

Youth Friendly Health Services (YFHS)

A Training Guideline for Vanuatu

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ANNEX

Trainers Tools

Training Slides

Abbreviations

ABR	Adolescent birth rate
ASRH	Adolescent Sexual and Reproductive Health
CEDAW	Convention on the Elimination of All Forms of Discrimination Against Women
CPR	Contraceptive prevalence rate
ECP	Emergency contraceptive pill
FLE	Family Life Education
HIV	Human Immunodeficiency Virus
ICPD	International Conference on Population and Development
IMR	Infant mortality rate
KPA	Key Policy Area
M&E	Monitoring and evaluation
MAF	MDG Acceleration Framework
MDG	Millennium Development Goal
MOH	Ministry of Health
MMR	Maternal mortality ratio
OCP	Oral contraceptive pill
RHCS	Reproductive Health Commodities Security
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health [Committee]
SGS	Second Generation Surveillance
SPC	Secretariat of the Pacific Community
SDG	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually transmitted infection
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCCT	Voluntary confidential counselling and testing [for HIV and STIs]
VNSO	Vanuatu National Statistics Office
WHO	World Health Organization
YFHS	Youth Friendly Health Services

Foreword

YFHS Team to write

Acknowledgements

YFHS Team to add further

Sincere thanks to the participants in the Youth Friendly Health Services Training of Trainers programme 27 – 30 September 2016 who provided invaluable feedback on the draft manual.

A range of existing resources was drawn on in the preparation of this manual. Activities and content were adapted and utilised with permission from the following resources:

- Youth Friendly Services: A Manual for Service Providers, Engender Health 2002
- Orientation Programme on Adolescent Health for Health-care Providers, WHO, 2006
- Training Manual for the Providers of Youth Friendly Services, FHI-UNFPA 2008
- Comprehensive Reproductive Health and Family Planning Training Curriculum: Module 16: Reproductive Health Services for Adolescents, Pathfinder International 2004
- Adolescent Sexual & Reproductive Health: A Training Manual for Program Managers, Catalyst Consortium, 2005

This manual was prepared for UNDP by Dr Robyn Drysdale, YFHS Consultant.

How to use the manual

NOTES TO THE TRAINER

PURPOSE

This training manual is designed to prepare participants to provide quality health services to young people. It is to be used to train health care workers and service providers. Parts of the program or individual modules may be adapted for use with community health workers or other staff. It is intended to be a dynamic and interactive program in which trainers/facilitators actively engage the participants in the teaching/learning process. A range of teaching and learning methods has been carefully selected to enable this to happen in an effective manner. All of the modules in the curriculum are designed to actively involve participants in the learning process. Sessions include simulation skills practice; discussions; case studies; role plays; and using objective knowledge, attitude, and skills.

The role of the facilitator

Facilitation is a helping or an enabling process, which is appropriate to working with adults who can bring a wealth of personal experience to any learning event. Facilitation is particularly relevant to this program because many of the participants are likely to have extensive clinical or other experience of working with young people and on youth health issues.

A facilitative approach enables participants to draw on that experience and learn in an active way. It also enables a more equal relationship between participants and those who run the workshop than is possible in the more conventional trainer-learner or teacher-student styles. A facilitative approach draws on people's experiences and promotes active learning. Workshop organizers/facilitators need to remember that many participants may have experience and expertise that equals, or even exceeds theirs.

Workshop participants – even if they are all health-care providers from the same country – may have different backgrounds in age, religion, level of responsibility, etc. Such diversity is desirable given the interactive and participatory nature of the YFHS training program. However, diverse backgrounds can also mean differences in accustomed and preferred ways of working and communication, and also in approaches to things in general, which are bound to come up during the workshop. The challenge facing facilitators is to put their own attitudes and preferences aside, and encourage all participants to appreciate these differences and learn from one another.

The program requires you to use a range of methods and approaches, from direct input in the form of short mini lectures to conducting role plays, and stimulating problem-solving exercises in small groups. A number of different teaching/learning methods have been proposed for use throughout the program. The program has been designed to include a balanced mix of methods in order to maximize the participants' interaction and benefit. An experienced facilitator will be familiar with these methods.

GROUND RULES FOR PARTICIPATORY LEARNING

To help ensure smooth interactions among the facilitators and the participants, it is very helpful to establish some ground rules at the start of the program. These would include:

- Treating everyone with respect at all times, irrespective of cultural, age or sex differences.
- Ensuring and respecting confidentiality so that facilitators and participants are able to discuss sensitive issues (such as those relating to sexual and reproductive health, mental health and substance use) without fear of repercussions.
- Drawing on the expertise of others, both co-facilitators and participants, in difficult situations.

- Asking for critical feedback on what you do and treating that feedback with respect, so that others see the fairness of your behaviour.
- Establishing from the start when and how the facilitators, resource person and participants will work together, how to give feedback – both positive and negative – and how to keep each other on track.
- Agreeing that every time a facilitator, participant or resource person makes a presentation or leads a session, another group member will be responsible for keeping an eye on the time and informing the speaker of this.

These, together with all the basic skills of facilitation, will help to ensure an effective learning environment. We have included an activity (establishing group norms/ ground rules) to draw up a “learning contract” at the outset of the program to ensure that facilitators and participants are agreed on the basic principles underlying adult learning.

This Facilitator Guide provides essential information to the organizers and facilitators to plan and implement the YFHS training module.

DESIGN

The YFHS training manual consists of 5 modules:

1. Introduction and rationale for YFHS training
2. Adolescent development
3. Youth Sexuality and Sexual Reproductive Health
4. Creating Youth Friendly Health Services
5. Action Planning and Conclusion

Included in each module is a set of trainer resources, participant materials, and training evaluation tools.

Each session details the following:

- Objective of the session
- Time required
- Materials needed
- Notes on any advance preparation for the trainer
- Steps in facilitating the session

Where slides are used, the slide number will be given as well as ‘Talking Points’ that accompany each slide. These talking points have been created to give you more information to help you explain the content of the slide. Also included are ‘Trainers Notes’ for any additional information about conducting the session/activity.

PARTICIPANT SELECTION

This training is meant for providers of health services (nurses, nurse midwives, nurse assistants, physicians, counsellors, Health Committees and others) who already have some skills and training in sexual reproductive health but need training on how to provide youth-friendly services. Clinic and program managers also need to have a clear idea of the goals, challenges, and resource requirements of a youth-friendly program so that they will be supportive and appreciative of provider efforts. For this reason, inclusion of a member of management staff, either in the training itself or in a separate sensitization, is highly desirable. All health facility staff, including reception staff, peer educators and volunteers should be sensitized to the needs of youth clients who come to the facility for sexual reproductive health (SRH) services. This can be accomplished by giving a

short course to these staff using Session 2 ‘The importance of working with youth’ and Session 3 ‘Service Provider Values’ from the Introductory Module’. Session 1 ‘Barriers to Youth accessing to SRH care’ from Module 4 could also be included.

USING THE MODULES

This manual includes training activities that can be conducted with various levels of staff that provide SRH services for youth. The activities can be adapted and tailored to address the participants’ specific needs. Additional activities can be created to enhance this basic foundation for training.

- The modules provide flexibility in planning, conducting, and evaluating the training course.
- The curriculum allows trainers to formulate their own training schedule based on identified needs of participants.

The modules can be adapted for different contexts by reviewing case studies and using only the ones that are appropriate. Additional case studies can be devised based on local cultural practices, social traditions, and health issues.

- The modules can be used independently of each other.
- The modules can also be lengthened or shortened depending on the level of training and expertise of the participants.
- In order to foster changes in behaviour, learning experiences have to be in the areas of knowledge, attitudes, and skills. In each module, general and specific objectives are presented in terms of achievable changes in these three areas.

The Trainer’s Manual contains the “**Training Guide**” and the “**Annex**.”

♦ The **Training Guide** presents all the information for facilitating each session including the training/learning methods (lecture, role-play, discussion, etc.) to be used, the materials/resources needed, any advance preparation needed to be done by the facilitator to prepare for the session and the time required to complete each activity.

♦ The **Annex** contains:

- “Training Slides” – Standardised Powerpoint Slides for use to deliver the training
- “Trainer’s Tools” including participant handouts, case studies/scenarios, learning, the pre- and post-tests questionnaires, and group performance matrix.

EVALUATION METHODS

Evaluation can be carried out at different levels to measure different things. In this program we have included methods for measuring change at three levels:

- Participants’ reactions to the workshop (daily review and reflections, personal diary, workshop evaluation)
- Changes in participants’ attitude and knowledge (pre & post training questionnaire; observation of group exercises)
- Changes in participants’ practice (personal diary, individual implementation plan [with monitoring post-workshop])

Personal workshop diary

We recommend that each participant be given a small notebook to be designated for daily input during the last session of each module, the “reflections” session.

To facilitate this reflections process you should write the following two questions on a flipchart for participants’ input at the end of each module:

- “List three important lessons that you learned through participation in this module.”
- “List three things that you plan to do in your work for/with youth.”

Encourage the participants to take a few moments to write down their answers to these questions at the end of each module. Answering these two questions will help them tap into – and remember – what they found in each module that was most relevant to their own attitudes and practices. It will also help them when they come to develop their individual implementation plan in the Concluding module of the whole workshop.

Sample Training program

Sample Program for a three and a half (3½) day Youth Friendly Health Services (YFHS) Training

Day 1: Introductory activities and rationale for YFHS training

Time	Training Content	Training Method
30 mins	Introductions	Icebreaker/warm up exercise
30 mins	Training Overview, Goals and Objectives	Mini-lecture
10 mins	Training norms	Group brainstorm & discussion
20 mins	Pre-training questionnaire	Participant survey
BREAK		
60 mins	The importance of working with youth	Sensitization exercise
LUNCH		
90 mins	Service provider values	Group work Plenary discussion
BREAK		
60 mins	Values Clarification about Youth Sexuality	Group continuum exercise
10 mins	Reflections	Individual reflection

Day 2: Adolescent development and youth sexuality

Time	Training Content	Training Method
10 mins	Where are we?	Group review
20 mins	What do I remember about my adolescence?	Group exercise
15 mins	Defining adolescence/ young people	Mini-lecture & plenary discussion
55 mins	The nature & sequence of changes & events in adolescence	Brainstorming Group work
BREAK		
50 mins	Youth vulnerabilities, risk-taking behaviours & their consequences	Case study
25 mins	Adolescent/youth health problems & priorities in Vanuatu	Plenary discussion Group work
LUNCH		
15mins	The role that health services need to play to promote youth health	Mini-lecture & plenary discussion
60 mins	Understanding sexuality	Brainstorm

		Mini-lecture & plenary discussion
	BREAK	
60 mins	Defining a sexually healthy young person	Case studies Group discussion
30 mins	Sexual & reproductive rights of young people	Group work
10 mins	Reflections	Individual reflection

Day 3: Creating Youth Friendly Health Services

Time	Training Content	Training Method
10 mins	Where are we?	Group review
45 mins	Barriers to Youth accessing to SRH care	Individual reflection Brainstorming Group activity
	BREAK	
70 mins	Communication with youth clients	Pair work Brainstorm Fishbowl exercise
	LUNCH	
80 mins	Role plays with youth clients	Role play
	BREAK	
60 mins	Creating Youth Friendly Health Services	Group work
30 mins	YFHS in Vanuatu	Ranking exercise
10 mins	Reflections	Individual reflection

Day 4: Action Planning and closing activities

Time	Training Content	Training Method
10 mins	Where are we?	Group review
60 mins	Action Planning for YFHS	Small group work followed by presentation to whole group
	BREAK	
50 mins	Ethical and human rights considerations	Case scenarios Plenary discussion
20 mins	Post-training questionnaire	Individual survey
20 mins	Workshop evaluation & closing	Group work Plenary
	LUNCH	

Background

Adolescents aged between 10 and 19 years account for 20% of the population of Pacific Island countries (SPC, 2010). Sexual activity is common during adolescence in this region. In Vanuatu, limited data indicate that around 10% of young people have had sex by the age of 15, with the median age of sexual debut 16.7 years for males and 17 years for females (UNICEF, 2010; MoH, 2008). Many are ill prepared for this transition, lacking comprehensive knowledge about sexual and reproductive health (SRH) and facing significant barriers to accessing quality SRH information and services (Kennedy et. al., 2013, UNFPA, 2005). More than a third of urban young people in Vanuatu have not heard of family planning and 27% lack knowledge about STIs (VYPP, 2006). Less than 15% of sexually active young people report consistent condom use and fewer than 35% of adolescent girls aged 15– 19 in Vanuatu who are married or in union are using a modern method of contraception (MoH, 2008; UNICEF & MoH, 2008). Consequently adolescents in Vanuatu, and the Pacific in general, suffer a disproportionate burden of poor SRH, including high rates of sexually transmitted infections (STIs) and adolescent pregnancy, often with significant socio-economic consequences (Kennedy et. al., 2011; UNFPA, 2005).

More than 36% of ni-Vanuatu males and 14% of females aged 15– 24 report ever being diagnosed with an STI, with surveillance data indicating the highest rates of Chlamydia occur among adolescents aged 15 – 19 (Cliffe et. al., 2008; UNICEF, 2010). Adolescent fertility is relatively high (66 births per 1000 girls aged 15– 19), and adolescent girls account for almost one in eight births (VNSO, 2009; VPMO, 2010).

The majority of SRH services in Vanuatu are provided by government facilities, with a small number of youth-oriented clinics provided by non-government organisations. Traditional healers are an important part of the informal health system in Vanuatu, particularly in more remote islands, although less is known about adolescents using their services (Bourdya & Walterb, 1992; MoH & WHO, 2012). Low utilisation of mainstream services is a significant barrier to improving adolescent SRH, a challenge noted by the Ministry of Health (Kalo, 2007; Kennedy et. al., 2013; MoH, 2008)

There are many opportunities to make existing SRH services more youth-friendly, including strengthening training of health workers to improve attitudes and skills. These training guidelines are part of the initiative to introduce and sustain YFHS service provision in Vanuatu. The training manual is designed to support the training of health care workers for the provision of YFHS nationwide.

Joe Kalo or Siula to add in further re. the National YFHS Guidelines

TRAINING GUIDE

Module 1: Introduction & rationale for YFHS training

Module Objectives

- To introduce the program, facilitators and participants and assess baseline knowledge on YFHS
- For participants to understand the rationale for the YFHS training and the importance of reaching youth with sexual reproductive health services

Training Methods:

Icebreaker exercise
Mini-lecture
Brainstorm
Group work
Participant survey

Evaluation Methods:

- Pre- and post-test
- Reflections
- Where Are We?
- Participant evaluation activity
- Trainer observation and assessment of group work

Materials/resources

- Marker pens
- Flipchart/butchers paper
- Handout 1: Training Program & Objectives (Annex: Trainers Tools)
- Handout 2: Pre-training Questionnaire (Annex: Trainers Tools)
- Index cards /small cards or A4 paper
- Slides 1 – 9
- Pens or pencils

Time

310 mins

Advance Preparation

1. On a flip chart write the following:
 - a. Name
 - b. Place of work
 - c. Two expectations of the workshop
 - d. Two thoughts regarding Youth Friendly Health Services (YFHS)
2. Make enough copies of Handout 1: Training Program & Objectives and Handout 2: Pre-training Questionnaire for distribution to all the participants
3. Prepare 2 pieces of A4 paper, one with the word “ACCESS” written on it, the other with “NEEDS MET” written on it in large letters
4. Four (4) signs: ‘Strongly Agree’, ‘Agree’, ‘Disagree’ and ‘Strongly Disagree’

Session 1: Welcome & introduction

Objectives

1. To enable participants to introduce themselves
2. To give participants an opportunity to learn about others in the group so they can better understand each other
3. To allow the participants to discuss their expectations of the training

Time

90 minutes

Materials

Butchers paper & marker pens

Slides 1 – 4

Index cards /small cards or paper

Activity 1 - Introductions

Steps

1. Welcome the participants to the Youth Friendly Health Services (YFHS) training for healthcare providers. Introduce yourself and any co-facilitator(s). Explain that before starting the program, a few minutes will be spent getting to know each other through a doing a warm up exercise.

Warm up exercise: Appreciative Interview (30 minutes)

2. Give each one of the participants an index card and a marker and instruct them to write down three (3) of their own physical characteristics that are easily noticeable (eg. glasses, wedding ring, wearing red) on the index card. Tell participants that they should not write their names.

3. Ask participants to give completed index cards to you.

4. Give each participant a completed index card (but not his/her own)

5. Ask each participant to move around the room and locate the person described on the index card. Whilst they are locating their partner, put up the flip chart paper with the 4 questions:

1. Name
2. Place of work
3. Two expectations of the workshop
4. Two thoughts regarding YFHS

6. Ask participants to take it in turns to interview each other using the 4 flipchart questions. The interviewer should records the answers to the 4 questions on the index card of the interviewed person (reinforce there is no need to write out the question - just write Q1 and response, Q2 and response etc.).

7. After 15 minutes, reconvene the group. Ask pairs to take turns to introduce their partner using the information they discovered through their 'interviews'.

NOTE: When they give the answers to question 3 - expectations of the workshop, write these up on a piece of butchers' paper for reference later.

Summary

After the introductions, stress that there is a wealth of experience among the participants present in the room. Clearly there will be much that every individual can share with and learn from others in the group.

Activity 2 - YFHS Training aim & objectives

Steps

1. After the introductions, show Slide 2 showing the overall aim of the YFHS training, and read it out.

The overall aim of the YFHS training

To introduce and orient health-care providers to the special characteristics of adolescence/youth and the appropriate approaches to address priority health needs of youth in Vanuatu

Slide 2

Talking points

Inform the participants that the specific characteristics of young people the needs and problems of young people, and approaches to meeting them will be discussed in subsequent modules.

2. Put up Slide 3. Explain to the participants that by participating in the YFHS training, they will be able to answer the two questions given in Slide 3. Stress that it is an orientation program for youth friendly health services and does not provide training in clinical (or counselling) skills for adolescent/youth health service provision.

The YFHS training will help answer 2 questions:

- What do I, as a Youth Friendly Service provider need to know and do differently if the person who walks into my clinic is aged 17, rather than 7 or 37?
- How could I help?
 - In the clinic
 - Away from the clinic
 - Are there other influential people in my community who understand and respond better to the needs and problems of adolescents/youth?

Slide 3

Stress that it is an orientation program for youth friendly health services and does not provide training in clinical (or counselling) skills for adolescent/youth health service provision.

3. Next put up Slide 4 and take the participants through it – asking for questions and comments and responding to them as you proceed.

Explain the overall expected outcomes of the YFHS training program.

Expected outcomes of the YFHS training

By the end of the training workshop, participants will

- Be more knowledgeable about the characteristics of youth and development
- Be more sensitive to the needs of young people
- Be better equipped with information and resources
- Be better able to provide Youth Friendly Health Services
- Have prepared a personal plan indicating the changes they will make in their work

Slide 4

Talking points

It is likely that the participants will raise some of the following questions. If they do not, you may want to raise them yourself.

<i>Question or comment</i>	<i>Possible response</i>
Why is the YFHS training program only focusing on health-care providers when many other "adults" also influence young people?	Explain that many groups including health workers, teachers, church leaders, chiefs and, of course, parents have important contributions to make to the health of young people. The MoH has a special responsibility in strengthening the abilities of health workers, and so this group has been identified as a priority, but it doesn't mean that other groups are less important.
I may have views about how to improve our health service, but I am not in a position to influence what happens.	Explain that, within the group, some people may be in a decision-making role, and that many others may not. Some may be able to do a lot, and others only very little. However, every one of us will be able to do something, and the YFHS training will help each of us to define what it is possible for us to do (in the positions that we hold).

4. Give the participants copies of the YFHS training program and objectives

5. Having covered the expected outcomes of the training, ask the participants to look at the schedule and briefly take them through each day's work.

Summary

To round off your introduction to the program, ask for and respond to any questions and concerns the participants may have. Refer back to their expectations of the training that were shared and written up as part of Activity 1 (answers to question 3). Confirm the expectations that will be able to be met during the training – if any seem really outside the scope of the program then say so (being as helpful as you can about where and how the participants can meet their expectation).

Activity 3 - Establish ground rules

Steps

1. Tell the participants that during this training they will be asked to reflect on their attitudes about a variety of issues related to sexuality and will participate in interactive activities. In order for people to participate fully, they need to feel safe and comfortable. Explain that you want them to brainstorm group norms or 'ground rules' that will establish a comfortable and respectful learning environment.

2. Brainstorm ground rules with the group and record these on the butchers paper. If group members become 'stuck' you can suggest some from the sample ones provided.

Sample ground rules are:

- Not interrupting when others are speaking
- Respecting others' views
- Turning mobile phones on silent
- Arriving on time
- Using 'I' statements (speaking from your own perspective)

3. After completing the brainstorm, facilitate a group discussion by asking the following questions:

- Would you like to revisit or clarify any of the ground rules?
- Are you comfortable with these ground rules? If not, how can we change them to make them acceptable?
- Can you agree to abide by these throughout the training?

4. Place the butchers paper on the wall where the ground rules are visible to all the participants – this should remain up for the duration of the training.

Summary

Tell the participants that each of them has agreed to abide by the ground rules. State that the group will make sure that all the participants follow these. If necessary, other ground rules can be added during the training.

Activity 4 - Pre-training Questionnaire

Steps

1. Tell participants that the Ministry of Health/your organisation is interested in measuring changes in their knowledge and attitudes in order to assess the achievement of the training objectives and also to improve the training. Explain that they will be asked to complete a questionnaire at the beginning and at the end of the training. Explain that the questionnaire is not a test – it is a survey that asks for their opinion – they will be asked to decide whether they agree or disagree with a range of statements. Assure them that all answers and information will be anonymous and confidential.
2. Distribute the “Pre-training Questionnaire” (handout 2) and the pens/pencils to the participants and ask them to complete it. Tell the participants they will have 15-20 minutes to complete the questionnaire.
3. Collect the questionnaires and inform the participants the material and topics in the survey will be covered in this training. Tell them that the survey will be administered again at the end of the training to determine whether the group’s knowledge and/or opinions have changed over the course of the training.
4. During a break, or at the end of the day, grade the surveys and record them on a copy of the Pre-workshop “Group Performance Matrix” (Annex: Trainers Tools p.20)

Session 2 - The importance of working with youth

Objectives

1. Explain the importance of reaching youth with sexual reproductive health services
2. Understand the impact of service provider values and attitudes may have on service delivery

Time

60 minutes

Materials

Helen’s story

Slide 5

Flipchart/butchers paper

Marker pens

2 signs “ACCESS” and “NEEDS MET”

Activity 1 – Sensitization exercise

Steps

1. Introduce the exercise by explaining that young people often face many barriers when trying to access health services and information, especially sexual reproductive health. The following story represents a typical experience of a young woman trying to access services and have her needs met.
2. While telling the story, ask two participants to hold up a sign - one with “ACCESS” another with “NEEDS MET”.
3. Each time the client in the story experiences an obstacle to her seeking/receiving SRH services, the ‘ACCESS’ sign holder should tear a piece of the sign, indicating the client’s reduced chance of accessing the service; likewise, the “NEEDS MET” sign holder should tear a piece of the sign, indicating a reduced opportunity/chance for the client to have her SRH needs met.
4. Encourage sign holders to continue to tear their sign/s throughout the story. At the end of the story, their signs should be mostly torn up.
5. Read Helen’s story slowly and clearly. (The story should be told in three segments, reflecting three different visits to the local clinic. The segments show several obstacles at each visit that would not be necessary if quality youth friendly health services existed.)

My name is Helen. I am 16 years old. I live 5 km from the health clinic and normally sell fruits at the small roadside markets to earn money for my mother and younger siblings. It was not easy for me to have the time to go to the clinic.

I went because I have a boyfriend and I don't want to become pregnant. Some of the girls in my village have become pregnant and I see how hard their lives are with a small child and no husband. I had heard that you could take some pills to prevent pregnancy so I wanted to find out if it was true.

I went to the clinic early in the morning because I needed to get back so I could sell something before the day ended. When I arrived there were several women waiting outside with small children. They kept looking at me and whispering. One of the older women asked me why I was there since the clinic only served women who were older with children and a husband. She told me this was no place for a "small girl" like myself.

The staff were late to arrive. I sat there for over an hour waiting for the front doors of the clinic to open. Once I was inside I wondered how I could talk with the nurse. I finally got up enough courage to speak to the woman behind the table with a sign saying "Reception". When I approached, her face became hard. She asked me why I was here and that I should be in school. When I explained that I wanted to talk with a nurse, she questioned me. I was too embarrassed to tell her why I was here. She then told me that the morning hours were for antenatal and maternal and child health services only and that I would have to come back later in the day. When I asked her what time, she just shrugged her shoulders and ignored me.

I came back at 2:00 pm. I hadn't eaten anything and had nowhere to go while I waited, so I had sat down under a tree for the last 4 hours. It was very hot out and I was hungry and thirsty. When I asked the receptionist if I could see the nurse, she told me that the nurses had taken a break for lunch. They would be back in an hour. The receptionist was very unfriendly and I could tell she didn't think I should be there.

After an hour, the nurses came back. I was told that I could go in and speak with one of them. She directed me to an examination room. When I went to the room, the nurse looked angry. She asked me why I was here. I told her that I didn't want to be pregnant and I had heard there were some pills to take. She told me that if I didn't want to become pregnant then I shouldn't have sex. I should be in school or helping out at home not running around with boys.

I explained that I wasn't running around with boys and that I only had one boyfriend. The way she was

looking at me, I could tell that she thought I was loose. She told me that before I could use the pill, I would need to have an exam and that she didn't have time today. I would have to come back on Friday.

On the way home, I questioned whether I should return. I didn't want to become pregnant, but I also felt like the nurse thought I was a bad person and I wasn't sure I could lose another day of work. I decided I would go one last time. Friday finally came.

This time I arrived later at the clinic. After I entered, I went to the receptionist. It was the same person as last time. She asked me why I was here. When I told her I was here for an exam and to get the pill, she said in a very loud voice "so, you are here for family planning". I could feel the eyes of the other women in the waiting room staring at my back. I was so embarrassed.

The receptionist told me to go back to the examination room. When the nurse came she told me to undress. She didn't give me anything to cover up with. I was a bit frightened looking at the equipment. She told me to put my feet in the stirrups. I didn't know what she was going to do. The next thing I knew she was putting something cold and hard in my vagina. I felt very panicked. Just then, there was a quick knock on the door and then this other nurse entered. She started to ask questions about another patient. The whole time the two nurses were talking, the door was ajar. I wanted to die of shame.

After the exam, the nurse gave me a packet of pills and told me to take one a day at the same time of day. She mentioned something called "side effects" but I didn't understand what she meant. She told me to come back when I have two or three pills left. I left and started taking these pills every morning. It isn't easy, sometimes I feel sick in the stomach and I don't know if I can keep taking them. I don't know how I am going to get back to the clinic and the thought of seeing the nurse again makes me think that perhaps I should just forget about taking these pills and pray to God that I don't get pregnant.

6. Ask participants how they feel about Helen's story – is it realistic? What are the possible consequences of this situation? Did Helen receive the service she needed? Invite comments from the whole group
7. Ask participants to work in groups of 2 or 3 to identify all the different obstacles that Helen faced when trying to access services. After 5 minutes, ask them to share some of comments from their group.
8. Ask participants to brainstorm why there should be a special training for youth friendly health services. Record their responses on a flipchart
9. Show Slide 5. Read the points out and use the talking points to provide further information

Why should there be a special training for youth-friendly health service provision?

- Adolescents/young people are different from adults
- Adolescence is a critical age for risk-taking.
- Adolescence is an opportune time for professional interventions
- Special training allows providers to be more responsive to the needs of young people

Slide 5

Talking points

Adolescents/young people are different from adults

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

Adolescence is a critical age for risk-taking.

- Adolescents are moving toward independence and tend to experiment and test limits, including practicing risky behaviours.

- Using substances or drugs for the first time typically occurs during adolescence.
- Sexual experiences (not always voluntary) usually begin during adolescence.
- Consequences of risky behaviours can have serious and long-term effects.

Adolescence is an opportune time for professional interventions

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

Special training allows providers to be more responsive to the needs of young people

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

Session 3 - Service Provider Values

Objectives

- To recognise that we all have values and that these guide us in the decisions we make both personally and professionally
- To ensure that there is a clear understanding of the role of values when working with young people on sexual and reproductive health.
- To assess the participants' attitudes about youth sexuality
- To help the participants understand the impact that their personal attitudes may have on service delivery

Time

90 mins

Materials/resources

Butchers paper & marker pens

Marker pens

Slides 6 – 9

A4 paper

4 signs: 'Strongly Agree', 'Agree', 'Disagree' and 'Strongly Disagree'

Advance preparation

1. Prepare the 4 signs: 'Strongly Agree', 'Agree', 'Disagree' and 'Strongly Disagree' (write in large letters, one term per card)
2. Put the signs around the room – on the walls is ideal, otherwise on the floor leaving enough space between them to allow participants to stand near each one

Activity 1 - Our values

Steps

1. Introduce this session by telling participants that we are about to identify and explore some of our own values. For some people this may be confronting and a little bit uncomfortable. For others it may be a positive and enjoyable experience.

2. Ask participants what they think a value is? Write this up on butcher's paper.

After some discussion, show Slides 6-7 - Values, value judgements and the link with attitudes.

Values

'A value is what we believe in – it reflects what we are for and what we are against. Values give us a direction to go in when we make decisions, set goals and act out behaviours.' (CEDPA) 2000)

The process of acquiring values is not static. Values change throughout our lives, as does how important some values are to us.

Values vary according to age, race, culture, sex, religion, income, education, life experiences and much more. An individual's value system is unique and contributes to the sense of self.

Values are so much a part of us, we are often not aware of their influence. As a result they may influence our decisions and the manner in which we view the actions of others.

Slide 6

Beliefs or assumptions

• Ideas or opinions we think are "true", or "false", "good" or "bad", without having consciously thought them through. We have 'always' assumed this to be true.

Value judgement

• Judgement made on the basis is people values or beliefs.

• A value or value judgement may give an opinion about the importance of an action or behaviour

Attitudes

• Behaviours or actions or words, which reflect values or value judgement

Slide 7

3. Ask participants to get into small groups and write down two values that are important to them.

Ask them to discuss with others in the group:

- The origin of those values (where they came from); and
- How they might impact on their role in being a provider of SRH services.

4. After 15 minutes, reconvene the large group and ask participants to share their ideas. Facilitate discussion and debate on the impact of values on people's role as health care providers. Finish this exercise by showing Slide 8 - Impact of values, beliefs and attitudes on practice. Discuss this.

Impact of values and attitudes on practice

- As health workers we constantly act and make decisions based upon our values and attitudes. Often we are not conscious of this.
- We interpret information and situations according to our value base. This then informs our response.
- Our values and attitudes are reflected in the attitudes and behaviours we demonstrate toward others. Often this is non-verbal and we may not be conscious of it.
- If we have not thought through our value base prior to situations, our actions may not have the best outcomes for the client.
- Our values and attitudes about sexuality and SRH influence how we view our role with clients, especially youth clients and the content and manner in which we provide information.

Slide 8

Trainers notes

The main point of this session is to get people to recognise that they have values and that these guide them in the decisions they make both personally and professionally. In Vanuatu these values are often based on Christianity. Values are also often based on people's personal experiences and by their education, family, culture and religion. For example, someone may have a family member who is gay. This experience may make them more accepting of a young person who is gay than someone else with no personal experience of this issue.

Sometimes someone's personal values can be in conflict with what they do in their work and they need to think about how they deal with this conflict.

Activity 2 - Values Clarification about Youth Sexuality

Steps

1. Tell the participants that this activity is designed to give them a general understanding of their own and each other's values and attitudes about working with adolescents/young people and youth sexual and reproductive health issues.
2. Explain that you will read aloud a statement. The participants will decide what they think about the statement and stand near the sign that most closely represents their opinion. After the participants have made their decisions, you will ask several of them to share their opinions with the group.
3. Remind them that everyone has a right to his or her own opinion and no response is right or wrong.
4. Also remind the participants that they must listen to each other. This activity is not about debate, but about dialogue. Instruct them to state their personal opinion to support their agreement or disagreement with each statement and not just to rebut other participants' opinions.
5. Read aloud the first statement and ask the participants to stand near the sign that most closely represents their opinion.

Statements:

- a. Condoms should be available to youth of any age
- b. Sex before marriage is acceptable
- c. Sex education can lead to early sex or promiscuity
- d. It is worse for an unmarried girl to have sex than for an unmarried boy
- e. Adolescents shouldn't be given condoms because it will encourage sexual activity
- f. Young people will not use Youth Friendly Health Services even if they are offered
- g. Adolescents who get STIs have had many sexual partners.
- h. Providing sexual and reproductive health services to youth may lead to early sex or promiscuity
- i. Adolescents should be able to get contraceptives without their parents' permission

(NB: not all of the statements need to be used – choose those most relevant/ appropriate for your group)

6. After the participants have made their decision and moved to the relevant sign, ask for 2 or 3 volunteers from each group to explain why they feel that way. If possible, try and hear from people standing at different signs, to get a range of opinions.
7. Read the next statement and again ask them to move to the sign that represents their personal opinion. Again invite one or two volunteers from each group to explain why they feel that way.
8. Continue to read the selected statements and follow the same process for each.
9. Once all the statements have been read, ask the participants to return to their seats.
10. After reviewing all the statements, facilitate a discussion by asking the following questions:
 - a. Which statements, if any, did you find challenging to form an opinion about? Why?
 - b. How did you feel expressing an opinion that was different from that of some of the other participants?
 - c. How do you think people's attitudes about some of the statements might affect their interactions with young clients or their ability to provide sexual and reproductive health services to adolescents/young people?

Trainers notes

For the sake of discussion, if the participants express a unanimous opinion (they all agree or all disagree) about any of the statements, ask a volunteer to play the role of ‘devil’s advocate’ by expressing an opinion that is different from theirs.

Summary

State that it is normal to have strong feelings and values about these topics. Tell the participants that learning to be aware of their own values will help them be more open to listening to different points of view. When young people notice that service providers are more accepting of differences, they will more openly and honestly assess and express their own values. This, in turn, can help young people assess the attitudes and beliefs that lead to high-risk behaviour.

Closing activity: Reflection*Objective*

- To reflect on ideas and information shared during the training day.

Steps

1. Tell participants that the final 10 minutes of each day will be devoted to the process of reflection. Ask “what is reflection?” and discuss the responses. If necessary explain that reflection is the process of thinking carefully about activities and events that have happened in our lives.
2. Show Slide 9, questions for reflection.

Reflection

- This day has taught me that
- I was surprised to find
- When it comes to my values, I
- I want to think more about

Slide 9

3. Ask the participants to use their personal diary/notebook to individually record their responses to these reflection questions.
4. Depending on how much time is left, you may want to ask participants to share their responses to one or more of the statements.

Trainers notes

Reflection questions should be used at the end of each day. Using the above as a basis, the trainer should adjust them according to the content covered during the day, and encourage participants to complete their reflections in their personal diary. These reflections will be referred back to in the final day when completing Individual Action Plans.

Module 2: Adolescent Development

Module Objectives:

- To help participants understand the psychological and social changes youth experience during adolescence
- To help providers identify adolescent vulnerabilities and understand adolescent risk-taking behaviour and its consequences in order to better serve youth clients and address their SRH needs.

Training Methods:

- Brainstorm
- Individual reflection
- Pair work
- Mini-lecture
- Group work
- Case study
- Plenary discussion

Evaluation Methods:

- Pre- and post-test
- Reflections
- Where Are We?
- Participant evaluation activity
- Trainer observation and assessment of group work

MATERIALS/RESOURCES:

- Markers
- Flipchart/butchers paper
- A4 paper
- Sticky tape/blu tack
- Slides 10 – 22
- Handout 3: Stages of Adolescence
- Handout 4: The case of Lucy and Rita

TIME:

230 minutes

ADVANCE PREPARATION:

1. Three pieces of A4 paper, each with one number on it: '12', '16', '19' – place these in 3 different areas of the room (on walls or floor)
2. Two pieces of butchers paper – write "Physical and sexual changes" at the top of one and "Psychological and emotional changes" at the top of another
3. Three pieces of butchers paper – write 'Early Adolescence' at the top of one, 'Middle Adolescence', at the top of the second, and 'Late Adolescence' at the top of the third.
4. Copies of Handout 3 "Stages of adolescence" for all participants
5. Five (5) copies of Handout 4 "The case of Lucy and Rita"

Introductory activity - What do I remember about my adolescence?

Steps

1. Ask the participants if they remember what it was like to be an adolescent. Ask one or two participants to share a brief memory or you share one of your own. Then ask why they think it is important to remember this now.

2. Tell the participants that during this activity they will explore their own adolescent experience. Explain that each person will be assigned a particular age.

3. Divide the room into thirds and direct participants' attention to the three numbers on the wall/floor in these areas – where the paper with '12' is on the wall/floor; tell this group that they will be reflecting on when they were age 12; where the paper with '16' is on the wall/floor; tell this group that they will be reflecting on when they were age 16; Finally, where the paper with '19' is on the wall/floor - tell the final group that they will think back to when they were age 19.

4. Distribute pieces of paper & pen/pencils to participants and show Slide 10. Read the questions aloud. Explain that you want them to think about and answer the six questions based on the age they were assigned. They can write or draw their answers on a sheet of paper (encourage them to make a small poster using basic figures). Tell them they have 10 minutes to complete the activity.

What do I remember about my adolescence?

- What were the most important things in your life?
- What did you like to do in your free time?
- Which adults played a significant role in your life?
- What did you think about the other sex?
- What was difficult about being a teenager?
- Where did you go to access health information?

Slide 10

5. After 10 mins, tell the participants that you want them to share their answers with one other person in the same age group (in pairs). Assure them that they only have to share what they feel comfortable discussing.

6. After 10 mins reconvene the whole group. Ask various participants to share some of the memories that the activity made them think about. Begin by taking comments from the 12-year old group, then the 16-year-old group, and finally the 19-year-old group.

7. Conclude the activity by discussing the following questions:

- What did you learn from this activity?
- Was it hard or easy to remember what it was like to be an adolescent? Why?
- Would you consider the issues that we just discussed to be similar or different at ages 12, 16, and 19? What does this mean in terms of the needs and concerns of young clients during the various stages of adolescence?
- How can this activity improve the way you interact with adolescent clients?

Summary

Tell the participants that it is important to reflect on our past in order to remember some of the positive and negative experiences we had as adolescents. This can help us to understand that youth today may have similar needs, concerns and experiences. It can also help us to be empathetic to young people when they seek health services.

Session 1: The nature and sequence of changes and events in adolescence

Objective

To help participants understand the nature and sequence of changes which occur during adolescence

TIME:
120 minutes

Materials:

- Slides 11 – 12
- Butchers paper & marker pens
- Handouts 3 – 4
- ‘12’, ‘16’, ‘19’ signs
- “Physical and sexual changes” & “Psychological and emotional changes” butchers papers
- ‘Early Adolescence’, ‘Middle Adolescence’, and ‘Late Adolescence’ papers
- Handout 3 – one per participant
- Five (5) copies of Handout 4

Activity 1 – Who are adolescents/young people?

Steps

1. Show Slide 11 - Definitions

Definitions

According to the World Health Organisation (WHO)

- ‘Adolescence’ covers ages 10 – 19 years
- ‘Youth’ covers ages 15 – 24 years
- ‘Young people’ covers ages 10 – 24 years

Slide 11

Talking points

1. Who are we referring to when we talk about “adolescents?” In general, the term “adolescent” refers to people in their second decade of life, meaning those between the ages of 10 and 19 years. Other commonly used terms are “youth” and “young people.” These terms have slightly different definitions (refer Slide 11) but are sometimes used interchangeably with the term “adolescent.” Adolescence has many dimensions: physical, psychological, emotional, and sociological. WHO acknowledges that adolescence has both biological (physical and psychological) and social-cultural dimensions. WHO also acknowledges that adolescence is a phase in an individual’s life rather than a fixed age band, and that this phase is defined differently across cultures and communities.

2. Ask participants - How is ‘youth’ or ‘young people’ defined in your province/community?

Activity 2 – Stages of adolescence

Steps

1. State that there are a number of changes that occur during adolescence. These are physical, sexual, psychological and emotional. Tell the group we will do 2 simultaneous brainstorms to consider these changes.
2. Break the group into two. Ask one group to move to one side/end of the room and one to the other. Put up the paper with “Physical and sexual changes” on one wall and the paper with “Psychological and emotional changes” on the other. Provide each group with 2 marker pens. Ask them to spend 5 minutes brainstorming all the changes in these categories that they can think of that occur during adolescence.
(NB: encourage the group doing “Physical and sexual changes” to consider those that happen for males, females & both).

3. After 5 minutes ask the groups to stop and share their work. Refer to Trainers Notes below for adding any additional points the group may not have covered.

Trainers notes

Physical and sexual changes that occur during adolescence:

In females:

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

In males:

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

In both females and males:

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

Psychological and emotional changes that occur during adolescence:

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

4. Tell participants that these changes occur in 3 overlapping developmental stages: Early, Middle and Late Adolescence.

5. Explain to participants that they will be broken into 3 groups to do a group exercise. In this exercise, they will identify 3 examples of events and/or changes that occur in each of these categories: Physical, Psychological and Social. Show Slide 12 with the blank table on the nature and sequence of changes and events during adolescence.

Nature and sequence of changes & events during adolescence			
Events/changes that occur	Early adolescence (10 – 13)	Middle adolescence (14 – 16)	Late Adolescence (17 – 19)
Physical			
Psychological: <i>Cognitive</i> <i>Emotive</i>			
Social			

Slide 12

6. Divide the participants into 3 groups. Explain that each group will work on a single column – this means they will take one stage of adolescence (early, middle or late) and consider the physical, psychological and social changes and events of that stage.

(Each group will be given one piece of butcher's paper to work on their column – these will then be joined at the end of the exercise to make a complete table).

7. Ask the groups to move to different parts of the room and tell them they will have about 15 minutes to complete their part of the table.

8. After 15 minutes, reconvene the group. Ask the first group in turn to come forward to join their part of the table and report their findings. Ask the participants for any comments and questions and encourage a brief discussion before the next group comes forward. (Use sticky tape or masking tape to join each of the sheets as these are brought forward).

9. Ask for additional comments or questions after all three groups have presented their findings. Distribute Handout 3 “Stages of adolescence”. Finally, thank the participants and refer them to the relevant section of the handout that summarizes the main changes and events during adolescence at each stage. Encourage them to review it later.

Talking points

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

Summary

Briefly review the handout. Remind the participants that developmental charts provide only general guidelines and that not all adolescents fit neatly into these categories. Different factors may affect individual youth as they experience the various stages of adolescence.

Session 2: Youth vulnerabilities, risk-taking behaviours and their consequences

OBJECTIVE:

- To identify youth vulnerabilities and understand youth risk-taking behaviour and its consequences in order to better serve youth clients and address their sexual reproductive health needs.

TIME

50 minutes

MATERIALS/RESOURCES:

- Butchers paper & marker pens
- Handout 4: The case of Lucy & Rita

Steps:

1. Divide the participants into groups of 4-5. Give each group a copy of the case study (Handout 4). Tell them that they will have 10 minutes to read together as a group.

The case of Lucy & Rita

Lucy a 15-year-old girl in Vanuatu attended a girl's boarding school and was the top student in her class. Her closest friend Rita was in the same class and they were the two star students in their class. Lucy came from a rural village in another province; Rita was the daughter of a prosperous businessman in Port Vila. The two girls shared many secrets. They were both virgins and members of the church youth group. One weekend while attending a student camp at the end of the school year, they became friends with two boys from a nearby school. The boys were really nice but Lucy was very reluctant to be alone with them, but Rita encouraged her. They ended up having sex with the boys, their first time. The next day they both travelled home for the end of year school holidays.

When Rita got home, she was very happy to see her family especially her big sister. That evening she talked to her sister and told her all about the boys and what had happened at camp. Her sister asked if she had used a condom, but Rita said no, she didn't think so but wasn't sure as she had never seen a condom before. The next day her sister took Rita to the clinic. They saw a nurse did not want to give the emergency contraception to Rita because 'she's too young and should not be having sex' but Rita's older sister insisted.

Lucy also returned home to her province and her remote village. She really wanted to talk to Rita about what had happened with the boys, but had no money to get phone credit. After a few days she stopped thinking about it and just spent time with her family and enjoyed village life. The following month she missed her menstrual period. Could she be pregnant? She didn't know who to talk to – the clinic was several hours walk from her village, and her aunty worked there so she was scared to go. She decided to put it out of her mind and hope for the best. After a few weeks she returned to school.

Lucy remained in school but was frequently unwell and moody, her performance in class deteriorated. The teachers were worried about her and the school nurse was summoned to examine her. Pregnancy was confirmed and according to the school's policy she was immediately suspended and given a letter to take to her parents. Lucy was devastated. She had no money to go home. Her parents were elders in their church and would kill her if they heard what had happened.

Rita gave her some money and Lucy left school and travelled to Port Vila to see her uncle, a construction worker who lived in one of the settlements. When her uncle returned from work in the evening Lucy pretended she was sick and told him that she had been sent away because of school fees. The uncle sympathized with her but could not raise any money, she would have to contact her parents and ask them.

Lucy was now four months pregnant and it became more difficult to hide. At 6 months her uncle's wife noticed the pregnancy. Her uncle was furious and chased her out of his house. Lonely, with no money and nowhere to go, Lucy accepted accommodation from a young man in the neighbourhood.

Two months later Lucy delivered a premature baby boy at a nearby health centre. The baby had to be kept in the hospital for 2 weeks. When Lucy was discharged from the hospital she found that the young man who had accommodated her had moved. She was now desperate! A 15 year old with a premature newborn, no money and homeless. Lucy took refuge in the only place that would accept her – a woman who owned a nakamal in the settlement area employed her to help serve her customers in return for her room rent. Lucy also exchanged sex for money with some of the customers to buy food and medicine for her sickly baby. That became Lucy's life.

Rita went on to graduate at the top of her year and got a scholarship to attend University. The friends have lost touch but Rita often thinks about Lucy and wonders what became of her.

2. Ask the groups to consider what are the aspects of vulnerability highlighted in this case study. (eg. What made Lucy vulnerable? What made Rita vulnerable?) *(NB: encourage them to consider physical, emotional, and socio-economic vulnerabilities that might be present).*

Write the following questions on a flipchart to guide their group work (or use Slide 13):

1. Who was most vulnerable in this case study and why?
2. What were the risk-taking behaviours in the case study?

3. What could have been done to reduce the vulnerability and risk in this case study?

3. After 20 minutes, call the group back together and invite them to share their work. Ask them to share back one question at a time – inviting all groups to share their response to question 1, then 2, then 3 (after the first group, ask other groups to add only points which have not been mentioned).

4. Conclude the discussion by highlighting the fact that many of the things they have mentioned in response to question 3 can be termed “Protective Factors”. Protective Factors are influences in the community that help young people to make healthy decisions. Protective factors may include support from the community; access to education and services, self-esteem, self-efficacy, skills, etc.

Trainer’s notes

The literal definition of “vulnerability” is the state or condition of being weak or poorly defended. The concept of vulnerability with regard to young people means those who are more exposed to risks than their peers. Gender issues have a marked influence on the socio-economic vulnerabilities of young people, as well as on their emotional and physical health, particularly in traditional cultures.

Below are some examples of each area of vulnerability; examples can be given to each group if they are having difficulty.

Physical vulnerabilities

- Psychological factors that put many adolescents at increased risk of physical harm include a general sense of invulnerability (‘it won’t hurt me’), the desire to try new things (including drugs and alcohol), and a willingness to take risks (e.g. having unsafe sex, changing sexual partners often, or having a partner who has multiple partners).

Emotional vulnerabilities

- Adolescents often lack assertiveness and good communication skills, which can make them unable to speak about their needs and stand up to pressure or force from peers or adults.
- Often there are unequal power dynamics between adolescents and adults (adults may still view adolescents as children).
- Adolescents may lack the maturity to make good, rational decisions.

Socioeconomic Vulnerabilities

- Adolescents may be living in family situations where there is little social and material/ financial support.
- During adolescence, young people’s need for money often increases, yet they typically have little access to money or gainful employment. This may lead adolescents to steal or take work in dangerous situations. Girls, in particular, may be tempted into transactional sex.
- Poverty and economic hardship can increase health risks, particularly if accompanied by poor sanitation, lack of clean water, or an inability to afford/access health care and medications.
- Adolescents are more likely to experiment with drugs and alcohol, and disadvantaged adolescents are at greater risk of substance abuse.
- Young women often face gender discrimination that affects food allocation, access to health care, adherence to care, the ability to negotiate safer sex, and opportunities for social and economic well being.
- Many young people are at risk due to other socioeconomic and political reasons. These especially vulnerable youth in Vanuatu include school dropouts, teenage mothers, displaced young people and those living away from home.

Risk-taking is a normal part of growing up and becoming an adult. Risk-taking can be healthy or unhealthy; Healthy-risk taking provides important opportunities for growth, whereas unhealthy risk-taking involves activities that are dangerous.

Important things to remember

- Risk-taking among adolescents varies with cultural factors, individual personality, needs, social influences and pressures, and available opportunities.
- Adolescents tend to test their limits and underestimate the risks involved; this type of behaviour is age appropriate, but adults must help adolescents avoid serious consequences.

Summary

This case study highlights several issues, including:

- Lack of communication on SRH matters between adolescents, their parents and other adults around them
- Lack of access by adolescents to the SRH information and services they need
- School policies on pregnancy and students, which are harmful at many levels to the affected students

It is important to consider what protective factors we, as YFHS providers, parents and community members can provide young people to reduce their vulnerability.

Session 3 - Adolescent/youth health problems & priorities in Vanuatu

OBJECTIVE

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

- Identify the key youth health problems and priorities in Vanuatu
- Understand the role that health services need to play to promote youth health

TIME

40 minutes

MATERIALS/RESOURCES :

- Markers
- Flipchart
- Slides 14 – 18

TIME

40 minutes

Activity 1: Identify local health needs

Steps

1. Ask participants “What are the health needs of young people in Vanuatu?” After a few minutes for responses from the group, show Slide 13. Discuss the content of the slide and invite comments.

What are the health needs of young people in Vanuatu?

Reproductive health issues

- Early unprotected sex and teenage pregnancy (& unmet needs for contraception among young people)
 - 10% of young people have had sex by the age of 15
 - Over 1/3 of urban young people have not heard of family planning
 - less than 35% of sexually active adolescent girls (15 – 19yr) using contraception
 - Adolescent girls account for one in 8 births
- Sexually transmitted infections (STIs)
 - More than 36% of males and 14% of females (15– 24yr) diagnosed with an STI
 - less than 15% of sexually active youth report consistent condom use

Slide 14

Substance abuse

The recent second-generation surveillance (SGS) conducted in 2008 in Vanuatu assessed alcohol and substance abuse among youth in the islands. Around 25% of participants reported that they consumed 5 or more standard drinks (binge drinking) on weekly basis. The survey also showed that marijuana, kava and tobacco are among the three most common substances abused by youth in the island

Sexual violence and abuse

National statistics on sexual violence is limited in Vanuatu. The recent SGS showed that forced sex is common in the islands where 20% of males and 45% females reported a history of forced sex.

General health problems

Youth are also affected by common and prevalent diseases that affect the general population in the country such as malaria, tuberculosis, acute respiratory infection, dengue fever etc. Other health related problems include injuries and accidents.

Slide 15

2. Divide the group into district/province or health facility (those that work in the same area to work together)
3. Write the following questions on the flipchart and ask participants to discuss in their groups:
 - What are the health problems affecting young people in your province/your district?
 - Is the health problem or problem behaviour a priority for your province/your district?
4. After 10 minutes, bring everyone back together and invite groups to share their locally identified issues/concerns and priorities. Compare these to those identified at national level.
5. Tell participants we will come back to these local issues on Day 4 when developing action plans.

Activity 2: The role that health services need to play to promote youth health**Steps:**

1. Put up Slides 15 – 17 one at a time and present them using the talking points.

What young people need (and why)

Information and skills (they are developing)

A safe and supportive environment (they live in an adult world)

Health and counseling services (they need a safety net)

Slide 16

Talking points

This slide is based on the common agenda for action on adolescent health and development defined by WHO, in conjunction with UNFPA and UNICEF.

Stress that the health services have an important role to play in promoting youth health and development, as part of a comprehensive approach that creates a safe and supportive environment, provides information, builds life skills, and provides health and counselling services.

Meeting the needs of both well and unwell young people

Providing information and advice

Screening for health problems and problem behaviours

Detecting and managing problems

Referring to other health and social service providers when necessary

Slide 17

Talking points

The role of health-care providers in helping unwell young people get back to good health is well recognised. In addition, they have an important role to play in helping well young people to stay well, and in helping them develop into healthy, competent and caring adults.

Keys to success: Putting young people ‘at the centre’

- Trying to understand the specific needs of each individual young person
- Regarding the young person as an individual; not just as a case of a health problem
- Acknowledging and paying attention to the viewpoints and perspectives of the young person
- Trying to prevent our personal beliefs, attitudes, preferences and biases from influencing our professional assessments and actions
- Respecting the rights of the young person, while at the same time taking into the account the rights and responsibilities of parents
- Taking into first consideration the best interests of the young person when making decisions or taking actions that affect them

Slide 18

Summary

As YFHS providers, we have an important role to play in ensuring the health and development of young people; in addition, those of us who are parents (of adolescents) have an important role to play in their health and development.

Module 3: Youth Sexuality

Module Objective

- To help participants gain an understanding of the broad concept of sexuality and what represents a sexually healthy young person.
- To recognise the sexual and reproductive rights of young people

TRAINING/LEARNING METHODS:

- Trainer presentation
- Brainstorming
- Plenary discussion
- Case studies
- Group work

EVALUATION METHODS:

- Pre- and post-test
- Reflections
- Where Are We?
- Participant evaluation activity
- Trainer observation and assessment of group work

MATERIALS:

- Markers
- Flipchart
- Slides 19 – 25
- Handout 5: 'The 5 circles of sexuality' (Annex: Trainers Tools p. 8)
- Handout 6: Case studies (Annex: Trainers Tools p. 9)
- Handout 7: Behaviours of a sexually health individual (Annex: Trainers Tools p. 11)

TIME:

Time

310 minutes

ADVANCED PREPARATION

Advance Preparation

1. Make enough copies of Handout 5: 'The Five Circles of Sexuality', and Handout 7: 'Behaviours of a sexually health individual' for distribution to all the participants
2. Make one copy of the Case Studies (Handout 6) & cut these into separate cases for group work
3. Index cards/small pieces of paper with the 9 rights critical to the realization of SRH, one right per card/paper (written or printed)

Session 1: Understanding sexuality

Objective

To help the participants gain an understanding of the broad concept of sexuality and the many areas of our lives that involve our sexuality

Time

40 minutes

Materials

Butchers paper & marker pens

Slides 19 – 21

Handout 5: The Five Circles of Sexuality

Steps

1. Write “Sex” and “Sexuality” in separate columns on a sheet of butchers paper
2. Explain that when many people see the words “sex” or “sexuality”, they most often think of sexual intercourse. Others also think of other kinds of physical sexual activities. Tell the group that sexuality is much more than sexual feelings or sexual intercourse.
3. Ask the participants what the term ‘sex’ means to them. Allow the participants to share their thoughts, and record their responses in the “Sex” column of the butchers paper.
4. Next, show Slide 19 and read out the definition of ‘sex’ and ask the participants for any comments on the definition.

Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. (WHO)

Slide 19

TALKING POINTS

In general use in many languages, the term sex is often used to mean “sexual activity” (which includes penis-vagina sex, oral sex, and anal sex), but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.

5. Ask the participants what the term ‘sexuality’ means to them. Allow the participants to share their thoughts, and record their responses in the “Sexuality” column of the butchers paper.
6. Show Slide 20 and read out the definition of ‘sexuality’ and ask the participants for any comments on this summary.

Sexuality

- An expression of who we are as human beings.
- Includes all the feelings, thoughts and behaviours of being male or female, being attractive, and being in love, as well as being in relationships that include intimacy and physical sexual activity
- Begins before birth and lasts throughout the life span
- Shaped by values, attitudes, behaviours, physical appearance, beliefs, emotions, personality, likes and dislikes, spiritual selves, and all the ways in which a person has been socialised
- The ways in which individuals express their sexuality are influenced by ethical, spiritual, cultural and moral factors

Slide 20

TALKING POINTS

Sexuality is an important part of who everyone is. It includes all the feelings, thoughts, behaviours of being male or female, being attracted to and attractive to others, and being in love as well as being in relationships that include sexual intimacy and physical sexual activity. It also includes enjoyment of the world as we know it through the five senses: taste, touch, smell, hearing, and sight.

Trainers Notes

The Slide is based on the WHO published ‘understanding’ of sexuality as: “...a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviours, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious and spiritual factors” (WHO, 2006a¹).

5. Explain that while many people often associate the term "sexuality" with the terms "sex" or "sexual intercourse", it covers much more than that. To help the participants understand the complex nature of sexuality, discuss five aspects of sexuality in a brief mini-lecture.

One way to present these five aspects is to draw 4 circles that slightly overlap each other (see the handout ‘The Five Circles of Sexuality’). Each circle represents one of the elements of sexuality. When all four circles are placed together, they suggest the total definition of sexuality.

6. Write “Sensuality” in the first circle. Use the information below to describe the concept to the participants. After you have described the concept, ask participants to provide examples to demonstrate their understanding of the element. Continue with the second circle and write “Intimacy & relationships” and again use the information below to describe the concept to the participants. Continue with each of the circles and concepts.

TALKING POINTS

Circle #1—Sensuality: *Using our senses (touch, smell, taste, sight, sound) to experience pleasure, physically & psychologically.*

The sensuality circle represents the way that we experience pleasure. We experience sexuality through our senses as pleasure, and our bodies physically respond.

Body image is the way that we feel about our bodies, and influences how and when we allow ourselves to experience sexual touch. Our sensuality also involves our need to be touched and held by others in loving and caring ways – this is called ‘Skin hunger’. All people have different levels – some people prefer little physical contact, while others prefer frequent contact (& everything in between). Adolescents typically receive less touch from family members than young children do, therefore many young people satisfy this need through close physical contact with a peer. Sexual intercourse may result from an adolescent’s need to be held, rather than from sexual desire. Fantasy is another part of our sensuality. Our brain gives us the capacity to fantasize about sexual behaviours and experiences without having to act on them. We receive very little formal education about sensuality and usually discover what brings us pleasure independently.

Circle #2— Intimacy & relationships: *The exchange of emotional closeness between people.*

The intimacy circle represents the process of becoming emotionally close with another person. This circle applies to all kinds of relationships, including family, friends and partners. Intimacy is a driving force behind many of the close relationships that we have in our lives. In order to become close with someone, we need to take risks (share feelings, personal information), be vulnerable, communicate effectively, and establish trust. Acts of care and sharing help to establish intimacy and liking/loving the other person is essential to establish strong intimacy.

People very rarely have any formal education on how to effectively establish and maintain intimacy. We learn about intimacy from the relationships around us, particularly those within our families.

Circle #3—Sexual Identity: *Who we are and how we label ourselves & our desires*

The sexual identity circle represents who we are and how we explain and express ourselves to other people. This includes how we see ourselves as male or female, who we are attracted to, and the types of sexual practices that excite us and bring us pleasure. It also includes gender roles, which are the cultural expectations placed on us to ‘act like’ men or women.

Four main elements make up an individual’s sexual identity: Biological sex (male or female); Gender

¹ “Challenges in sexual and reproductive health: Technical consultation on sexual health” (WHO, 2006a)

identity (how we feel about being male or female)²; Gender roles (society's expectations of us based on our biological sex); and Sexual Orientation (the biological sex we are romantically attracted to). Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex).

People often confuse sexual orientation and gender roles. For example if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. However, they are actually expressing different gender roles – their feminine or masculine behaviour has nothing to do with their sexual orientation. A gay man may be very feminine, very masculine, or neither. The same applies to heterosexual men. Also, a person may engage in same-sex sexual behaviour and not consider himself or herself homosexual (eg. men in prison may have sex with other men but may still think of themselves as heterosexual).

People are rarely taught about sexual identity in formal settings (eg. schools). We are usually left to figure out our identities and find ways to communicate about them. This is particularly true for people who have minority identities such as lesbian, gay, bisexual or transgender.

Circle #4—Sexual Health and Reproduction: *The components of our bodies and how they function.*

This circle represents the physical facts of our bodies, how they function sexually, the components of reproduction, the physical changes that happen from birth to death, and the challenges that people face, including STIs, sexual dysfunction, and infertility.

The Sexual Health & Reproduction Circle is the one that most people receive the most education about. Most people learn the basics of anatomy, reproduction and STIs in school classes (eg. Family Life Education, or Biology/Science). These tend to focus on the changes of puberty and negative outcomes of sexual activity.

7. After discussing these 4 circles of sexuality, draw a 5th circle that is not connected to the other 4. This circle is a negative aspect of sexuality and can prevent an individual from living a sexually healthy life. Say that this circle can 'cast a shadow' on the other 4 circles of sexuality and describe it as follows:

Circle #5—Power & sexuality to control others: *The role of power in sexuality - this element is not a healthy one.*

This Circle represents negative aspects of power. Unfortunately many people use sexuality to violate someone else or get something from another person. Rape is a clear example of using sex to control somebody else, sexual abuse is another. The media (including pornography) play a significant role in our informal learning about sexuality, and use power to influence our perceptions of sexuality, often in negative ways. Note if we do not educate young people about sexuality through formal settings/programs (schools, health workers, peer educators) then often their only source of information is the media. People often do not learn anything about this circle – at a minimum, young people should learn how to recognize and protect themselves from abuses of sexual power.

8. Show Slide 21 - Facilitate a group discussion by asking the questions on the slide.

Group Discussion

- Where is 'sexual intercourse' included within the definition of sexuality? Does the term play a large or small role in the definition?
- How does culture influence the various circles of sexuality?
- Which circles of sexuality are very different between males and females? Do men and women experience sensuality the same way? Do men and women view relationships the same way? Do men and women have the same sexual health needs?
- If adolescents receive sexuality education (eg. Family Life Education), which circles of sexuality will they be most likely to learn about? Which circles are usually left out? Why do you think this is?

Slide 21

² Gender identity starts to form around age 2, when a little boy or girls realises that he or she is different from the opposite sex. If a person feels like he or she identifies with the opposite biological sex, he or she often considers him or herself transgender.

Summary

Finish up the session by reminding the group that people tend to define sexuality in simple terms. Typically, they consider only the sexual act. Sexuality is much more complex and is influenced by many factors, including culture, gender, age and family values. Many of these factors are well established by the time a person enters adolescence, so it is critical to remember that adolescents and young people are sexual beings.

Session 2: Defining a sexually healthy young person

Objective

To help the participants identify the qualities and characteristics of a sexually healthy young person

Time

60 minutes

Materials

Butchers paper & marker pens

Handout 6: Case studies

Handout 7: 'Behaviours of a sexually health individual'

Slide 22

Steps:

1. Tell the participants that in this session we will consider what it means to be sexually healthy.

We will start by considering what 'sexual health' means. The WHO defines sexual health as:

- Enjoyment of sexual relation without exploitation, oppression or abuse.
- Safe pregnancy and childbirth, and avoidance of unintended pregnancies.
- Absence and avoidance of sexually transmitted infections, including HIV.

Unhealthy sexual behaviour can lead to deviance from any of these three points.

2. Show the WHO definition of sexual health on Slide 22 and read out to the group. Ask for any comments.

According to WHO, sexual health is:

"...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not only the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO, 2006a)

Slide 22

3. Divide the group into small groups of 3 or– 4 per group. Explain that they will be given a case study to assess. Each case study describes a particular young person or group of young people and they will be asked to identify whether the subject/s of the case study is/are sexually healthy.

4. Distribute one case study to each group, asking them to read and discuss it. Ask them to determine which behaviours, qualities and characteristics of the subject would be considered sexually healthy or unhealthy. Tell the participants they will have 10mins to complete the activity.

5. After 10 minutes, reconvene the whole group. Invite a spokesperson from each group to read out their case study and present the group's assessment of the healthy or unhealthy qualities, characteristics and behaviours of the subject.

Trainer's notes:

Encourage participants to think beyond what the subject does or doesn't do and consider the required knowledge, skills and attitudes they have which would make them healthy.

6. Write up the qualities, characteristics and behaviours that the groups identified as healthy and unhealthy in 2 columns on a piece of butchers paper ('Healthy' on one side; 'Unhealthy' on the other).

7. Distribute the handout 'Behaviours of a sexually health individual'. Review the list and ask the participants to share any thoughts they have.

Trainer's notes:

It is important that the participants' values about youth sexuality do not interfere with their assessment of sexual health. Some participants may feel that any unmarried young person who is sexually active should automatically be considered sexually unhealthy. Try to encourage the participants to base their assessment of SRH on factors that go beyond age and marital status. In many respects the criteria for a sexually healthy adolescent should be no different for those of an adult.

8. Facilitate a group discussion by asking the following questions:

- a. Was it difficult to assess and identify healthy and unhealthy qualities and characteristics? If so, why?
- b. Where do you think the young people learned their behaviours?
- c. Do you think that the young people knew they were being healthy or unhealthy?
- d. Did the group disagree about whether the young person was healthy or unhealthy?

Summary

Conclude the session by stating the importance of helping youth be sexually healthy. Remind the participants that assessing a client's sexual health may be more difficult than it seems at first. Note that an individual can be sexually active and still considered healthy if he or she engages in certain safe sexual behaviours and demonstrates sexual knowledge. Also point out that a person can be sexually unhealthy and without being sexually active.

Session 3: Identify the sexual & reproductive rights of adolescents*Objective*

Identify the sexual & reproductive rights of young people

Time

30 minutes

Materials

A4 paper

Butchers paper & marker pens

Slides 23 – 25

Steps:

1. Tell the participants that there is a growing consensus that sexual health cannot be achieved and maintained without respect for, and protection of, certain human rights.

Sexual and reproductive rights embrace certain human rights that are already recognised in national laws, international human rights documents. These rights are closely linked with other human rights, for example those in the Universal Declaration of Human Rights and other consensus

documents such as the UN Programme of Action adopted at the International Conference on Population and Development (ICPD) in 1994.

2. Show Slide 23. Read through the content, making sure that participants understand the meaning of each of the nine rights. Ask participants if these rights also apply to young people as well as adults.

Rights critical to the realization of sexual and reproductive health include:

- The rights to equality and non-discrimination
- The right to be free from torture or to cruel, inhumane or degrading treatment or punishment
- The right to privacy
- The rights to the highest attainable standard of health (including sexual reproductive health) and social security
- The right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage
- The right to decide the number and spacing of one's children
- The rights to information, as well as education
- The rights to freedom of opinion and expression, and
- The right to an effective remedy for violations of fundamental rights.

Slide 23

2. Divide participants into small groups of 2 or 3 (if possible assign the groups according to the area or clinic in which the participants work). Designate each small group one or two of the above rights (this can be done verbally or give each group a card/paper which states one of the rights). Ask participants to identify **how** each right applies to young people in terms of SRH. Tell them they have 10 minutes to discuss.

3. After 10 minutes, reconvene the whole group and ask each group to share their responses with the whole group. Facilitate a discussion on which of these rights most directly relate to them as health workers/service providers.

4. Show Slide 24 - Sexual Reproductive Health Rights are articulated as a guiding principle of the Vanuatu National Reproductive Health Policy. Show Slide 25 - Adolescent Sexual and Reproductive Health (ASRH) is also a key priority area for reproductive health service provision and programming.

Vanuatu National Reproductive Health Policy, 2015

Guiding Principles: Human rights/Sexual Reproductive Health Rights (SRHR)

The upholding of human rights is the fundamental, guiding principle of the 2015 Reproductive Health Policy, and respect for an individual's reproductive health and rights, **regardless of their age**, gender, ethnicity, religious persuasion, place of origin or marital status remains paramount in the meeting of their reproductive health needs, including the delivery of reproductive health services, provision of commodities and/or the provision of information.

Slide 24

Adolescent Sexual and Reproductive Health (ASRH)

Policy Statement: *Improved sexual and reproductive health of adolescents and young people in Vanuatu through reduction of teenage pregnancy and STI cases, and strengthened HIV prevention.*

ASRH includes: the prevention of unintended teenage pregnancy; the prevention and treatment of STI/HIV; the provision of targeted information to promote awareness of sexual and reproductive health issues; the provision of youth friendly services; and youth participation.

Slide 25

5. In addition to rights established within individual countries, major international conventions (1990 UN Convention on the Rights of the Child (CRC), 1994 International Conference on

Population and Development (ICPD) Programme of Action, Pacific Sexual Health and Well-being Shared Agenda 2015-2019 etc.) have articulated sexual and reproductive rights, including those that are specific to young people. These policies provide the basis for the following adolescent rights – show Slide 26

Youth SRH rights

- The right to good reproductive health.
- The right to decide freely and responsibly on all aspects of one's sexuality.
- The right to information and education about SRH so that good decisions can be made about relationships and having children.
- The right to own, control, and protect one's own body.
- The right to be free of discrimination, coercion, and violence in one's sexual decisions and sexual life.
- The right to expect and demand equality, full consent, and mutual respect in sexual relationships.
- The right to quality and affordable reproductive health care regardless of sex, faith, ethnicity, marital status, or location. This care includes:
 - Contraception information, counselling, and services
 - Prenatal, postnatal, and delivery care
 - Healthcare for infants
 - Prevention and treatment of reproductive tract infections (RTIs) & STIs
 - Prevention and treatment of infertility
 - Emergency services

Slide 26

- The right to privacy and confidentiality when dealing with health workers and doctors.
- The right to be treated with dignity, courtesy, attentiveness, and respect.
- The right to express views on the services offered.
- The right to gender equality and equity.
- The right to receive reproductive health services for as long as needed.
- The right to feel comfortable when receiving services.
- The right to choose freely one's life/sexual partners.
- The right to celibacy.
- The right to refuse marriage.
- The right to say no to sex within marriage.

Slide 27

6. Read through the rights listed on Slides 26 - 27 and ask participants for any comments. Point out the similarities between these rights and those they came up with in the group work.

7. Ask participants - what obstacles or barriers that might prevent each of the assigned rights from being fulfilled in the local context?

10. Share ideas in the whole group. Use the talking points below to add in any further detail.

TALKING POINTS

The following is only a partial list of obstacles/barriers that may prevent youth SRH rights from being fulfilled:

- Provider's personal views.
- Heavy client load, lack of time.
- Local laws, customs, or policies.
- Religion.
- Provider was not adequately trained.
- No clinic guidelines exist to ensure youth rights are met.
- Community pressure.
- Family pressure.
- Peer pressure.

- SRH services are not accessible to adolescents/young people.
- Hours of SRH services for adolescents/young people are inconvenient.
- There is no method for providing client feedback.

Summary

Conclude the session by reminding participants that SRH recognise the basic rights for all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to the highest attainable standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents. These rights are regardless of age – so apply equally to young people as well as adults. SRH rights have been endorsed through major international conventions to which Vanuatu is a signatory, as well as articulated at national level in Vanuatu, within the National Reproductive Health Policy and Family Planning guidelines.

Module 4: Providing Youth Friendly Health Services

Module Objective

To enable participants to understand how to provide effective youth friendly health services

TRAINING/LEARNING METHODS:

- Trainer presentation
- Brainstorming
- Plenary discussion
- Individual reflection
- Small group work
- Roleplay
- Verbal/nonverbal communication exercise
- Value clarification exercise

EVALUATION METHODS:

- Pre- and post-test
- Reflections
- Where Are We?
- Participant evaluation activity
- Trainer observation and assessment of group work & role plays

MATERIALS:

- Markers
- Flipchart
- Slides 28 – 36
- Post it notes
- Handout 8: Roleplay Scenarios; Handout 9: “Characteristics of Youth Friendly Health Services” and Handout 10: “Increasing adolescents’ access to sexual and reproductive health services in Vanuatu” Kennedy et al., 2013 article

TIME:

275 minutes

ADVANCE PREPARATION:

1. Write the following on butchers paper in large letter, one word per piece: ‘Personal’, ‘Interpersonal’, ‘Institutional’
2. Prepare a flipchart with the following closed-ended questions written on it:
 - a. Do you want counselling?
 - b. Do you have any questions about puberty?
 - c. Are you scared to talk to me?
 - d. Do you have problems at home?
 - e. Were you upset when your friends made fun of you?
 - f. Are you sexually active?
3. Prepare a flipchart with the following statements written:
 - “I hate condoms because they don’t feel right. Its not the real thing”
 - “I don’t use condoms because I hear they don’t work”
 - “I don’t like coming to this clinic”
 - “Whenever I tell somebody what I really think, they get mad at me”
4. Nine (9) cards or A4 paper with the following written on them (one per card/paper):
 - ☐ Friendly service providers

- ☐ Reliable commodity supply
- ☐ Free services & commodities
- ☐ Confidentiality
- ☐ Male & female providers available
- ☐ Convenient opening hours
- ☐ Things to do in the waiting room
- ☐ Privacy
- ☐ Separate, standalone youth clinic

5. Copies of the handouts “Characteristics of Youth Friendly Health Services” & “Increasing adolescents’ access to sexual and reproductive health services in Vanuatu” Kennedy et al., 2013 article – for each participant

6. One copy of the role play scenarios (Handout 8) – cut these up so that each group only gets one scenario.

7. If possible – organize youth peer educators to join the session ‘Role Plays with youth clients’ to play the client roles.

Session 1 - Barriers to Youth accessing to SRH care

Objective

Understand the barriers to young people obtaining SRH information and services

Materials/resources:

- Markers
- Flipchart
- Post it notes
- Slides 28 – 30

TIME:

45 minutes

Steps

1. Tell the participants that in this session we will consider important barriers to the provision of health services to young people (and their utilization by young people).
2. Put up Slide 28 – Barriers to the provision and use of health services and read out the questions.

Barriers to the provision and utilisation of health services

What are the important barriers to:

- The provision of health services to youth?
- The utilisation by youth of the health services they need?

Slide 28

3. Explain to the participants that you want them to identify what they believe are important factors that act as barriers to health-service provision and use (supply and demand barriers).
4. Distribute a small number of post-it notes to each person. Ask the participants to put down their ideas on the post-it notes (one idea on each note and suggest a maximum of three cards per person). Give them five minutes for individual reflection, and then go round the room asking for their post-it notes and put them up on the flipchart.

5. Once all the suggested barriers are put up, it will be apparent that they can be categorized in certain ways. You can use three categories of barriers:
- Personal
 - Interpersonal
 - Institutional

Here are some examples of each of these three categories:

- **Personal barriers** – e.g. an adolescent girl is suffering from very heavy menstrual bleeding but does not seek help because she is ashamed of her problem, and does not want to draw attention to it, and to herself.
- **Interpersonal barriers** – e.g. a receptionist who is rude to adolescents, or a health-care provider who is judgemental.
- **Institutional barriers** – e.g. charging fees for services, distance to health facilities, long waiting times, lack of privacy.

5. Put up the 3 pieces of butchers paper with ‘Personal’, ‘Interpersonal’, and ‘Institutional’ on the wall (if you cannot use the wall, the floor can be used for this activity). Use the categories and work with participants to decide to which category each barrier belongs. Add additional categories (or sub-categories) if proposed by the participants. Take your time over this and probe points where necessary. Ask one of the participants to put up any useful additional barriers identified in the discussion.

6. Bring up the following issues (if they have not been raised spontaneously) and encourage some reflection and discussion on them:

- Do laws and policies restrict the provision of certain health services to individuals (based on considerations of age or marital status)?
- Do concerns about confidentiality hold back young people from using health services?
- Does the tension between the rights of parents to know about the health problems of their adolescents, and the rights of adolescents to privacy, get in the way of the ability of adolescents to use health services?
- Are the barriers that have been identified the same for all young people, or are they different for some categories of adolescents (based, for instance, on gender or socio-economic status)?

7. To draw this discussion to a close, show Slide 29 and discuss with participants. Use the talking points below to explain each point.

Do existing services meet the needs of youth?

Young people can be excluded from health services by:

- Lack of knowledge and experience on the part of the young person
- Legal, social or cultural restrictions
- Physical or logistical restrictions
- Poor quality of clinical services
- Unwelcoming services
- High cost

Slide 29

TALKING POINTS

-Lack of knowledge & experience: Most young people do not have the knowledge or experience to distinguish between conditions that go away on their own and those that need treatment. They do not understand their symptoms or the degree of risk they may be taking. They do not know what health services exist to help them, or how to access them.

In a recent study, Vanuatu youth describe a lack of ‘awareness’ about SRH as a reason why they don’t access services. There is a perception that services were only for married people or mothers and not available to adolescents. Inadequate knowledge about condoms and contraception was the

major reason for not using family planning. Lack of knowledge about what they would be asked or what would happen at the clinic and not knowing how to talk with nurses were also reasons for not accessing services. A lack of experience attending a health service contributed to anxiety, as did misinformation or discouragement from friends.

- *Legal, social or cultural restrictions:* Reproductive health services, such as family planning clinics or abortion services, are often restricted. Abortions may be illegal and highly restricted in Vanuatu but the health system deals with the consequences of unsafe abortions. Even if condoms are available, health-care workers may withhold them from adolescents. Young people may need consent from their parents for medical treatment.

In Vanuatu, fear and shame related to socio-cultural norms and attitudes regarding youth sexual behaviour have been identified as the most significant reasons why young people find it difficult to access SRH services. This contributed to a perception among adolescents that they were ‘underage’ or ‘too young’ to be sexually active or seek SRH services and fear of disclosing sexual activity to judgmental providers. As one young woman said: “*We are ashamed to go [to clinic] because we are underage; we’re afraid we’ll get scolded*”.

- *Physical or logistical restrictions:* Services may be a long way from where the young person lives, studies or works, or available only at inconvenient hours. In Vanuatu lack of services and distance to care are a particular barrier in rural areas. Not being able to see a provider of the same sex was a barrier, particularly for girls.

- *Poor quality of clinical services:* Quality may be poor because health-care providers are poorly trained or motivated, or because a health facility has run out of medicines or supplies. In Vanuatu youth reported that providers lacked skills (particularly counselling skills) or gave poor quality care to adolescents. Many described concerns about being ‘rushed’ by nurses or being given the wrong advice or treatment by poorly trained providers. In Vanuatu unreliable commodity supply (of medicines and contraceptives) was also a noted barrier.

- *Unwelcoming services:* Of special concern is the way services are delivered. Young people are very sensitive to privacy and confidentiality, and do not want their dignity to be stripped away. Adolescents are more likely than older people to be put off by long waiting times and administrative procedures, especially if they are made to feel unwelcome. Unfriendly health-care providers who do not listen or are judgemental, make it difficult for young people to reveal concerns. They may not return for follow-up care. Vanuatu youth reported fear of unfriendly and judgmental providers, most concerned that they would be ‘lectured’, ‘scolded’ or made to feel ashamed for being sexually active, or experiencing an unintended pregnancy or STI. Young people also suggested that some judgmental providers who disapproved of adolescent sexual behaviour would deny them services (eg. contraceptives or condoms). Vanuatu youth also feared others finding out they had attended SRH services. In particular they were afraid of their parents, of being teased or talked about by friends, and being the victim of community ‘gossip’. The lack of privacy at hospitals and government clinics was emphasised, resulting in fear of being seen by friends, relatives or community members. In addition, young people described a lack of trust in providers and concern that confidentiality would not be maintained, particularly in small communities where providers were likely to be known to the adolescent and their family.

- *High cost:* Young people usually cannot afford to pay for health services but must ask an adult to support them. When desperate, young people will “beg, borrow or steal” money for treatment, or may seek help from traditional healers so as to protect their privacy, even if this treatment is less effective. In Vanuatu the costs of services, commodities and transport are barriers for many adolescents due to high unemployment and little access to household resources. Having to pay for SRH services and commodities prevents young people from seeking care.

8. Ask the participants to add from their own personal/professional experience.

Trainers notes:

These barriers can also be expressed as demand side and supply side barriers, as below from the research in Vanuatu. You may wish to draw participant attention to this table in the Kennedy et al., 2013 article (see Handout 9 or show Slide 30).

Barriers to accessing SRH services reported by adolescents	
Demand-side barriers	Supply-side barriers
Socio-cultural norms and taboos regarding sex and adolescent sexual behavior: <ul style="list-style-type: none"> - Stigma and shame - Fear of disclosure - Fear of being seen attending services - Opposition and disapproval from parents & communities - Community or religious 'rules' that inhibit discussion of sex or access to services 	Judgmental attitudes of health service providers Cost of services and commodities Lack of privacy and confidentiality Lack of services/skilled service providers Inconvenient location of services Insufficient time for counseling Unreliable commodity supply
Uncertainty about what they will be asked by a service provider and/or anxiety about physical examination Lack of knowledge about SRH and services Lack of experience attending health services	

Summary

Summarise the session by telling participants that young people face inter-related barriers that prevent them from accessing facility-based RH services. These include: **personal barriers**, such as feelings of shame, fear or anxiety about issues related to sexuality and reproduction, lack of awareness about the services available, poor health, or advice-seeking behaviors and the perception that services will not be confidential; **interpersonal barriers** (often socio-cultural), such as social norms which dictate the behavior and sexuality of both young men and women, stigma surrounding sexually active adolescents, cultural barriers which limit the ability of women, girls or certain sub-sets of the population from accessing health services (eg. gay or transgender young people), educational limitations, language differences, the attitudes of health care providers towards adolescents or their unwillingness to attend to their SRH needs; and **institutional or structural barriers**, such as long distances to health facilities, lack of facilities for clients with disabilities, inconvenient hours of operation, long waiting times, charging fees for services and lack of privacy.

Session 2 - Communication with youth clients**Objectives**

- To enable the participants to communicate clearly and effectively with young people by understanding the young person's perspective and responding to specific needs of the youth client.
- To demonstrate good counselling techniques to be used with adolescent clients.

TIME:

120 minutes

Materials/Resources:

- Butchers paper & marker pens
- Post it notes
- Slides 31 – 33
- Handout 8: Role play scenarios
- Youth peer educators (if possible)

Activity 1 – Effective communication & counselling skills

Trainer's notes

BEFORE STARTING

Ask for 2 participants to volunteer to role play effective and ineffective counseling skills. Talk through the characteristics of a good counselor (Slide 32). Explain that they will do the same role play twice. The first time they will demonstrate an ineffective interaction between an adolescent and a counselor at a RH clinic. At the end of the session, they will re-enact the same scenario, but as an effective counseling session. Spend some time conceptualizing the role play with the two participants, and make sure they have a clear vision of what they want to act out. Explain that they will have 10 minutes to prepare the scenario and 5 minutes to present it.

Steps

1. Tell the participants that during this activity they will be discussing and reviewing some key concepts of interpersonal communication that are the foundation for effective counseling.
2. Explain to the group that two participants have volunteered to demonstrate a counseling session. Set up the scenario for the group but do not tell them that the first role play will demonstrate an ineffective session. Tell them to watch the interaction that takes place and to be prepared to discuss their observations after the role play.
3. After the role play, ask the participants to identify what went wrong during the counseling session. Write their responses on a flipchart.
4. Inform the group that a major part of communication does not involve any words at all. This is called “nonverbal communication”. Ask the participants to give examples of both positive and negative nonverbal communication by demonstrating actual nonverbal cues. Examples may include those on Slide 31 (use this slide to summarise).

Nonverbal Communication	
Positive nonverbal cues Leaning toward a client Smiling Presenting interested facial expressions Maintaining eye contact (as culturally appropriate) Making encouraging gestures, such as nodding your head	Negative nonverbal cues Reading from a chart, papers or document Looking at your watch Yawning Looking out the window Answering your phone/ reading a text Fidgeting Frowning Not maintaining eye contact (unless culturally appropriate) Sitting with arms crossed
(ROLES) Relax Open up Lean towards client Eye contact Smile	Slide 31

TALKING POINTS

Providers should remember ROLES when communicating with the youth (or any) client:

R = Relax the client by using facial expressions that show interest.

O = Open up the client by using a warm and caring tone of voice.

L = Lean towards the client, not away from him or her.

E = Establish and maintain eye contact with the client (if culturally appropriate).

S = Smile

5. Ask the group to explain the impact that positive and negative nonverbal language has on establishing and maintaining a good relationship with a client.

6. Tell the participants that another important aspect of effective communication is called “verbal encouragement”. This lets the client know that the service provider is interested and paying attention. Ask the participants to give examples of verbal encouragement that service providers can use to encourage clients to feel comfortable disclosing personal information. Examples may include the following:

- “yes”
- “I see”
- “Right”
- “okay”
- “really? Tell me more about that?”
- “that’s interesting”

7. A part of verbal encouragement involves asking “open-ended questions”. These require the person answering the questions to reply with full answers, rather than a simple “yes” or ‘no’. Questions that require only a “yes” or ‘no’ response are called “close-ended questions”.

8. Put up the flipchart with the close-ended questions:

- a. Do you want counselling?
- b. Do you have any questions about puberty?
- c. Are you scared to talk to me?
- d. Do you have problems at home?
- e. Were you upset when your friends made fun of you?
- f. Are you sexually active?

Ask the participants to work in partners to change these closed-ended questions to open-ended questions. After 5 minutes, go around the room and ask for an open-ended alternative to each question. Possible options include:

- a. *Please tell me why you are here today. What can I help you with?*
- b. *What sort of questions do you have about puberty?*
- c. *Why are you scared to talk with me?*
- d. *Tell me about your home life?*
- e. *How did you feel when your friends made fun of you?*
- f. *If you are comfortable enough, please tell me about your sexual activity.*

9. Tell the participants that when they speak with young people, it is important to use ‘simple language’ that youth can understand. Ask the participants to provide examples of all reproductive health terms that health workers often use that an adolescent/young person may not understand (eg. menses, testicular, symptomatic/asymptomatic, cervical, ovulation, viral, immune system, discharge etc.). Brainstorm these on a flipchart. Also ask them to suggest words that could be used instead - use a different coloured marker pen to write these up next to the technical terms.

11. State that appropriate responses from a service provider can also help with the client-health worker relationship. On a new piece of flipchart paper write the word “Paraphrasing”. Paraphrasing is a way to make sure that the service provider has accurately understood what the client is communicating. Here is an example of paraphrasing (read out to participants):
Client: “I want to use pills, but my sister says that they will make me sick and weak”

Nurse: “So, you have some concerns about the side effects of pills”.

12. Display the flipchart that lists the following statements.
 - “I hate condoms because they don’t feel right. Its not the real thing”
 - “I don’t use condoms because I hear they don’t work”
 - “I don’t like coming to this clinic”
 - “Whenever I tell somebody what I really think, they get mad at me”

Ask the participants to work in partners again and paraphrase the statements.

12. After 5 minutes, reconvene the group and ask volunteers to share their paraphrase of the statements. If time allows, get 2 examples of paraphrasing per statement.

13. Explain to the group that they are now going to look at how communication skills can be one of the many important ways to improve counselling with clients.

Tell the participants to imagine that they find themselves with symptoms that make them worried that they have an STI – how would they feel? (Embarrassed? Scared? Ashamed? Angry? Disbelief?). They attend a clinic to seek help from a health worker.

Provide all participants with a post-it note. Ask them to list the behaviours that they would want the health worker to exhibit.

While they are working, write “A good counsellor....” on a flipchart. After a few minutes, ask participants to put their post-it note on the flipchart – ask the last 2 participants who put their post-it note up to read all of the responses to the group.

Responses should include those on Slide 32. Show this slide to summarise.

A good counsellor

- Always places the clients’ needs first
- Conducts counselling in a private setting that ensures confidentiality
- Gives the clients his or her full attention
- Never makes judgemental remarks to clients
- Respects the clients regardless of their age, educational level, ethnicity, sex, language, marital status, religion, or socioeconomic status

Slide 32

14. Ask the two role-play volunteers to re-enact the role play from the beginning of the session. This time they will implement as many skills of a good counsellor – positive nonverbal cues, verbal encouragement, open-ended questions, simple language, and paraphrasing – as possible during the interaction.

15. After the role play, ask the participants for their observations.

16. After the group share their responses to the second role play, facilitate a discussion by asking the following questions:

- What was the difference between the first and second role play?
- Which skills are the most important to use during a counselling session with young people?
- Which skill is easiest for you to implement?
- Which skill is the one you want to improve on?

Summary

Remind the participants that it is important to be conscious of their interactions with young people. It is also important to help youth feel comfortable during their first visit. Encouraging them to come for other visits if they need to is helpful. Tell the participants that young people are extremely aware of and sensitive to, nonverbal messages. Explain that improving communication and counselling skills will contribute to quality services for youth.

Activity 2 – Role plays with youth clients

Steps

1. Tell the participants that during this activity they will practice effective communication and counselling skills.

Trainers notes

If you have been able to organise youth peer educators to join this session, introduce them to the group and explain that they will be playing the role of the youth clients in the upcoming role plays. If this is the case, the participant groups will be 3 including the youth peer educators. More than one group may need to do the same scenario – make sure you have enough copies of the scenarios (Handout 8) to go around.

2. Divide the participants into small groups of 3 - 4 people (ideally 3).
3. Explain that 2 people per group will be assigned a character in a role play. Tell the participants that one person in each group will play the 'client' and one will play the 'service provider'. Give each participant a sheet of paper containing the appropriate information for his or her role. The third group member will be the observer.
4. Tell the other participant/s in the group to observe the interaction by trying to understand the client's perspective and to identify which of the service provider's behaviours appear to be effective or ineffective in dealing with the client. Give the role-playing participants 5 - 10 minutes to perform the role play.
5. After 10 minutes, reconvene the group. Facilitate a discussion by asking the observer in each group to comment on what he or she observed. Tell the observer to report on the effective counselling strategies that the service provider used. List the strategies on a flipchart. Ask the observer to suggest other techniques that may have been useful in dealing with the client; list these as well.
6. Next, ask the service provider and then the client in each group to discuss what went well during the role play and what they felt could have gone better.
7. If time allows, ask the groups to swap role play scenarios (so each group has a different one), and for group members to swap roles (ie. observers now have a turn in the role play). Repeat the process.
8. After all the groups have reported on their role play experiences, facilitate a discussion by asking the following questions:
 - a. What did all the role plays have in common?
 - b. Did any strategies work in all the role plays?
 - c. What strategies were unique to each role play?
 - d. What are the most important points to keep in mind when working with adolescents?

Conclude the discussion by showing Slide 33. Read through the slide with participants.

Counselling the youth client

Counselling is a two-way communication session during which the counsellor:

- Provides enough information to help the young person make an informed decision
- Helps the young person evaluate her/his feelings and opinions regarding the problem they sought help for

- Acts as emotional support for the young person

Counselling is not:

- About providing solutions to the young person's problems
- Telling them what to do
- Promoting of a way of life the counsellor believes in

The purpose of counselling a young person on SRH issues is to help them:

- Exercise control over their life
- Make decisions using a rational model for decision-making
- Cope with their existing situation

Slide 33

Trainers notes

Achieving control over behaviour, understanding oneself, anticipating consequences of actions, and making long-term plans are characteristics of maturity – one of the goals of youth counselling.

Summary

Conclude the activity by explaining the importance of effectively communicating with young clients. They are often anxious and embarrassed when asking for help regarding contraception, condoms or other SRH issues. Young people may have trouble trusting adults and are extremely sensitive to any judgemental attitudes they perceive in adults. It is important for service providers to communicate non-judgementally and empathetically to make sure that youth are open about their sexual experience and SRH needs.

Session 3 - Creating Youth Friendly Health Services

Objective

Understand the characteristics of Youth Friendly Health Services and approaches to making health services more youth friendly in the Vanuatu context

TIME:

60 minutes

Resources/Materials:

- Butchers paper & marker pens
- Post it notes
- Slides 34 – 36
- Handout 10: “Characteristics of Youth Friendly Health Services”
- 9 cards or A4 paper with the YFHS features
- Chalk

Activity 1: Characteristics of YFHS

Steps

1. Tell the participants to think about the number of young people they serve at their health centres/facilities. Ask them if they think that enough youth access the services, and why or why not. Take a few responses
2. Explain that during this activity they will have an opportunity to think about what type of facility would attract youth. What would the site look like? What services would be available for youth? Who would provide the services to youth?

3. Divide the participants into three groups. Ask each group to go to a specific part of the room. Distribute a sheet of butcher's paper and marker pens to each group.
4. Explain that you want them to imagine that they have been given funding to create a new youth sexual reproductive health facility.
5. Ask the groups to draw and describe what this facility would be like. Show Slide 34 and read the questions out.

Creating a YFHS

Programmatic Characteristics

What types of services would be offered?

How would the services be designed?

Service Provider Characteristics

What would the staff be like?

How would they treat adolescent/youth clients?

Health Facility Characteristics

What would the site look like?

Where would it be located?

Slide 34

6. Give the groups 20 minutes to discuss and design their YFHS facility on the butchers paper provided, including the programmatic, service provider & health facility characteristics. Monitor the groups and remind them when 5 minutes remain to complete the task.
7. After 20 minutes reconvene the groups and tell them that each group will have 5 minutes to present their vision for a YFHS. Probe them for the programmatic, service provider & health facility characteristics. After the first group reports, each successive group can add only what the other groups did not already mention under each category.

Following the presentations, show Slide 35. Discuss these definitions with the group

Definitions:

YFHS – are services that are **accessible, acceptable, comprehensive** and **appropriate** for young people. They are in the **right place** and delivered in the **right style** to be acceptable to young people. They are effective, safe, and **affordable** (free when necessary). They are **equitable** and **do not discriminate** on grounds of gender, ethnicity, religion, disability, social status or any other reason. Indeed, they reach out to those who are **most vulnerable** and **those who lack services**. They meet the needs of young people who return when they need to and recommend these services to friends*

YFHS - are wide range of health and related services provided to young people (15-24 years) to meet their individual sexual and reproductive health needs in a manner and environment to attract interest and sustain their motivation to utilize such services.

Services are youth friendly - if they have policies and attributes that attract youth to the facility, provide comfortable and appropriate setting for serving youth, meeting the needs of young people and are able to retain the youth clientele for follow up and repeat visit.

**Adolescent friendly health services an agenda for change, page 25. WHO 2002*

Slide 35

Summary

Summarise and highlight the most important characteristics from the lists. Remind the participants that some of the characteristics can be modified or added with little effort or cost, while others will require administrative support and approval. Provide all participants with a copy of Handout 10:

“Characteristics of Youth Friendly Health Services” from the Vanuatu YFHS National Operational Guidelines (Draft), 2010 for review. Refer the participants to the characteristics that may be on the handout but that they did not mention during their discussion.

Activity 2: YFHS in Vanuatu

We have considered the characteristics of a YFHS from the perspective of providers, in the next activity we will look at what are the most important features of a YFHS according to youth.

Steps

1. Tell the participants that we have considered the features of a YFHS from the perspective of individuals providing health services; now we are going to consider these characteristics from the perspective of adolescents/ young people themselves. More specifically, from the point of view of Vanuatu youth.
2. Tell the group that during a 2010 research project involving over 300 Ni-Van young people in rural and urban settings, the important features of a YFHS were identified. We are going to consider these and try to rank them according to order of importance to young people.
3. Ask the group to stand and make a large circle in the room, making sure that all will be able to see the floor space in the centre of the circle. While they are moving, in the middle of the circle, use chalk to write the numbers 1 – 9 on the floor in a vertical list (during the ranking exercise, participants will place a card next to each of the numbers).
4. Hand the 9 cards/papers to 9 participants in the group (one per person). Explain to the group that each person holding a card has one of the important features identified by young people. Invite each person to read out what is written on the card and then place it on the floor so all can read it.
5. Explain that as a group, we are going to try and rank these features in the correct order - from most important to least important according to young people. Invite any participant who would like to start to select a card to put at the top of the ranking next to the number 1. Encourage discussion and participation by as many of the group as possible during this process. Once all the cards have been placed, ask for comments and if any participants wish to move any cards – they should explain why.
6. Thank the group and show Slide 36 with the correct ranking. Invite comments on how close they got and reflection on any differences.

Important features of a YFHS in Vanuatu

The features of a YFHS ranked from most important to least important by adolescents include:

- Friendly service providers
- Reliable commodity supply
- Free services and commodities
- Confidentiality
- Male and female providers available
- Convenient opening hours
- Things to do in the waiting room
- Privacy
- Separate, standalone youth clinic

Slide 36

TALKING POINTS

1. A ‘friendly’ provider as someone who was non-judgmental and kind, who understood adolescents and their rights, who kept confidentiality, who gave adolescents adequate time, and

who was trained in SRH and counseling.

2. Having a reliable commodity supply was the second most important feature identified by adolescents, and the most important feature identified by rural groups. As one young man said: *“Must have medicine every time, otherwise you spent money on transport for nothing.”* (Male 18 years)

3. Adolescent girls in particular described the need to have a provider of the same sex, and some boys also had a preference for seeing a male nurse. (Providers and policymakers have identified that staff shortages, particularly in rural areas, made this challenging, however).

4. Having a standalone or youth-only clinic was the least important feature. Some adolescents reported that having a separate youth clinic would improve access to services by overcoming concerns about privacy at mainstream health facilities. However, many reported that other features were more important and that a lack of privacy could be overcome by providing separate entrances and waiting areas for adolescents (where youth-oriented activities and resources could be provided) or having separate youth-only clinic hours.

Summary

To conclude the session, stress that there is no “single or simple solution” to making health services youth-friendly. Stress that the most important thing is the need to understand the needs and preferences of adolescents/young people, and to orient the delivery of health services to respond to these.

Module 5: Conclusion & Action Planning

Module Objective

For participants to reflect on how they have been working with youth and on the ways they aim to improve and to draft the outline of an action plan for implementation to improve their work for and with youth when they return to their respective positions.

To reflect on the ethical and human rights issues raised in the program.

TRAINING/LEARNING METHODS:

- Trainer presentation
- Brainstorming
- Plenary discussion
- Small group work
- Individual action plan

EVALUATION METHODS:

- Pre- and post-test
- Reflections
- Where Are We?
- Participant evaluation activity
- Trainer observation and assessment of group work
- Completion of action plan

Materials/resources

- Markers
- Flipchart
- Slides 37 – 42
- Handout 11: ‘Individual implementation plan’
- Handout 12: Ethical and Human Rights Scenarios
- Handout 13: Post training questionnaire

Time

150 mins

Advance Preparation

1. Enough copies of the handout ‘Individual implementation plan’ for distribution to all the participants
2. One copy of the Ethical and Human Rights Scenarios – cut up into the 4 individual scenarios. Please study the four scenarios associated with this activity.
3. Enough copies of the Post training questionnaire for distribution to all the participants.

Session 1: Back at work - The changes participants propose to make

Objective

To consider what changes participants propose to make in their work for and with young people upon their return to work.

Time

70 minutes

Materials/resources

- Markers
- Flipchart paper
- Slides 37 – 39
- Handout 11: ‘Individual implementation plan’

Activity 1 – Individual implementation plan**Steps**

1. Show Slide 37 and explain the five columns.

Sample individual implementation plan							
Column 1	Column 2		Column 3		Column 4	Column 5	
The changes I plan to make in my everyday work with or for young people	Why I believe this change is important: who or what will benefit and why?		How will I know whether or not I have been successful and when will I know this?		Any challenges or problems I anticipate in carrying out the changes	What help am I likely to need and who could provide me with this help?	
	Who/ what will benefit?	Why?	How?	When?		Help needed	Source
EXAMPLE							
Contact the local schools to provide info. on the new YFHS being provided by our clinic. Offer to do a student/ teacher presentation	Students in local schools. Friends of students, & family members of school staff who are not in local schools.	They will find it easier to obtain the services they need.	A steady increase in the no. of students who come to the clinic to obtain services.	Six months after making contact with the schools.	Lack of interest from the school administration. Resistance from the teachers.	Support from the MoE Seminar to convince them of the value of this work.	The director of the local hospital could request this. Leaders of the parent teachers association.
Slide 37							

Talking Points*Column 1*

Changes you personally plan to make in your everyday work with or for adolescents. Stress that each change could relate to something they learned during any of the modules they have worked through. Each of the remaining columns raises particular questions about each change. Explain each remaining column in turn.

Column 2

Why you believe this change is important: who or what will benefit and in what way?

Column 3

How you will know whether or not you are being successful?

Column 4

Are there any personal or professional challenges and problems you anticipate in carrying out the changes?

Column 5

What help are you likely to need and who could provide you with this help?

2. Explain that participants can either draw up the implementation plan on butchers paper, A4 paper, or in their personal diaries. Whichever they find easiest to work on. NB: If participants draft

their plan on butchers paper first, by the end of the session it will need to be transferred onto an A4 sheet of paper or into their diaries/workbooks so copies can be made for workshop facilitators/program managers and participants can take the plan away with them.

3. Explain that the first task is to concentrate on the first two columns only. To assist with this, show Slides 38 – 39 - ‘Minimum standards (essential package) provision of youth friendly health services’ and discuss.

YFHS – Minimum Standards:

Minimum standards (essential package) – are the minimum expected ranges of sexual and reproductive health services to be provided at youth friendly health facilities at the primary health care setting using the available resources in the country

Advanced package - refers to services to be provided at the secondary or tertiary health facilities as part of routine care or YFHS.

Slide 38

Minimum standards (essential package) provision of youth friendly health services

- Provision of information, education and counseling services on sexual and reproductive health and interrelated issues;
- STI diagnosis and treatment.
- HIV testing-VCCT, and appropriate referral for treatment;
- Provision of a full range of appropriate contraceptives options for youth;
- A referral system for services that are not available.

Slide 39

Ask the participants to consider the Minimum Standards and also to bring out their Workshop Personal Diary and to look through the entries they made at the end of each module. This should lead them to identify at least 4 possible changes. Ask them to state why the proposed changes are important. Allow them, working individually, 10-15 minutes to fill in columns 1 to 2.

4. Plenary discussion: After 15 minutes ask participants to stop work on the implementation plan for now (but they will be returning to it soon). Tell them you are going to ask them to share the changes they propose to make (using short sentences), provided that someone else has not previously mentioned it. Go round the room encouraging the participants to be as precise as they can, and answering any questions they might have.

5. Ask a volunteer to note on a flipchart the changes the participants propose to make, with an explanation if any of these are not clear. Ask why the suggested change is important and how they would know if it is successful. As the discussion evolves, highlight noteworthy issues that arise and, if necessary, open the floor to discuss them.

6. Cluster the suggested changes with the participants' help (eg. programmatic changes, facility changes)

7. Lead a brief discussion on the third column, *“How will I know whether or not I have been successful and when will I know this?”* asking the participants to suggest how they could measure their success.

Ask a volunteer to record the ideas on a flipchart. This should be helpful to those who are unsure how to assess the changes they hope and expect to make in their work (column 3). Ask all participants to complete column 3.

Activity 2 - The personal and professional challenges/problems that participants may face

Steps

1. Ask the participants to return to their activity sheets and take them through columns 4 and 5 below.

Column 4: Are there any personal or professional challenges and problems you anticipate in carrying out the changes?

Column 5: What help you are likely to need and who could provide you with this help?

2. Ask the participants to complete columns 4 and 5, addressing each change they plan to make in column 1. Allow them 10 minutes to complete this task.

3. Plenary discussion: After 10 minutes ask participants to stop work on the implementation plan. Encourage the participants to share the problems they anticipate and base the discussion on questions such as:

- Who else believes this is a problem or challenge?
- What can you do to solve this problem or challenge?
- Who could support or help you?

Point out that if anyone believes that the challenges facing them are impossible/too difficult to overcome, suggest that they consider altering their proposed improvement to make it more “do-able”.

4. Ask a volunteer to record on a flipchart useful ways to solve often-anticipated problems.

5. Ask participants to return to their plans and complete all the columns – adding any further detail from the discussion. The finished plan should be either copied onto Handout ‘individual implementation plan’ or photographed by the participant. The trainer should also take a copy (photograph or photocopy) so that the plan can be used in follow up.

Session 2 - Some ethical and human rights considerations

Objective

- To examine some ethical and human rights considerations, within the context of participants’ responsibilities to their clients and within their communities

Time

50 minutes

Materials

Handout 12: Ethical and Human Rights Scenarios

Steps

1. Tell participants that they will have an opportunity to consider ethics and SRH rights in the context of a number of scenarios. Divide the participants into four groups.

2. Give each group one scenario to work on (Handout 12). Also give each group a blank piece of paper to record their response on.

4. On a flipchart write the following questions:

- *How do you think health-care providers would respond when faced with this situation?*
- *Why?*

5. Ask each group to discuss their scenario, providing answers to these questions.

6. Allow the participants 10-15 minutes to come up with their response. Tell them that, if possible, they should try to agree on their answers on how to respond to the situation and note them on their paper. If they cannot agree, they should write down the different answers, each on its own piece of paper.

7. After 10-15 minutes, bring the groups back to the plenary. Ask each group, in turn, to share their conclusions and to respond to any comments or questions that the others pose. Allow about 5 minutes per group for the plenary discussion, so that you have about 20 minutes at the end to draw out any significant issues.

8. Keep an eye on the issues that each scenario highlights (Slide 40), because you need to address each group's suggested response as sensitively as you want them to deal with their young clients, given the legal and ethical context. Show Slide 40 to summarise at the end of the discussion.

Scenario 1

- Highlights the rights of individuals (including adolescents/young people) to the health services they need.

Scenario 2

- Highlights the tension between the rights of parents to know about the health problems of their (adolescent) children, and the rights of adolescents to privacy

Scenario 3

- The need for health care providers to tackle difficult internal family issues in some situations
- The challenge of tackling these – and other – difficult situations in the absence of systems, structures, rules and procedures
- The pressure to overrule the categorically expressed wishes of adolescent clients 'for their own good'.

Scenario 4

- The challenge of making sure that the entire team of health care providers and health facility/health centre workers maintains the confidentiality of young people and other clients.

Slide 40

9. In the discussion following each group's response to the scenario, try to draw out answers to probing questions such as those on Slide 41.

Checklist in working for and with young people

Is the suggested response (of the health care provider) legal?

Is it ethical?

Is it in the best interests of the young person concerned?

Does it infringe on the rights of the health care provider?

What alternative does the health care provider have – and how would they apply to the above questions?

When the rights of different people conflict, how could this be resolved?

Slide 41

10. Summarize the key points that have come up during the discussion.

Summary

In concluding, make the following points:

- Some of the issues that health-care providers face when dealing with youth health problems are simple and clear-cut (refer to an appropriate example that has arisen in discussion)
- Others are complex and less clear-cut; for instance, they raise a conflict: between the rights of the young person and those of the parents, or between the law and the best interests of the young person.

The challenge to health-care providers is to find a course of action that is legal, ethical, and lies in the best interests of the young person – a course of action that does not harm the young person or the healthcare provider. This is often not an easy decision. We hope that this program has enabled you to meet and better resolve those issues.

Session 3: WORKSHOP WRAP UP & EVALUATION

Objectives

- To measure any shifts in participants' knowledge and attitudes as a result of the training
- To provide participants' with an opportunity to evaluate the training and provide feedback to the facilitator.

Time

40 minutes

Materials

Marker pens
Butchers paper
Slide 42

Activity 1 - Post-training Questionnaire

Steps

1. Tell participants that the MoH/your organisation is interested in measuring changes in their knowledge and attitudes in order to assess the achievement of the training objectives and also to improve the training. Explain that they will be asked to complete the same questionnaire that they were given at the beginning of the training. Explain that the questionnaire is not a test, and assure them that all answers and information will be anonymous and confidential.
2. Distribute the "Post-training Questionnaire" handout and the pens/pencils to the participants and ask them to complete it. Tell the participants they will have 15-20 minutes to complete the questionnaire.
3. After 20 minutes, collect the questionnaires. If time allows, share the results of the "Pre-training Questionnaire" and discuss some of the questions that had low scores.
5. At the end of the day (or while the group are doing the workshop evaluation), grade the surveys and record them on the post-workshop copy of the Group Performance Matrix (Annex: Trainers Tools p.21),
- 4.

Activity 2 - Workshop evaluation

Steps

1. Divide participants into groups of 4 or 5 and provide each with a piece of butchers paper.
2. Show Slide 42 with the 6 workshop evaluation questions and read out.

Workshop Evaluation

1. What is your overall evaluation of this training? (consider content, materials, activities)
2. Were your expectations met? (rate out of 10 i.e. 10 = all expectations met)
3. The most important thing I learned in this training was:
4. Session/s you enjoyed the most (& why):
5. The session/s you liked the least (& why):
6. Suggestions on how to improve the training or a particular session:

Slide 42

3. Ask the groups to read and discuss each of questions, putting their responses on the butchers paper – explain that they do not need to come to a consensus, they can include each person's opinion (if different).

4. At the end, thank participants (there is no need for group feedback/sharing, just collect the paper for your own records).

CLOSING

Congratulate the participants for having completed the YFHS Training program.

Thank participants warmly for their active participation in what has been a lively and challenging workshop. Once any administrative matters are dealt with, close with a plea for continued reflection and self-appraisal on their work for and with young people.

Rainstorm group exercise

Steps

1. Ask participants to arrange the chairs in a circle and stand in front of their chair (NB: this activity can also be done by sitting on the floor, but works best on a wooden floor).
2. Ask participants to repeat your actions when you look at them.
3. Explain that they are going to create a rainstorm. Begin this process by rubbing your hands together. Then look at the person to your left. This person should also rub his or her hands together. Look at all the participants in the circle (one by one around the circle) until all of them are rubbing their hands together.
4. As the participants continue to rub their hands, begin to snap your fingers. Look at each participant until they all change from rubbing their hands to snapping their fingers.
5. Once all the participants are snapping their fingers, slap your hands on your thighs. Again the participants should do the same as you look at them.
6. Once all the participants are slapping their thighs, slap the seat of the chair in front of you (or floor, if sitting on the floor). Again, look at each participant until they all change.
7. Once everyone is slapping the chair, lead the participants through the same process backward until only one person is rubbing his or her hands together. When he or she stops, the rainstorm is over.

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