Youth Friendly Services for Sexual and Reproductive Health:

Facilitators' Guide for Training of Providers

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PREFACE

There are 251 million young people in India between the ages of 15-24 years, contributing to nearly one fifth of its total population. Youth is the most valuable section of the population, with highest potential for development. Life events and circumstances during adolescence and youth shape individuals' entire lives, and nations in consequence. That period of life provides them with opportunities to achieve a satisfying life and ability to contribute to the society. The onset of adolescence brings not only opportunities, but also, along with changes to their bodies, new vulnerabilities in the areas of sexuality, marriage and childbearing.

Both unmarried and married young people in the age group 15-24 years face significant challenges in obtaining age-appropriate sexual and reproductive health (SRH) information and services in India and many parts of the World. Even when a young person is able to overcome their family and society level challenges, they may face barriers in a health facility, including negative provider attitudes.

The needs of young people are reflected in the fact that 27 percent of girls in India are married before the age of 18, and only 5.6 % of married women use a modern contraceptive before having their first child (NFHS-2015-16). These factors increase the likelihood of a pregnancy during adolescence or young age, which in turn can adversely affect the health of the girl, as well as her ability to pursue educational aspirations and employment opportunities.

In order to improve access of health services for young people, it is essential to go beyond the providers in Adolescent Friendly Health Clinics. It is important that all health care providers in facilities as well as community, follow the principles of youth friendliness. Such a mainstreamed approach will have a much larger impact; this has been demonstrated to be both scalable and sustainable in many countries.

UNFPA has developed this Youth Friendly Services (YFS) training package, which consists of a handbook and a facilitator's guide. Through a series of case scenarios, this training package enables the health providers to understand the common SRH needs of young people, and helps to build their skills to provide respectful, confidential and non-judgmental SRH services to young people.

We expect that by addressing the health system barriers faced by young people, the package will enable improved health outcomes and help to contribute to India's efforts towards achieving its commitments for FP 2030, and SDG indicators 3.7 and 5.6.

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Recognising the rapidly changing situation of young people especially under the challenges posed by the Covid -19 Pandemic, the contents may have to be adapted for different situations. The content may be used freely for non-commercial purposes, with acknowledgement to UNFPA India.

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INTRODUCTION

'Youth Friendly Services for Sexual and Reproductive Health: Facilitators' Guide for Training of Providers' is a guide for trainers for facilitating capacity building training program of service providers on making SRH services and health facilities youth-friendly. The objective of the training is to bring attitudinal transformation and values clarification amongst providers on young people's SRHR. The overall goal of the program is to improve the quality and youth-friendliness of SRH service delivery. It is a two-day training manual that will enable the facilitators in facilitating the discussions on young people's sexual and reproductive health and rights (SRHR) through interactive methodologies such as group discussions, games and activities, role plays, powerpoint presentations etc. The manual is supported by the handbook for providers that the facilitator can refer to during the training.

The facilitator must keep in mind that SRHR issues are sensitive topics and some participants may not feel comfortable to discuss it openly. If the facilitators observe that some participants are feeling uncomfortable as it could be their first training of the kind, they can have a separate discussion after the session with them. The facilitator can identify a few things that may make them feel comfortable, like motivating them to participate freely or pairing them with another participant.

DETAILED SESSION PLAN

Day 1

Welcome and Filling Pre-Training Form

Time: 15 minutes

Preparations required: Photo copied pre-test questionaires

Material required: Pre-training form

Steps for the facilitator:

- Begin the day by introducing yourself and welcoming all the participants to the two-day training on making SRH service youth-friendly.
- Provide the Pre-Training Form to fill (see Annexure 1) to all the participants. Give everyone 10 minutes to fill the form. Close the activity after everyone has submitted their forms.

Session 1: Introduction, Expectations, Goals/Objectives and Training Norms

This session will help to open communication channel between trainees and trainers and create a learning environment.

Objectives

- Identify names of fellow trainees and members of the training team.
- Share their expectations.
- Get familiar with goals, objectives and schedule of training.
- Create a relaxed and open training environment.

Preparations required

- Ice breaker activity for introduction
- Pre-prepared charts for agenda

Introduction of participants and the trainers

Time: 45 minutes

Methodology: Game/ice breaker activity

Material required: Flip charts, Cards, White board, marker and 15 pairs of chits (in total 30 chits) of pictures with complimenting objects like raining clouds and umbrella, mirror and face, spectacle and eyes, shoes and foot, table and chair etc. The number of pairs can be increased if there are more than 30 participants in the training.

Steps for the facilitator:

Step 1: Begin with giving your and your co-trainer's introduction to the participants. Tell them all the participants will introduce themselves through an activity.

Step 2: Give one chit to each participant. Announce that they have to find their partner who has a chit with the complimenting object. They cannot talk while searching for the partner. The chits should be folded well and nobody can show the picture on their chit either.

Step 3: Through the game, each participant will make pairs with another participant. Give them 10 minutes to find their pair. After that the participants will be given 15 minutes to introduce themselves to their partner and get to know them.

Step 4: Announce/ write down the points for introduction on a white board.

- Personal information (Name, family, liking/disliking, years of service, place of posting etc.)
- What you wanted to be when you were 15 years old?
- Any memory that you would like to share when you were 19-20 years old.
- One childhood secret that you have not told anybody in your family.

Step 5: After the discussion in pairs, ask each pair to introduce their partner to the larger group. The facilitator will have 20 minutes for the exercise.

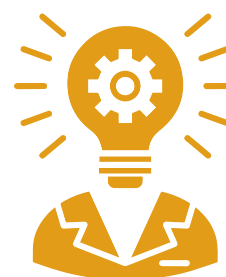
Step 6: After presentation from all the pairs ask participants how they found this activity different from simply giving their own introduction!

Some points may be:

- It was fun to communicate without talking and search for the person who has a complimentary chit.
- It helped to learn about a new person as we usually tend to talk more with people we work with or already know.

Step 7: The facilitator can conclude the discussion by highlighting that the training will be the most meaningful if everyone participates and has fun together in learning for the two days. They should be open to having discussions with new people during the training.

Expectation Setting



Time: 15 minutes

Methodology: Brainstorming

Material required: Marker and flip chart

Steps for the Facilitator:

Step 1: Ask the participants to list their expectations from the training on making SRH services youth-friendly.

Step 2: As the participants respond, the facilitator can create a list of the expectations on the flip chart. They can expect the following responses: how to get more young clients in the facility, how much information should be provided to young people on SRHR, how to provide counseling to them, etc.

Step 3: After everyone has shared their expectations, the facilitator can divide them in categories of attitude and perspective on SRHR, information and knowledge, skills and practice to work with youth etc.

Step 4: The expectations sheet can be displayed on the wall of the training hall for everyone to view.

Goals and Objectives

Methodology: Discussion

Material required: Marker and flip chart, training agenda

Time: 30 minutes

Steps for the facilitator:

Step 1: Based on the expectations emerged during the previous activity, inform the participants that the overall goal of the programme is to develop youth-friendliness of the providers and improve the quality of service provision for young people.

Step 2: To achieve this goal, inform the participants that during the course of the training, multiple activities will be conducted with the following objectives:

Objectives:

- To develop understanding of providers about the barriers that young people have to access health services.
- To enable them to understand how their personal values and attitudes affect service delivery related to sexual and reproductive health to young adults.
- To develop their skills to communicate effectively with youth clients.
- To help them in developing strategies to make the health facility youth-friendly.

Step 3: The trainers can share and go over the agenda of the training before closing this activity.

Setting the Training Norms

Time: 15 minutes

Methodology: Brainstorming/ discussion

Materials required: Marker and flip chart

Steps for the facilitator:

Ask participants to develop some norms for the training that all the participants should follow. Encourage them to set norms that would be helpful in meeting their expectations and achieving training objectives. Some norms may emerge as:

- Maintaining time/ arriving on time,
- Keeping their phones on silent mode and not taking calls in training hall,
- Letting other participants speak and do not interrupt when others are speaking,
- Respecting others views,
- Maintaining confidentiality during and after the training.

Tea Break (15 Minutes)

Session 2: What Impacts Young People's Access to Services

Objective: Identify the socio-cultural factors and barriers that impacts young people's access to health services

Time: 2 hours (1+1)

Methodology: Group work

Resources Required: Case studies from the handbook

Steps for the facilitator:

Step 1: Divide the participants into smaller groups. For making groups, ask participants to count from 1 to 5 (depending upon the no. of groups you want to make, remembering not to have more than 5-6 members in a group). Ask all the participants who said 1 to come together and sit in a small circle. Similarly, other groups will be formed and will be asked to sit in separate places so that no group disturbs others.

Step 2: Each group will be given five different case studies from the handbook.

Following are the case studies for the discussion:

Following are the case studies for the discussion to discuss the socio-cultural factors affecting health of young adults (10 minutes).

Group 1:

(Case study 2 in the handbook)

Laxmi is 20 years old and has been married for around 3 years. She has 2 daughters and she lives with her husband, children and mother-in-law in the city. One day, Laxmi realises that she has missed her period for 2 consecutive months, and purchases a pregnancy testing kit. The pregnancy test result confirms that Laxmi is pregnant. Thus, Laxmi accompanied by her mother-in-law visits the nearby district hospital, to consult a gynecologist. Laxmi did not want another child but she knew that her mother-in-law was waiting for a son in the family. The doctor asks the two of them to take a seat, and listens silently to the details provided by Laxmi's mother-in-law. The doctor asks Laxmi as to how she would like to proceed. Laxmi tells the doctor that she wants to know if she is pregnant or not. The doctor undertakes a test and confirms early signs of pregnancy. Laxmi's mother-in-law is overjoyed and asks the doctor what are the chances of a male fetus. The doctor says that she will be unable to predict the same, and also informs the mother-in-law that sex determination is illegal. The doctor also congratulates Laxmi and requests the nurse prepare Laxmi's antenatal schedule.

Group 2:

(Case study 3 in the handbook)

Sunil is 19 years old, unmarried young boy and lives in a village. He is studying in college. He volunteers his time at an NGO where he educates people on safe sex and HIV prevention. Sunil visits the male service provider once for his HIV testing. The service provider inquires "why do you need HIV testing?" Sunil says that he had had unprotected sex with his partner a few days ago. The service provider further asks if he is married to his partner. Sunil says that he has a male partner and they are not married. The service provider in a polite manner responds "Sunil, how do you have sex with a man? I want to know". Sunil gets embarrassed and asks if he can get his test done. The provider then responds, "Sunil, I want to talk to you as my own child. I'm telling you so that you can learn early in life and develop interest for girls. If someone gets to know about it, it will bring shame to your family. And your families will be ostracized from society." After saying this, the provider gets him tested and tells him to visit again the next day to collect the report.

Group 3:

(Case study 6 in the handbook)

Rubina is 19 years old and resides in a slum dwelling with her parents. She runs a general store with her father. Rubina has a boyfriend who lives close to her house. Rubina has missed her period in the last two months and she visits a female doctor for a pregnancy test with a friend. The doctor was accompanied by the nurse in the consultation room. There were no other patients in the room. The service provider asks Rubina if she had had sex with someone. Rubina says that she had had sex with her boyfriend 2 months back. After testing, the provider confirms that Rubina is 9 weeks pregnant. Rubina begins to feel very scared of the consequences of her parents getting to know about the pregnancy. The service provider tells Rubina that she should have thought of her parents earlier and now she should not complain. Rubina asks the provider about abortion and the provider says that she will only be able to do it if she brings her mother along. Rubina leaves the consultation room unsatisfactorily and is approached by the nurse who was there in the consultation room. The nurse tells Rubina that she can do abortion for her without the guardian's consent. She will charge 15,000 (INR). The nurse gives her the contact number to get in touch. When Rubina asks when and where she has to come, the nurse says that she will call Rubina to her house.

Group 4:

(Case study 7 in the handbook)

Hema is 16 years old. It has been 2 years since she started menstruating. Her menstrual cycle is not very regular. Her cycle is disturbed and she bleeds every 1.5 to 2 months. Sometimes the bleeding is only for 2 days and sometimes there is spotting for 7-8 days. When she tells this to her mother, she says that it is very common and it will get regular. However, she continues to feel worried and decides to visit the female doctor in the PHC with her elder sister. The doctor asks her about her menstrual cycle, prescribes a medicine and tells her to visit again after her next cycle. When Hema asked the doctor why her cycle was disturbed, the provider also says that it is very common and there is nothing to worry about. The session lasted only for 2 minutes. Hema was not satisfied with the response as she didn't understand the reason for her irregular cycle and how the medication would regularise her cycle. She however, decides to take the medication prescribed and make the visit next month.

Group 5:

(Case study 8 in the handbook)

Aradhana is 25 years old and lives with her husband and father-in-law in Gwalior. Aradhana and her husband have completed one year of marriage. Aradhana works in a bank and enjoys her work. Last month Aradhana missed her period and when she did a pregnancy test at home, the result was positive. As it was an unwanted pregnancy, she feels that she is not prepared for it yet and wants to focus on her professional life. Aradhana visits a female doctor in a private clinic. She is accompanied by a colleague. She tells the doctor that undertook a pregnancy test and feels unprepared for it. The doctor repeated the pregnancy test, and found it as positive. The doctor congratulates her for her first pregnancy. Aradhana explains to her that she is not ready yet. The doctor tries to cheer her up and says that she should think of her family's happiness also. If she aborts her pregnancy, she may not be able to conceive again and become a mother. She tells Aradhana that it is better not to have this abortion, and if she still wants, she should come back with her husband for his consent.

Group 6:

(Case study 9 in the handbook)

Sohail is 14 years old. He lives in a town in Jhansi. He and his friends come back from school together in the afternoon. One day Sohail tells his friends that he has been waking up in the morning with wet underwear. He sometimes also feels pressure in his penis and the urge to rub his penis. Two of his friends begin to make fun of him and start saying, "you have grown up." Sohail is confused and does not get an answer to his question. He feels disgusted and thinks that something is wrong with him. One day Sohail secretly asks one of his other friends to visit a doctor with him. They had heard about a counselor in CHC and decided to make a visit there. He meets the male counselor there. Privacy was maintained during the consultation. He tells Sohail that what he is having is wet dreams. It is a very normal phenomenon and that the white fluid is semen which gets discharged from his body. When Sohail asks the counselor why this is happening, the counselor says that this is because he watches adult films. If he avoids watching adult films, he will not get wet dreams. Sohail feels shy to ask anything further and returns back.

Step 3: Ask the participants to have a discussion in their group after reading the case study. Give them 45 minutes for the discussion. Announce that each group will report back to the plenary and present the highlights in 5 minutes. Following are the questions for the discussion in smaller groups:

- What are the socio-cultural challenges and barriers that young person in your case study had to face to visit the provider? (Cue: tell them to list barriers at multiple levels like social, legal, economic, as well as, attitudinal and behavioural of service providers)?
- What did the provider do right and what did the provider not do right in service provision in each case study?

Step 4: After the discussion in smaller groups, invite each group to present their discussion in the plenary. Each group will be given 5 minutes to present.

Step 5: As the participants present their discussion points, the facilitator will list down the important factors and barriers identified by the groups on the flipchart. The list can be something as follows:

- **Economic factors:** Young people, especially those from poor economic backgrounds cannot afford overpriced SRH services (such as in Rubina's case story).
- **Social factors/ social norms:** Taboo and social stigma on 'SRH' issues instill fear in young people to access services especially in case of premarital or same-sex relationship (such as in Sunil's case story).
- **Viewed as immature to take the decision:** Older family members as well as providers view them as immature and minor to take decisions (such as Laxmi's grandmother and doctor did not ask her for her decision). This is especially true for younger women to make decisions if/ when/ how many children to have.
- **Lack of information about youth-friendly providers:** Young people lack the information about where a youth-friendly provider, who wouldn't question them, would be available. For example, in all the case studies, the young people did not know that they can visit a youth-friendly provider who will provide quality services.
- **Attitude, information and behaviour of the providers:** The moralistic attitude of the providers, not giving complete and accurate information to the clients and asking unnecessary questions (such as asking Aradhana to visit with her husband or asking Sunil how he has sex with a man) discourage young people to visit the provider.
- **Lack of privacy and confidentiality:** Presence of support staff members or other patients is a big barrier in seeking quality and safe SRH services, such as in Rubina's case story.
- **Lack of information on laws such as MTP Act:** Young people do not know that abortion is legal in India. They have low legal knowledge of MTP Act and therefore, feel scared to approach the providers.
- **Restrictive laws and legal barriers:** Laws, such as Protection of Children from Sexual Offences (POCSO) Act and Medical Termination of Pregnancy (MTP) Act that mandate service providers to report to guardians or other administrative authorities in case of young people below the age of 18 seeking services.

Step 6: Conclude the session by highlighting multiple barriers that young people face in accessing quality SRH services.

Remind the participants that if they want to be youth-friendly in their practice, they will have to commit to support young people in overcoming these barriers.

LUNCH BREAK (60 MINUTES)

Session 3: Values Clarification About Youth & SRH (Sexuality/ FP/ Safe Abortion and Other STIs)

Time: 2 hours

Methodology: Game/Quiz

Activity 1: Quiz

Step 1: Put two charts in two different corners of the training hall and write on one AGREE and on the other 'DISAGREE'. Ask participants to stand in the centre of the hall in a circle. Read a statement (one by one) from the list loudly and ask the participants who agree to the statement to gather near the chart written 'AGREE' and those who disagree to go to the other corner where 'DISAGREE' is displayed.

Step 2: After reading each statement, ask the participants to give a reason for choosing 'AGREE' or 'DISAGREE'. Guide the discussion on centering the rights of young persons in service provision such that it minimises the personal bias and judgements of the participants. Refer to the handbook (Section 4) for providing accurate information in case participants have any myths or misconceptions related to any of the topics.

Note for the facilitator: Depending on time, you can pick 5-10 statements so that enough time can be devoted for the discussion.

1. Giving unmarried and/or minor youth information regarding sexual intercourse and contraception will encourage sexual activity and risk taking behaviour among youth.
2. Regular use of emergency contraception is harmful to health.
3. Giving women ECPs in advance (before they need them) will discourage them to use regular contraceptive use.
4. If a woman wants to buy ECPs, she needs a prescription from the doctor.
5. The ECP is not recommended as a regular form of contraception because it's not as effective at preventing pregnancy as regular contraceptives.
6. Easy availability of emergency contraception will encourage irresponsible sexual activity.
7. ECPs are not appropriate for adolescents.

8. Spousal consent is essential in matters of contraceptive use by women.
9. Getting an abortion results in infertility.
10. Aborting is morally incorrect.
11. Medical abortion method (using the mifepristone and misoprostol pills) is a dangerous method and will result in incomplete abortion.
12. Being transgender is a mental disorder
13. If any adolescent girl has irregular periods it is a sign of pregnancy
14. The right age for women to have children and complete the family is before thirty.
15. If a young woman wears revealing clothes or is friendly with boys, she is inviting abuse/violence against herself
16. Masturbation leads to blindness or impotency
17. A menstruating woman should not cook food or even enter kitchen. As dping so would spoil food items in the kitchen and anyone consuming them will fall sick.

Statements	Discussion Points
Providing sexual and reproductive health education to adolescents will lead to early sex.	Between the ages of 10 and 15, adolescents experience menarche, their first nightfall, other physical, mental and emotional transformation. It is commonplace for them to begin to experience pressure of getting married from family and community members. At this critical juncture, incomplete and inaccurate information renders them vulnerable to sexual exploitation and adverse SRH outcomes. To deny them relevant information on SRH is to deny their diverse needs and realities. Therefore, access to evidence based and medically accurate information around bodies and sexuality is their right and will equip them to make informed decisions that safeguard their health and wellbeing[1].
A young adult woman (18+) should not be given abortion service if she is coming alone.	There is no reason to deny abortion to a young adult woman as it is her legal right under MTP Act 2020 to take autonomous decision to abort[2].
Women go for abortions because they engage in irresponsible sex.	A woman may get pregnant even if she and her partner/ husband had used protection. Failure of contraceptive can happen even if it is correctly used. A rights-based approach will take into account that the reason for abortion is not irresponsible sex.

[1] See Section-4, Myth and Clarification-1 in the handbook.
[2] See Section-3, Case study-6 in the handbook for more information about the law.

If we promote emergency contraception, there will be no need for abortion services.	Emergency contraception may fail and therefore, the abortion services should be available for women at all times.
Statements	**Discussion Points**
If we promote emergency contraception, it will encourage irresponsible sexual activity.	Safer sex is a responsibility of both the partners. Emergency contraception helps prevent the pregnancy if the partner does not agree for condom use. Therefore, for women to have control over her fertility, it is important to promote it[3].
Abortion is equal to the act of taking baby's life.	There is a difference in a fetus and a baby. A fetus takes life only when it is out of the womb of the woman. It is important to detach this value judgement and keep the pregnant woman's decision and autonomy at the center of rights-based safe abortion services[4].
It is best for women to have children before the age of 30.	It is important to remember that there is no fixed or right age to have a child. It depends on when the couple is ready to plan and become parents. Economic factors, professional careers, individual preference are some of the factors that are important for family planning. If the woman wants to delay her pregnancy, the provider must not coerce her based on their value judgement. Women can have children from post-menarche through their menopause. As long as women are ovulating, they can conceive and have a child unless they have been diagnosed with a condition[5].
Condoms should be available to young people of any age regardless of their marital status or gender.	Condoms help to prevent unintended pregnancy and is the only method to protect from sexually transmitted Infections (STIs). They should be easily available to young people regardless of their marital status or gender.
It is worse for an unmarried girl to have sex than for an unmarried boy.	This is a gender bias that we see in the patriarchal society which gives unequal rights to men and women. Everyone should have a right to have consensual and pleasurable sexual activity, free of violence and without any gender bias and value judgements.
Spousal consent is mandatory for contraceptive use by women.	No, it is a woman's autonomous decision and providers cannot force spousal consent[6].

[3] *See Section 4, Myth and Clarification-7 in the handbook.*
[4] *See Section-4, Myth and Clarification-12 in the handbook.*
[5] *See Section-4, Myth and Clarification-16 in the handbook.*
[6] *See Section-4, Myth and Clarification-9 in the handbook.*

Same sex relationship is against nature and is a disease.	Just like people feel attracted to the opposite gender, there are people who feel attracted to the same gender. While religious texts may say that same sex relationships are against the nature, many of those texts are archaic. Religious opinions must not influence the provider's attitude and they must abide by providing comprehensive SRH services to a person in same sex relationship.
Note: *See Annexure - 3 for more statements.*	

Step 3: Conclude the discussion by highlighting the role of providers in ensuring rights-based and medically accurate service provision to young people. If they are unable to identify their value judgement in their practice or they propagate myths, their attitude and knowledge will continue to be a barrier for young people's good healthcare. They will not be able to provide non-judgemental counselling and treatment and will do a disservice to young people.

CLOSING THE DAY

The facilitator can close the day by asking all the participants to think about two new learnings and two persisting doubts. Let them know that there will be an activity on this the next day.

Day 2

Session 1: Warming Up Session: New Learnings and Persisting Doubts

Objective: Assess the learnings and progress of all the participants and address the questions and doubts

Time: 45 minutes

Activity: Reflections by each participant

Methodology: Writing on cards

Resources required: 60 blue cards and 60 yellow coloured cards

Steps for the facilitator:

Step 1: Participants will be asked to recall/share the sessions that happened the previous day.

Step 2: Each participant will be given two blue cards and two yellow cards. On the blue cards, ask them to write the two key learnings from the previous day sessions/discussions and on the yellow cards, ask them to write two queries/ doubts they have from the previous day.

Step 3: Ask some participants to share their learnings and doubts with the larger group.

Step 4: Put the learning cards on the wall. The facilitator can check that it matches with the expectations, goals and objectives of the training.

Note for the facilitator: *Remember to address the queries/doubts in the coming relevant session wherever it is possible.*

Session 2. Social Exclusion and Marginalization

Objective: Sensitize the participants on social exclusion faced by vulnerable groups in accessing the healthcare

Methodology: Game

Resources required: Folded chits with the identities written on it

Time: 1 hour

Steps for the facilitator:

Step 1: On a small piece of paper write different identities and fold it. Ask about 8-10 participants to volunteer and ask them to stand in one straight line. Ensure there is enough space in front of them to take steps forward. Ask them one by one to pick one folded chit. Announce that nobody is allowed to reveal their identity written on the chit to anybody.

Ask the remaining participants to observe the activity as they will be asked to share their observations.

Different identities can be-

- A 19-year old illiterate rural woman who has 2 children,
- A 16-year old tribal man,
- A 22-year old man working in government office,
- A 22-year old man who is a shop owner,
- A 21-year old transgender woman,
- A 20-year old Dalit woman who works as a farmer,
- A 24-year old female nurse,
- A 23-year old man who is a school teacher,
- A 20-year old unmarried disabled woman,
- A 20-year old man whose father is a Hindu priest,
- A 17-year old boy whose father is an industrialist,
- A 15-year old daughter of a sex worker,

Step 2: Read the statement and ask the participants with identities to think if that statement applies to him/her. If it applies to them, ask them to take a step forward. If it does not, they should keep standing on the same spot.

Situation statements

- I can easily go and visit the doctor alone for a cold and cough.
- I can go and purchase a condom easily from a pharmacy/ medical store.
- I can persuade my partner not to have sex, if I am not in mood and the partner is in the mood.
- I can go to a doctor to seek services for a red, itchy spot on my genital area.
- I fear that I could be raped or molested.
- I can use open areas easily anywhere for urinating.
- The attitudes of doctors are positive and empathetic towards me.
- I can take a rest if I am feeling unwell.
- I can easily afford to eat nutritious food in all three meals.
- If the ANM comes to the village, she comes and meets me.
- I can decide when I want to marry and have children.

At the end of this step, all the identities will not be in one straight line but in different spots, depending on how many steps they took. Ask them to keep standing there only.

Step 3: Ask the following questions to the observants:

- Guess the identities of all the volunteers.
- Why do you think some participants are ahead of others?

- In which statements do you think those who are behind could not take a step forward? What do you think are the reasons?

Step 4:

Points of discussion

Guide the discussion towards how certain populations are unable to take steps forward due to unequal power relations in society on the basis of gender, disability, class and caste.

To include them in the health and nutrition programmes, it is important to bring about structural changes. For example, disabled people can access healthcare only if the facility has disabled-friendly infrastructure and the provider is non-judgemental and non-discriminatory towards them.

Highlight that even though all the identities given to the volunteers were of young people in the age group of 15 to 24, still we saw there was diversity amongst them. Some identities were more vulnerable like the young Dalit woman farmer, daughter of the sex worker etc. Others, like the son of the Hindu priest, the son of the industrialist, the school teacher were more powerful due to their gender, profession, economic condition and social stature. This suggests that the providers must ensure that they build efforts to reach to the vulnerable/ socially excluded young people as well. For example, children of sex workers, transgender young people, tribal young people etc.

The facilitator can conclude the session by listing down important measures that the service providers can take for higher uptake of services by socially excluded groups.

TEA BREAK (15 MINUTES)

Session 3: The SRH Status of Youth in India and the Key Principles of Youth Friendly Services

Objective: Build knowledge on the status of SRH of youth key principles of providing youth friendly health services

Methodology: Power-point presentation

Time: 30 minutes

Resources required: Projector, screen and Powerpoint presentation

Steps for the facilitator:

Step 1: Flash the Powerpoint presentation on the screen and detail out each slide for the participants.

Note: *There are few slides where the facilitator can pause and ask questions from the participants to make the session interactive.*

Step 2: Sum up the discussion by presenting the principles to be followed by the service providers in making services youth friendly.

In conclusion, the following should be said:

Key Principles for Providing Youth Friendly Services

Key Principles - Provider

- Acknowledging the Autonomy of Youth and Taking Informed Consent
- Ensuring Privacy and Confidentiality
- Rights-Based Approach and Just and Respectful Care
- Non-Judgemental Attitude
- Ensuring Truthfulness and Doing No Harm
- Acknowledging Sexuality and Sexual Rights of Youth
- Acknowledging Diversity among Youth
- Accurate and Comprehensive Information

Key Principles – Services

- Comprehensive and Integrated Counseling Services
- Menstrual Health and Hygiene Management Counseling
- Provision of Contraceptives
- Safe Abortion Services
- STI and HIV management
- Care for Survivors of Violence
- Diagnosis and Management of SRH related services like pregnancy testing, diagnosis of RTI and STI
- Maternal Health related Services
- Mental Health Services

Key Principles- Facility

- Creating Visibility
- Facility Environment
- Waiting time
- Visual and Auditory Privacy
- IEC Material
- Availability of Male and Female Service Providers
- Stocking of all Different Types of Contraceptives
- Youth Feedback and Engagement
- Services Integration and Follow up

Session 4: Communicating with Youth

Objective: Build skills to communicate and provide youth-friendly services as well as learn dos and don'ts of providing youth-friendly services

Time: 150 minutes

Methodology: Role play and discussion

Resources Required: 3 sets of case stories from the handbook. You can choose the same case studies that were used in session II of day 1.

Steps for the Facilitator:

Step 1: Divide participants in three groups by asking everyone to count from 1 to 3. Explain the task to each group:

Group 1: Youth as service seeker: Each group member will be asked to think of himself/ herself as youth and will be given different situations from the module.

Group 2: Provider: Each group member is a provider. The service seeker will come to them with their situation. The provider has to provide the services based on the principles of youth friendly services.

Group 3: Observer: Each group member will observe the conversation between youth and service provider based on principles to be followed by providers. Give this group the questions mentioned under each case study respectively for observations.

Step 2: Provide role play situations to group 1 from the handbook.

Step 3: Invite each member from group 1 and 2 to begin the role play. At the end of each role play, invite the observer from group 3 to share their observations.

Step 4: Initiate a discussion on each case study after the role play based on the points of discussion in Section-3 of the handbook.

The facilitator may want to ask the groups to repeat the same role play after feedback and discussion till the time all the principles are followed.

Note for the facilitator: *Reinforce and reconfirm the following do's and don'ts for the service providers in the light of this discussion and highlight the required communication skills.*

S. No.	DON'Ts	Do's
1	Don't counsel a client in front of anyone else, irrespective of their relationship with the client, unless the client explicitly requests for their presence. If they are not trained, do not counsel the client in front of them.	Do conduct counselling in private. As much as possible, ensure that there are separate cabins/rooms with doors that facilitate private one-on-one counselling. Doors or curtains should be shut ensuring auditory and visual privacy. Ensure that the support staff is trained in maintaining the privacy and confidentiality protocols.
2	Don't reveal the documents or identity of a client to anyone else unless it is for administrative purpose.	Do keep the identity and documents of the clients safely to maintain confidentiality.
3	Don't disclose SRH test results in front of an accompanying relative/ spouse/friend.	Do ensure client privacy during the time of disclosure of test results.
4	Don't ask the client why they need a sexual health service.	Do sexual health counselling with comfort, ease and calmness without blaming or questioning the client.
5	As much as possible, don't provide singular stand-alone services to youth.	Do ensure comprehensive and integrated SRH counselling for all clients, especially youth clients who are less likely to come back.
6	Don't begin the session by asking the client their marital status to know their sexual history. It can be uncomfortable for unmarried clients to reveal their sexual history.	Do let them know that to provide comprehensive services, you need to know their sexual history. Ask comfortably, if they are sexually active.
7	Don't assume the client's sexual orientation and that all the clients are in heterosexual relationship.	Do ask the client, what is the gender of their partner. This is especially important to make the service inclusive for LGBTQI community.
8	Don't deny sexual and reproductive health services to unmarried youth on social/ moral grounds.	Do ensure a sensitive and non-judgmental attitude towards premarital sex.
9	Don't provide incomplete or inaccurate information on contraception. Don't propagate any myths or misconceptions.	Do enable them to make an informed decision on contraception usage.
10	Don't delay the termination of pregnancy if the client wants to get an abortion.	Do give the option of safe abortion if the client discloses that they have had an unwanted or unintended pregnancy. Do provide quality abortion services.

S. No.	DON'Ts	Do's
11	Don't rush the session and prescribe medicine without listening to the client.	Do encourage the client to ask questions before closing the session.
12	Don't end it without ensuring that the client is satisfied.	Do take a verbal feedback from the client at the end of the session.
13	Don't impose social norms related to right age of marriage or having children upon the client.	Do acknowledge and support the client in their decision related to marriage or having children.
14	Don't display any signs of judgment/embarrassment on or with any SRH topic.	Do practice stigma-free, respectful and non-judgmental service provision. This can be communicated by addressing them by their name, not blaming them for anything and ensuring they get good quality services.
15	Don't assign male provider to female client or female provider to male client especially when the case concerns SRH issues.	Do assign providers of the same gender to male and female youth clients.
16	For transgender clients, don't blame him or let him feel that he is at fault.	For transgender clients, do acknowledge their chosen gender identity by telling them that he is not doing anything wrong or not at fault.

LUNCH BREAK (60 MINUTES)

Session 5: Making Services Youth Friendly

Objective: Identify the existing gaps and challenges in making services youth friendly

Time: 60 minutes

Methodology: Group work, discussion and filling the checklist for self-assessment of the facility

Resources Required: Chart papers and markers, checklist for assessing youth-friendliness of a health facility

Steps for the facilitator:

This session is divided into two activities.

Activity 1: Group work

Step 1: Participants will be divided in three smaller groups by counting from 1 to 3. Each group will be provided with a chart paper and marker. Give them the following questions to discuss:

Questions for discussion:

According to the participants, what are the gaps/challenges that exist at following levels in providing SRH services to young adults? Ask them to write their discussion points on a chart paper. They should be given 15 minutes of this activity.

- Group 1: Service provider level
- Group 2: Facility level
- Group 3: Outreach Program / community level

Step 2: Ask each group to save their group discussion. It will be used in the next activity.

Activity 2: Self Assessment of the facility on YFS indicators

Step 1: Ask participants to refer to the checklist in their handbook.

Step 2: Referring to points that emerged in the previous session, summarize the checklist, indicators for youth friendly services which can be used by Medical Officers to monitor their facility regularly for youth friendliness. Ask participants to fill in their respective checklist.

Step 3: Based on the group discussion and self-assessment checklist, invite participants to share the key indicators that they may find difficult to achieve. The facilitators can provide possible solutions to overcome those challenges and create a roadmap for them.

Reflection on Training

Objective: Assess the learnings and progress of all the participants and seek feedback from them on the training

Time: 60 minutes

Methodology: Individual exercise

Resources required: Post training questionnaire, 30 yellow cards, 30 blue cards and 30 pink cards

Steps for the facilitator:

- **Activity 1:** Participants will fill up Post training questionnaire (see Annexure 3)
- **Activity 2:** Participants will answer the following questions on three different cards

Step 1: Participants will be given 3 colored cards and on each card they will be asked to write as follows:

- **Yellow Card:** 3 Key learnings from this training
- **Blue Card:** 3 learnings which at their level they will implement for making their facility youth friendly
- **Pink Card:** 3 suggestions for the trainers to make this training better

Note for the facilitator: *put all the cards on 3 different walls as per the category. Conclude the training with vote of thanks to the participants*

Annexure 1

Youth Friendly Health Services

Training for Clinical Service Providers

Pre and Post-training Questionnaire

Date: _______________

Decide whether you agree (A) or disagree (D) with each of the following statements.

Write your response (A or D) to each statement in the space provided.

S. No.	Statement	Agree (A)/ Disagree (D)
1	All youth should be able to receive reproductive health services, regardless of their marital status.	
2	For a reproductive health program to be successful, staff must propagate the same values about sex and sexuality that the society expects youth to adhere to.	
3	Service providers should tell an unmarried youth who has been having sex that he or she should not be engaging in sexual activity before marriage.	
4	Youth's voices and needs must be considered when programs for youth are designed.	
5	Service providers should give contraceptives to an unmarried girl if she requests.	
6	Young people do not want to learn about reproductive health issues.	
7	Youth have many legitimate questions about sex that require honest and factual responses.	
8	Masturbation is a healthy expression of a young person's sexuality.	
9	Homosexuality is a disease.	
10	Service providers should not bother discussing condoms with young people because most of them do not have sex.	
11	Youth with sexually transmitted infections (STIs) deserve their illness because of their behavior.	
12	Sexuality education should be provided in education institutions.	
13	Boys do not need any information as they would learn eventually by themselves.	
14	Young girls who complain of pain during menstruation are usually overreacting.	
15	Besides abstinence, condom use is the only method that prevents both pregnancy and STIs.	
16	A woman with two children should be advised for female sterilization for family planning.	

S. No.	Statement	Agree (A)/ Disagree (D)
17	The highest reported cases of STIs are among young people (ages 15 to24).	
18	Premature ejaculation is a common concern of young men.	
19	Surgical abortion is better than medical abortion and should be preferred.	
20	Female sterilization is the best option of family planning for women	

Annexure 2

Checklist for assessing youth friendliness of a facility

S. No.	Indicators	Yes	Partially	No
1.	**Attitude and Code of Conduct of the Providers**			
1.1	Appropriate conduct showing respect and dignity			
1.2	Non-judgemental Attitude			
1.3	Does the provider listen to them without getting the conversation interrupted by mobile or entry of other staff?			
2.	**Environment**			
2.1	Does the facility display IEC material/posters with messages to destigmatize SRHR for the youth?			
2.2	Does the facility have publicly displayed information with the message- 'this is a youth friendly facility'?			
3.	**Timings**			
3.1	Does the facility ensure that the provider is available outside school and college hours for youth?			
3.2	Does the receptionist ensure that the waiting time for youth is not more than 15 to 20 minutes?			
4.	**Privacy**			
4.1	Are the doors of doors of the OPD/consultation room shut during consultation?			
4.2	Are more than one clients present in consultation room simultaneously?			
4.3	Is there waiting space for other clients especially for the youth?			
5.	**Confidentiality**			
5.1	Does the facility ensure the confidentiality regarding both the consultation(s) and medical records?			
5.2	Is all staff (including support staff) aware that matters of one client should not be discussed with anyone else (e.g. other clients, any neighbours, villagers, family members) except facility staff directly involved in the care of client?			

S. No.	Indicators	Yes	Partially	No
6.	**Minimum Package of Services** [Note: The minimum package may vary depending on the type of facility and the services offered at that level of facility as mandated by the MOHFW.]			
A	**Are the following services offered to the youth on-site:**			
6.1	Information and counseling on safe sex and reproductive health?			
B	**Does the facility provide the following services?**			
6.2	At least 5 reversible contraceptive methods			
6.3	STI diagnosis and management?			
6.4	HIV risk screening, counseling and testing (and referral for care)?			
6.5	Pregnancy testing, ante-natal, delivery and post-natal care,			
6.6	Safe abortion services, post-abortion care (PAC), counseling and contraception?			
6.7	Counseling on sexual violence and abuse (and referral for needed services)?			
C	**Does the facility provide outreach programmes for the youth in community?**			
	Range of FP Methods Offered			
6.8	Are the following FP methods offered- condoms OCPs injectibles emergency contraception			
6.9	Does the service provider explain each method with its advantages, disadvantages and side effects?			
6.10	Does the facility have regular supply of condoms, OCPs, injectable contraceptive and emergency contraception?			
6.11	Do the providers offer contraceptives to newly married women and men coming alone, without family members?			
6.12	Do the providers offer contraceptives to unmarried women and men coming alone, without family members?			
7.	**Safe Abortion Services**			
7.1	Is the facility comprehensive abortion care centre?			
7.2	Is it displayed outside the facility and in the waiting area that the facility provides safe abortion services?			

S. No.	Indicators	Yes	Partially	No
7.3	Do the providers provide abortion services to a newly married woman without insisting on consent/ signatures of a family member?			
7.4	Do the providers provide abortion services without insisting on consent by a family member to unmarried women (above 18 years)?			
7.5	Are women seeking abortion offered a choice between medical and surgical methods?			
7.6	Do providers give abortion services without insisting on specific contraceptives?			
8.	**Youth Involvement and feedback**			
8.1	Are there mechanisms set to involve the youth in planning and programmes?			
8.2	Do young adults have representation in Rogi Kalyan Smiti?			
8.3	Is there a mechanism for the youth to provide confidential feedback?			
8.4	Does the provider summarise the discussion and take verbal feedback from the client before ending the session?			
8.5	Is there a feedback box placed where the youth can conveniently drop her/his feedback without any hesitation?			

Annexure 3

Clarifying Myths And Misconceptions

MYTH	CLARIFICATION
1. Giving unmarried and/ or minor youth information regarding sexual intercourse and contraception will encourage sexual activity and risk taking behaviour among youth.	On an average, adolescent development begins right from the age of 10, young people begin to enter into puberty and experience physical, mental and emotional transformation. Between the ages of 10 and 15, adolescents experience menarche or their first nightfall, and around the same time it is commonplace for them to begin to experience pressure of getting married. At this critical juncture, their lack of knowledge when combined with their diminished personal autonomy renders them vulnerable to sexual exploitation and adverse SRH outcomes. To deny them relevant information on SRH is to deny their diverse needs and realities. **Thus, it is imperative for adolescents and youth to have access to evidence based and medically accurate information around their bodies and sexuality, so that they are equipped to take informed decisions that safeguard their health and wellbeing.**[7]
2. Regular use of emergency contraception is harmful to health.	Emergency contraceptive pills are not dangerous to a woman's health and have no known serious medical complications. There is no evidence that if a woman uses ECPs multiple times, it causes any health risks. They can cause minor side effects, such as menstrual irregularities and nausea, which typically last only a short time. This is because the dose of hormone is very small, and there is only one dose involved. These effects are not medically harmful. Women should feel free to use the emergency contraceptive pill whenever they think it's necessary[8]. Each woman should decide for herself whether they are acceptable for her[9].

[7] https://www.euro.who.int/__data/assets/pdf_file/0008/379043/Sexuality_education_Policy_brief_No_1.pdf
[8] https://www.cecinfo.org/icec-publications/repeated-use-emergency-contraceptive-pills-facts/
[9] https://www.cecinfo.org/wp-content/uploads/2015/01/Repeat-Use-Fact-Sheet-for-distribution-Nov-2.pdf

MYTH	CLARIFICATION

3. Giving women ECPs in advance (before they need them) will discourage them to use regular contraceptive use.	No, giving ECPs in advance does not discourage regular contraceptive use, and it is essential so that women can start ECP as early as possible, but definitely within 72 hours of unprotected intercourse. Studies of women given ECPs in advance report these findings[10]:
	• Women who had ECPs on hand took them sooner after having unprotected sex than women who had to seek out ECPs. Progestin-only ECPs are more likely to be effective when taken sooner.
	• Women given ECPs ahead of time were more likely to use them when needed than women who had to go to a provider to get ECPs.
	• Women continued to use other contraceptive methods as they did before obtaining ECPs in advance.
	• Women did not have unprotected sex more often.
	Additionally, ECPs help a woman avoid pregnancy after:
	• Any unprotected sex, including sexual coercion and rape and
	• Mistakes or failures in using contraception, such as:
	  ◦ Condom was used incorrectly, slipped, or broke,
	  ◦ Centchroman missed by > 7 days
	  ◦ Woman has missed her MPA injection by more than 4 weeks after scheduled date and has unprotected sex
	  ◦ Fertility awareness method not used correctly (failed to abstain or use another method during fertile days),
	  ◦ Man failed to withdraw before ejaculation,
	  ◦ Woman had unprotected sex after missing 3 or more combined oral contraceptive pills or after starting a new pill pack 3 or more days late,
	  ◦ IUD has come out

4. If a woman wants to buy ECPs, she needs a prescription from the doctor.	Taking ECPs is simple, and medical supervision is not needed. The label and instructions are easy to understand. In India, ECPs are approved for over-the-counter sales by chemists without a prescription.

[10] *https://www.fphandbook.org/questions-and-answers-about-emergency-contraceptive-pills*

MYTH	CLARIFICATION
5. The ECP is not recommended as a regular form of contraception because it's not as effective at preventing pregnancy as regular contraceptives.	• On average, LNG ECPs reduce pregnancy by 59 to 95% for each individual act of intercourse; UPA ECPs reduce pregnancy by 85% and have been found to be comparatively more effective than LNG. The precise efficacy of ECPs depends mostly on the woman's cycle day when ECPs are taken and how soon they are taken after unprotected sex. There is no evidence to suggest that ECPs become less effective when used repeatedly. Repeat use of ECPs is classified as Level 1 in the World Health Organization's Medical Eligibility Criteria.[11] • Moreover, although ECP can be used more than once in the same cycle, women who need continuous protection should be advised to use a regular contraceptive method since ECPs are not as effective as regular contraceptive methods.

6. Easy availability of emergency contraception will encourage irresponsible sexual activity.	• Emergency contraception plays an undeniably important role in the following scenarios:
	  • When one is unable to negotiate safe and protected sex
	  • In case of contraceptive failure.
	  • When one has limited or no access to other contraceptive options.
	Remember, it can be upto 95% effective if used within 24 hours, while its effectiveness declines with time. Therefore, if it is easily available, wide availability and access is essential to advance one's control over their own fertility outcomes. Comprehensive counselling on how emergency contraception does not prevent sexually transmitted infections (STIs) can deter unsafe sexual intercourse.
	Irresponsible behaviour bears no connection to the availability of a commodity, instead could be a result of lack of accurate information and inappropriate shaping of gender related attitudes.

7. ECPs are not appropriate for adolescents.	• ECPS are safe for adolescents. A study of ECP use among girls 13 to 16 years old found it safe, and all of the study participants were able to use ECPs correctly. Also, access to ECPs does not influence sexual behavior[12,13].

[11]*World Health Organization. Medical Eligibility Criteria for contraceptive use Fifth edition 2015 http://apps.who.int/iris/bitstream/10665/172915/1/WHO_R HR_15.07_eng.pdf*

[12]*Gold MA.Emergency contraception.a second chanse at preventing adolescent unintended pregnancy.Curr.Opin.Pediatr.1997 Aug;9(4):300-309.*

[13]*https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1783598/#:~:text=Several%20emergency%20contraceptives%20exist%2C%20including,avoided%20for%20a%20few%20days.*

MYTH	CLARIFICATION
8. Spousal consent is essential in matters of contraceptive use by women.	• **Spousal/partner consent delays and deters a client's access to contraception.** Most importantly, conditional access to contraception is in direct violation of the medical principle of client autonomy that guarantees clients the right to choose whether, when and which (contraceptive method) to uptake. • In many parts of India, a prevalent misconception is that contraception encourages adultery, owing to which males often restrict their female partners or wives from accessing contraception. Similarly, sometimes men avoid using condoms, as they are under the misconception that condoms will diminish their masculinity[14]. Under such circumstances, if providers insist that woman brings her husband/ partner for consent to use contraception, it **will only serve as an additional barrier for a woman's access to their SRHR.**
9. Getting an abortion results in infertility.	• If abortion is done using safe technique (medical abortion or manual vacuum aspiration), and by a skilled provider, it cannot lead to infertility. • Induced abortions by using medical abortion (MA) drugs (Tab mifepristone and misoprostol) doesn't affect future fertility.[15,16] • Usually a safe surgical method of abortion (such as vacuum aspiration) will not affect future fertility of the woman. However, if proper infection prevetion procedures are not observed, there is a very small risk of infertility[17] if a woman develops a uterine infection and it is not treated promptly which can spread and lead to pelvic inflammatory disease (PID). • Infact, getting unsafe abortions may lead to developing an infection and the infection may cause tubal infertility. • When surgical abortion is done using D&C technique, very rarely, there can be a risk of uterine scarring due to deep curettage (known as Asherman syndrome), resulting into infertility. However, please note that D&C is not a recommended technique of abortion.

[14] *Char, A., Saavala, M. & Kulmala, T. Assessing young unmarried men's access to reproductive health information and services in rural India. BMC Public Health 11, 476 (2011). https://doi.org/10.1186/1471-2458-11-476*
[15] *https://www.plannedparenthood.org/learn/abortion/the-abortion-pill/how-safe-is-the-abortion-pill*
[16] *https://www.healthline.com/health/womens-health/can-abortion-cause-infertility*
[17] *https://www.nhs.uk/common-health-questions/womens-health/can-having-an-abortion-affect-my-fertility/*

<table>
<tr><th>MYTH</th><th>CLARIFICATION</th></tr>
<tr><td>10. Aborting is morally incorrect.</td><td>

The need for abortion can arise at any point in a woman's reproductive lifespan. It is in difficult circumstances that women decide to abort pregnancy. Reasons for abortion can be the following:

Unmet need of contraception resulting in unintended and unwanted pregnancy,
Sexual violence or coercion from partner,
Failure of contraception resulting in unintended and unwanted pregnancy
Lack of autonomy for women to use a contraceptive of their choice
Change in circumstances of a pregnant woman's life, for example divorce or death of the husband/ partner,
Detected foetal anomaly

Trained service providers should be sensitive to these issues and shuld not deny providing comprehensive abortion care to women as per MTP Act, since continuation of pregnancy or denial of services can result to adverse health outcomes.
</td></tr>
<tr><td>11. Medical abortion method (using the mifepristone and misoprostol pills) is a dangerous method and will result in incomplete abortion.</td><td>

Medical abortion method has been approved by WHO as a safe, effective and acceptable method of abortion[18]. The Indian government has approved this method in its national guidelines indicating mifepristone and misoprostol may be provided upto the 63rd day of gestation period.[19] It is a non-invasive method of abortion and women can use the pills as per instructions by themselves.

The risk of serious complicaitons after medical aboriton is extremely low, are very rare - the chances of incomplete abortion needing treatment is only 2-3%[20].</td></tr>
</table>

[18] *file:///C:/Users/ki/Downloads/9789241550406-eng%20(1).pdf*
[19] *Ministry of Health and Family Welfare. Comprehensive Abortion Care: Training and Service Delivery Guidelines. New Delhi, India: MOHFW; 2010.*
[20] *https://www.ipas.org/resource/clinical-updates-in-reproductive-health/*

MYTH	CLARIFICATION
12. Being transgender is a mental disorder	• Transgenders do not have a mental disorder. Because the mainstream society only recognises two genders, men and women, transgender persons are stigmatised in society. • When a child is born, a doctor typically assigns the sex 'female' or 'male' on the basis of genitals. However, gender-specific stereotypes related to one's behaviour traits, roles, responsibilities, clothing and accessories are not inherited, but taught to us by society. Growing up, some people may choose to follow these norms/stereotypes, while others may challenge the same. People around us challenge and break gender norms and stereotypes all the time and gender norms and stereotypes keep changing too. • **A transgender person is someone who rejects their gender assigned at birth, and makes a conscious decision to identify with an alternate gender of their choice. Transgender is an umbrella term for people who do not identify with the gender assigned to them at birth.** According to the Census of India, 2011 there is a population of 4.9 lakh transgender persons in the country. This was the first Census which included an official counting of transgender people in the country. This counting only included transgender women (assigned gender male at birth) and not, transgender men (assigned gender female at birth). • The Constitution of India guarantees citizens the right to make such decisions around their own bodies (personal autonomy) and expression, and the NALSA Judgment[21] protects transpersons from discrimination and violence. • Congruently, in 2020, WHO also removed gender nonconformity from the category of "disorder". • **It is important to ensure that the transgender community is not excluded from their access to quality healthcare, education and livelihood opportunities. Discrimination and violence pushes them to margins. It is important to build a society that upholds their right to equality.**
13. If any adolescent girl has irregular periods it is a sign of pregnancy	Irregular periods occur due to hormonal changes in the body. It cannot simply be assumed that a late or irregular period is due to pregnancy. Irregular periods are common during adolescence.

[21] *https://translaw.clpr.org.in/wp-content/uploads/2018/09/Nalsa.pdf*

MYTH	CLARIFICATION
14. The right age for women to have children and complete the family is before thirty.	• Some providers believe that women should have children before 30 since their fertility may decline after that age, and to avoid complications. • Biologically the fact is that each woman's body and fertility is unique and different from another individual's. Women are able to have children from post-menarche through their menopause. As long as women are ovulating, they can conceive and have a child unless they have been diagnosed with a condition. • It is important to remember that there is no fixed or right age to have a child. It depends on when the couple is ready to plan and become parents. Economic factors, professional careers, individual preference are some of the factors that are important for family planning. • Moreover, a woman's fertility is not the only factor responsible for pregnancy. Sperm count of the male partner is also a factor. • Not all women desire to become mothers in their twenties. Providers should help individuals and couples to have children when they are ready for it, and should provide contraceptives to manage their fertility. • If a woman does not want to have biological children, her right should be respected by the service providers. Except biological reproduction, adoption and assisted reproductive technology are also methods of having children.
15. If a young woman wears revealing clothes or is friendly with boys, she is inviting abuse/ violence against herself	Several studies have shown that women who wear conservative clothing like salwar-kameez or sarees also experience violence. Clothes are not the reason for sexual violence. It is the patriarchal society and thinking that gives some men the thought that they have the license to abuse women. Therefore, this idea that women invite violence through their clothes needs to be challenged. It is important to stress the need for consent in any sexual relationship rather than blame women.

MYTH	CLARIFICATION
16. Masturbation leads to blindness or impotency	• No, masturbation does not lead to blindness or impotency. Neither does it lead to a loss of sperms because they are being regularly produced by the body. • Masturbation is a natural and completely safe and secure method of obtaining sexual pleasure through stimulation of one's own sexual organs. It is nothing to be ashamed about. All of us have sexual needs and this is a common way of fulfilling them. Only if it starts interfering with our day-to-day functioning in any way then a counsellor or medical practitioner may be referred to.
17. A menstruating woman should not cook food or even enter kitchen. As dping so would spoil food items in the kitchen and anyone consuming them will fall sick.	Entering the kitchen during menstruation wil not harm anybody. As long as general hygiene measures are followed, menstruating women can prepare and handle food just like any other day

Annexure 3

Youth Friendly Sexual and Reproductive Health Services

Youth Friendly

Sexual and Reproductive Health Services

Who are youth / young people?

Adolescents:
10-19 years

Youth:
20-24 years

Numbers of 15-24 years:

251 million

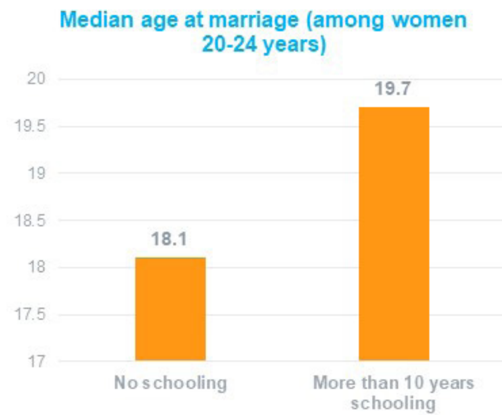
2

Large proportion of young people in 15-24 years age group are married

Marriage among **females between 18-20 years** (SRS Statistical report, 2020):

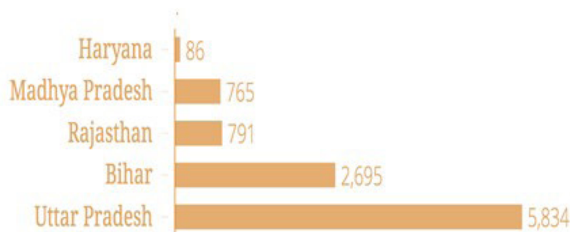
- Rural: 37.4 %
- Urban: 23.2 %

65% women aged 20-24 years are married (NFHS-4)



3

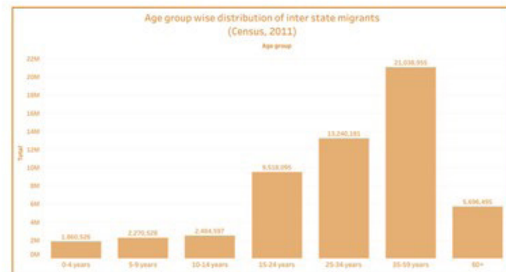
Large proportion of young people migrate to other states



As couples/ as single men

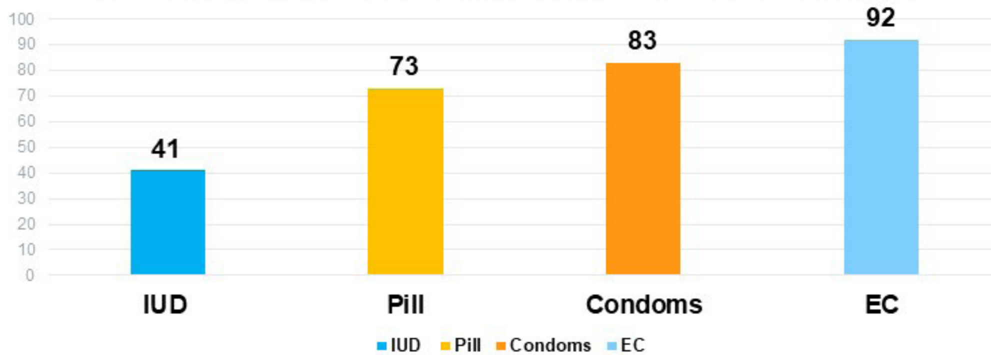
Additional issues related to:

- Needs related to contraception, abortion,
- Risk of STI/ HIV
- Living conditions
- Quality of health care received



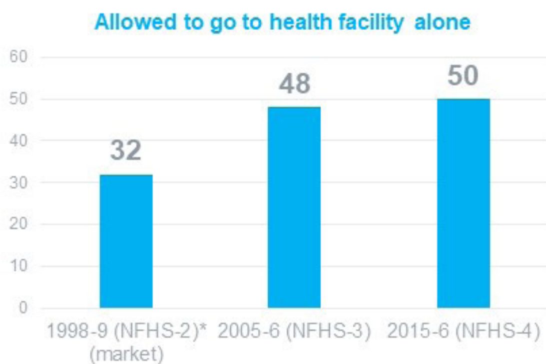
4

Where do people go to seek reversible contraceptives services?



Why is it difficult for young people to access services?

Low autonomy



Provider attitudes:

- Judgmental attitudes
- Unnecessary requirements for consent from spouse, parents etc.
- Not providing sufficient choices

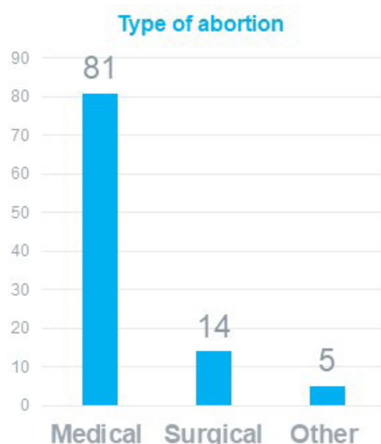
Health facility characteristics:

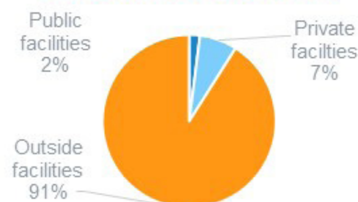
- lack of privacy
- confidentiality

Unintended pregnancy situation in India

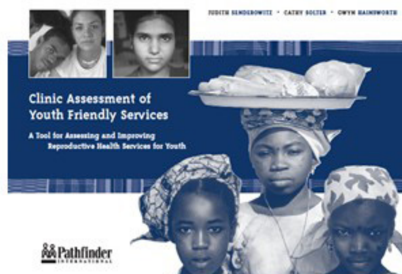
(Singh S et al. The Lancet. 2015-16)

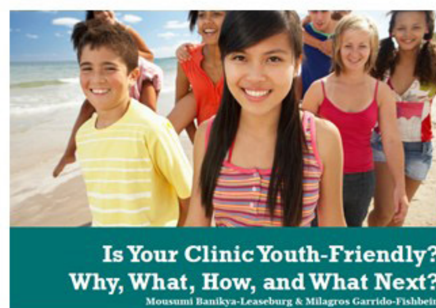
- Nearly **24 million unintended pregnancies** in India (half of all pregnancies)
- **Estimated number of abortions: 15.6 millions**
- 1/3 of all pregnancies end in abortions
- Public sector - 5% of all abortions





Characteristics of Youth Friendly Services





Youth friendly services =

all providers working in all settings (doctors, nurses, ASHAs, counsellors, others) are youth friendly

What are youth friendly services? -1

1. **Privacy**
   - Visual privacy: doors of consultation room shut, other clients & unnecessary staff not present
   - Auditory privacy
2. Staff treat clients with **respect** and listening attentively
3. Staff provide **confidentiality for** clients
   - Matters of one client not be discussed with anyone else:
     - e.g. other clients, any neighbours, villagers, family members or
     - other staff not directly involved in the care of client

What are youth friendly services? -2

4. A **wide range of reproductive services** are provided
   - Information and counseling on sexuality, Safe sex and reproductive health
   - Wide range of reversible contraceptive methods (e.g. condoms, oral pills, centchroman, ECPs, etc.)
   - STI diagnosis and management
   - HIV risk screening, counseling and testing (and referral)
   - Pregnancy testing
   - Maternal care
   - Safe abortion services, post-abortion care (PAC) and counseling
   - Counseling on sexual violence and abuse (and referral for needed services)

What are youth friendly services? -3

5. **Informed choices** are offered:
   - staff don't impose their own prescriptions on clients
   - Provides information about *all methods* to all clients-
     - Staff does not provide incomplete information to illiterate/ rural clients/ certain castes / religions
   - Postpartum counseling includes "all methods", e.g. LAM, Centchroman, DMPA (after 6 weeks), condoms, IUCD
   - Takes proper consent - no FP method without consent
   - Their counseling is not affected by "Targets/ ELAs"

What are youth friendly services? -4

6. Staff have **non-judgmental attitude**
   - Behaviour depends on marital status
   - Not asking how the unwanted pregnancy occurred
   - Not having negative attitudes towards:
     - unmarried having sexual relations
     - persons suffering gender based/ sexual violence
7. Staff **honor autonomy** of clients, e.g.
   - will not ask for family member if a woman seeks FP services
   - does not ask for parental consent for a girl above 18 years who comes for abortion

What are youth friendly services? -5

8. Providers have **accurate technical information** that enables to provide proper counseling, e.g.
   - About all contraceptives incl. injectables & ECs
   - About methods of abortion, incl. medical abortion
   - About "correct" age to have children
   - About masturbation, night fall
   - Do not scare the clients giving medical facts to impose

What are youth friendly services? -6

9. Do **not impose unnecessary barriers**, such as:
    - Number of packets of OCPs given
    - Place where condom boxes are kept
    - Asking unnecessary details from client
    - provides abortion services to a 16 year girl coming for abortion who brings a non-family guardian
    - Does not impose pre-condition of sterilization/ IUCD to provide abortion services

10. Proper **information**:
    - Use samples of contraceptives
    - Use IEC materials / charts / posters during counseling

Thank You

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Notes

Notes

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