shtml

WEB SITE 5A

Center for Reproductive Rights: Human Rights publications
http://www.crlp.org/pri_humanrights.html

WEB SITE 5B

Center for Reproductive Rights: The Reproductive Health and Rights of Adolescents
http://www.crlp.org/ww_iss_adolesc.html

WEB SITE 5C

UN Convention on Eliminating all Forms of Discrimination against Women.
http://www.un.org/documents/ga/res/44/a44r073.htm

WEB SITE 5D

Convention on the Rights of the Child.
http://www.unhchr.ch/html/menu3/b/k2crc.htm

WEB SITE 5E

Summary of United Nation Agreements on Human Rights. (Including links to the documents).
http://www.hrweb.org/legal/undocs.html.

WEB SITE 5F

Human Rights Web. (Listing and links to human rights organizations)
http://www.hrweb.org/resource.html

WEB SITE 6A

UNICEF. *The Participation Rights of Adolescents: A Strategic Approach.* Working Paper Series. UNICEF.
http:// www.unicef.org/programme/youth_day/assets/participation.pdf

WEB SITE 6B

Senderowitz, J. 1998. *Involving Youth in Reproductive Health Projects.* FOCUS on Young Adults.
http://www.pathfind.org/pf/pubs/focus/IN%20FOCUS/h-involve%20youth%20.html

WEB SITE 6C

Klindera, K. and J. Menderweld. 2001. *Youth Involvement in Prevention Programming.* Issues at a Glance. Advocates for Youth.
http://www.advocatesforyouth.org/publications/iag/involvement.htm

WEB SITE 6D:

Sonti, S. and W. Finger. 2003. Youth-Adult Partnerships Show Promise. *YouthLens* 4. YouthNet.
http://www.fhi.org/en/Youth/YouthNet/Publications/YouthLens+English.htm

WEB SITE 6E:

Norman, J. and K. Klindera. *Youth as Assets: Building Effective Youth-Adult Partnerships.* YARH Brief 3. FOCUS on Young Adults.
http://www.pathfind.org/pf/pubs/focus/pubs/YARH%20Briefs/bri3fin.pdf

WEB SITE 6F:

YouthNet. *Youth Involvement Web sites.*
http://www.fhi.org/en/Youth/YouthNet/ProgramsAreas/YouthInvolvement/youthinvolvewebsites.htm

WEB SITE 7A:

Canadian International Development Agency (CIDA). 1999. *CIDA's Policy on Gender Equality.* Quebec: CIDA.
http://www.acdi-cida.gc.ca/equality

WEB SITE 7B:

Organization for Economic Cooperation and Development (OECD). 1998. *DAC Guidelines for Gender Equality and Women's Empowerment in Development Co-operation.* Paris: OECD.
http://www.oecd.org/dataoecd/36/44/1887530.pdf

WEB SITE 7C:

Paulson, S. 1998. Opinion: Gender Insights Can Improve Services. *Network* 18(4). Family Health International (FHI).
http://www.fhi.org/en/ReproductiveHealth/Publications/Network/v18_4/nw184ch7a.htm

WEB SITE 7D:
Paulson, S., Gisbert, M. and M. Quinton. 2000. *Rethinking Differences and Rights in Sexual and Reproductive Health: A Training Manual for Health Care Providers.* FHI.
http://www.fhi.org/en/ReproductiveHealth/Training/trainmat/rethinkDiff/index.htm

WEB SITE 7E:
Barnett, B. 1997. Gender Norms Affect Adolescents. *Network* 17(3). FHI.
http://www.fhi.org/en/ReproductiveHealth/Publications/Network/v17_3/index.htm

WEB SITE 7F:
Lane, C. 1995. *Gender Bias: Perspectives From the Developing World. T*he Facts.Advocates for Youth.
http://www.advocatesforyouth.org/publications/factsheet/fsgender.htm

WEB SITE 9A: Lipovsek, V. et al. 2000. *Risk and Protective Factors for Unplanned Pregnancy among Adolescents in La Paz, Bolivia.* FOCUS on Young Adults.
http://www.pathfind.org/pf/pubs/focus/pubs/bolcorsu.pdf

WEB SITE 10A:
UNICEF. Life Skills-based Education: What Do All These Terms Mean?
http://www.unicef.org/programme/lifeskills/whatwhy/define.html

WEB SITE 10B:
World Health Organization. 1998. Health Promotion Glossary. Geneva. WHO/HPR/HEP/98.1
http://www.wpro.who.int/hpr/docs/glossary.pdf

WEB SITE 10C:
Moya, C. 2002. *Life Skills Approaches to Improving Youth's Sexual and Reproductive Health.*
Issues at a Glance. Advocates for Youth.
http://www.advocatesforyouth.org/publications/iag/lifeskills.htm

WEB SITE 10D:
Moya, C. *Life Skills Approaches to Improve Youth Adult Reproductive Health.* YARH Brief 2.
FOCUS on Young Adults.
http://www.pathfind.org/pf/pubs/focus/pubs/YARH%20Briefs/bri2fin.pdf

WEB SITE 11A:
Barnett, B. 2000. Chapter 8: Youth friendly Programs. *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents.* FHI.
http://www.fhi.org/en/ReproductiveHealth/Publications/servdelivery/adolguide/Chapter8.htm

WEB SITE 11B:
Senderowitz, J., Solter, C. and G. Hainsworth. 2003. *Clinic Assessment of Youth-Friendly Services: A Tool for Improving Reproductive Health Services for Youth.* Pathfinder International.
http://www.pathfind.org/site/PageServer?pagename=Publications_Programmatic

WEB SITE 11C:
Senderowitz, J. 1999. Making Reproductive Health Services Youth Friendly.
FOCUS on Young Adults.
http://www.pathfind.org/pf/pubs/focus/RPPS-Papers/makingyouthfriendly.PDF

WEB SITE 11D:
Senderowitz, J. Solter, C. and G. Hainsworth. 2002. *Module 16: Reproductive Health Services for Adolescents.* Pathfinder International.
http://www.pathfind.org/site/PageServer?pagename=Publications_Training_Modules

WEB SITE 12A:
Adamchak, S. et al. 2000. *A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs.* [FOCUS Tool Series 5]. FOCUS on Young Adults.
http://www.fhi.org/en/Youth/YouthNet/Publications/FOCUS/ToolsGuides/index.htm

WEB SITE 13A:
International Planned Parenthood Federation (IPPF). 2001. *Advocacy Guide for Sexual and Reproductive Health & Rights.* IPPF.
http://mirror.ippf.org/pubs/advocacyguide/index.htm

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Rosen, J. 2000. *Advocating for Adolescent Reproductive Health: Addressing Cultural Sensitivities.* In FOCUS. FOCUS on Young Adults.
http://www.pathfind.org/pf/pubs/focus/IN%20FOCUS/nov_2000.htm

WEB SITE 13C:
Advocates for Youth. 1996. Advocacy Kit. Advocates for Youth.
http://www.advocatesforyouth.org/publications/advocacykit.pdf

WEB SITE 15A:
Advocates For Youth. *Sexually Transmitted Diseases to Know.*
http://www.advocatesforyouth.org/teens/health/stds/types.htm

WEB SITE 15B:
Barnett, B. 2000. Preventing Sexually Transmitted Infections. *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents.* FHI.
http://www.fhi.org/en/ReproductiveHealth/Publications/servdelivery/adolguide/Chapter4.htm

WEB SITE 15C:
Best, K. 2000. Many Youth Face Grim STD Risks. *Network* 20(3). FHI.
http://www.fhi.org/en/ReproductiveHealth/Publications/Network/v20_3/index.htm

WEB SITE 15D:
FHI. 2003. *Reproductive Health of Young Adults: Contraception, Pregnancy and Sexually Transmitted Infections/HIV.* Training module: Contraceptive Technology and Reproductive Health Series. FHI.
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WEB SITE 15E:
Finger, W. 2002. HIV: Voluntary Counseling and Testing. *YouthLens* 3. YouthNet.
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WEB SITE 15F:
Hainsworth, G. and T. Colton. 2002. *Preventing HIV/AIDS Among Youth.* HIV/AIDS Fact Sheet. Pathfinder International.
http://www.pathfind.org/site/DocServer/Topic_Briefs_-_adolescents2.pdf?docID=281

WEB SITE 15G:
Advocates for Youth. *Defining Sexual Abstinence.*
http://www.advocatesforyouth.org/lessonplans/defining1.htm

WEB SITE 16A:
Center for Communication Programs, Johns Hopkins University. POPLINE.
http://db.jhuccp.org/popinform/basic.html

WEB SITE 16B:
Center for Communication Programs, Johns Hopkins University. Population Reports.
http://www.jhuccp.org/pr/

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WEB SITE 16D:
Pathfinder International. 2003. *Adolescent Cue Cards* (Contraceptive Methods).
http://www.pathfind.org/site/PageServer?pagename=Publications_Programmatic

WEB SITE 16E:
Advocates for Youth. 2003. *Condom Effectiveness.* The Facts. Advocates for Youth.
http://www.advocatesforyouth.org/publications/factsheet/fscondom.htm

WEB SITE 16F:
FHI. 2002. Quick Reference Chart for the Medical Eligibility Criteria of the WHO For Initiating the Use of Combined Oral Contraceptives, Noristerat, Depo-Provera, and Copper IUDs. *Network* 21(3). FHI. ***http://www.fhi.org/en/ReproductiveHealth/Publications/servdelivery/quickreferencechart.htm***

WEB SITE 16G:
Barnett, B. 2000. Preventing Pregnancy. *Meeting the Needs of Young Clients: A Guide to Providing Reproductive Health Services to Adolescents.* FHI.
http://www.fhi.org/en/ReproductiveHealth/Publications/servdelivery/adolguide/Chapter3.htm

WEB SITE 16H:
Advocates for Youth. Contraceptives: *What Are Your Choices?*
http://www.advocatesforyouth.org/teens/health/contraceptives/index.htm

WEB SITE 16I:
FHI. 1997. Contraceptive Methods for Young Adults. *Network* 17(3). FHI.
http://www.fhi.org/en/ReproductiveHealth/Publications/Network/v17_3/nt1735.htm

WEB SITE 16J:
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http://www.advocatesforyouth.org/teens/health/contraceptives/mythsfacts.htm [July 11, 2003]

WEB SITE 17A:
Men and Reproductive Health section of Reproductive Health Outlook (RHO) website.
http://www.rho.org/html/menrh.htm

WEB SITE O1A: Sexuality Information and Education Council of the United States (SIECUS).
http://www.siecus.org

WEB SITE O1B: Advocates for Youth. 2000. *Transitions*12(2). Advocates for Youth.
http://www.advocatesforyouth.org/publications/transitions/transitions1202.htm

General

Advocates for Youth: publications.
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http://www.cedpa.org/publications/index.html

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http://www.pathfind.org/site/PageServer?pagename=Publications_FOCUS_Publications

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Reproductive Health Gateway.
http://www.rhgateway.org/

The Sexuality Information and Education Council of the U.S. (SIECUS).
http://www.siecus.org

YouthNet. 2002. *Intervention Strategies that Work for Youth –Summary of FOCUS on Young Adults End of Program Report.* Youth Issues Paper. YouthNet.
http://www.fhi.org/en/Youth/YouthNet/Publications/YouthIssuesPapers.htm