FRONTLINE AIDS

READY
RESILIENT & EMPOWERED
ADOLESCENTS & YOUNG PEOPLE

# READY to LEARN

**A guide to facilitating workshops on delivering HIV and sexual and reproductive health and rights services for young people in all their diversity**

READY WORKSHOP GUIDE

# Acknowledgments

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## About READY

READY is a movement of youth-led and youth-serving organisations, which aims to build resilient and empowered adolescents and young people. We know this is vital because HIV is the leading cause of death among young people (aged 10-24) in Africa and the second globally.

Young people all over the world can join the READY movement to demand their right to a healthy life whatever their circumstances, sexual orientation, gender identity or expression. Young people helped create the READY movement in order to expand our READY portfolio. Today, they remain at its core.

### READY Movement

www.yplusnetwork.org/ready-movement/

fb.me/READYMovement

@READY_Movement

@readymovement

## About Frontline AIDS

Frontline AIDS wants a future free from AIDS for everyone, everywhere. Around the world, millions of people are denied HIV prevention, testing, treatment and care simply because of who they are and where they live.

Together with partners on the frontline, we work to break down the social, political and legal barriers that marginalised people face, and innovate to create a future free from AIDS.

# CONTENTS

# BACKGROUND

Frontline AIDS is committed to increasing the coverage, scope and quality of HIV and sexual and reproductive health and rights (SHRH) programmes for those who need it most, including adolescents and young people, particularly those most vulnerable to and affected by HIV. This includes work to educate and create greater awareness among people of their health needs, their rights and the duties of the public sector to provide for them. Frontline AIDS has a number of resources to support the delivery of this specific objective, including the original version of this workshop guide, published in 2015.

The original version of this guide was produced under the Link Up project, which aimed to make a significant contribution to the integration of vital SRHR and HIV interventions for young people living with and at higher risk of HIV within programme countries. The original workshop was delivered to Link Up staff in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda.

This version has been revised under READY, a portfolio of projects that specifically aims to advance the SRHR of adolescents and young people. Revising the guide in this modular format will enable it to be delivered in smaller, thematic sessions or in its entirety. This is intended to widen its potential use with frontline implementing partners and healthcare providers, supporting them to provide appropriate service delivery to adolescents and young people in their diversity, parents and caregivers.

## Note on language

As indicated by the subtitle of this guide, our aim is to support the health and rights of 'young people in all their diversity.' This phrase is used by Frontline AIDS to emphasise the importance of being fully inclusive. Young people in all their diversity include (though are not limited to) young people living with HIV, young LGBTIQ+ people, young people with disabilities and young key populations. Key populations are groups disproportionately affected by HIV, such as young men who have sex with men, young transgender people, young sex workers, young people who use drugs and young people in prison.

For ease of reference, we use the term 'young people' as a shorthand throughout the guide, but it should always be understood to include all of the above groups. Where appropriate, we refer specifically to young key populations.

Although the main focus of the guide is on young people rather than adolescents, we hope that those who work with adolescents will also find much of value in this resource.

# INTRODUCTION TO THE GUIDE

This facilitator's guide describes how to plan, deliver and evaluate the training effectively. The guide is designed in a modular format so that it can be adapted for shorter or longer trainings as needed.

Each module covers a different area relating to SRHR and HIV, with the order and flow of sessions within each module designed to relate back to each other.

## Learning objectives

**1** Enhance understanding of the critical concepts of rights, integrating SRHR and HIV, gender, power, sexuality, stigma and discrimination

**2** Enhance understanding among partners and service providers of the entry points for providing integrated services for young people in all their diversity and encouraging uptake

**3** Enable self-reflection on working effectively with young people, particularly on 'sensitive' topics such as sexuality, gender identity, sexual health, mental health and well-being

## Pathways

Your choice of modules will depend on many things, such as your local context, your participants' needs and priorities, their existing level of knowledge and experience, and the time you have available. We invite you to map out the most appropriate pathway for your own circumstances, **but in all cases to start with Module A, the Core Module for all users**. We also strongly recommend that you use each chosen module in its entirety, rather than 'cherry-picking' individual activities, in order to cover each topic in a well-rounded way. On the next page are a few examples to guide you.

## Example 1

An HIV-focused organisation wanting to add a youth mental health component to the work of its staff and volunteers



MODULE A
Core Module

MODULE B
Young people

MODULE F
Looking after our safety

MODULE G
Mental health and wellbeing
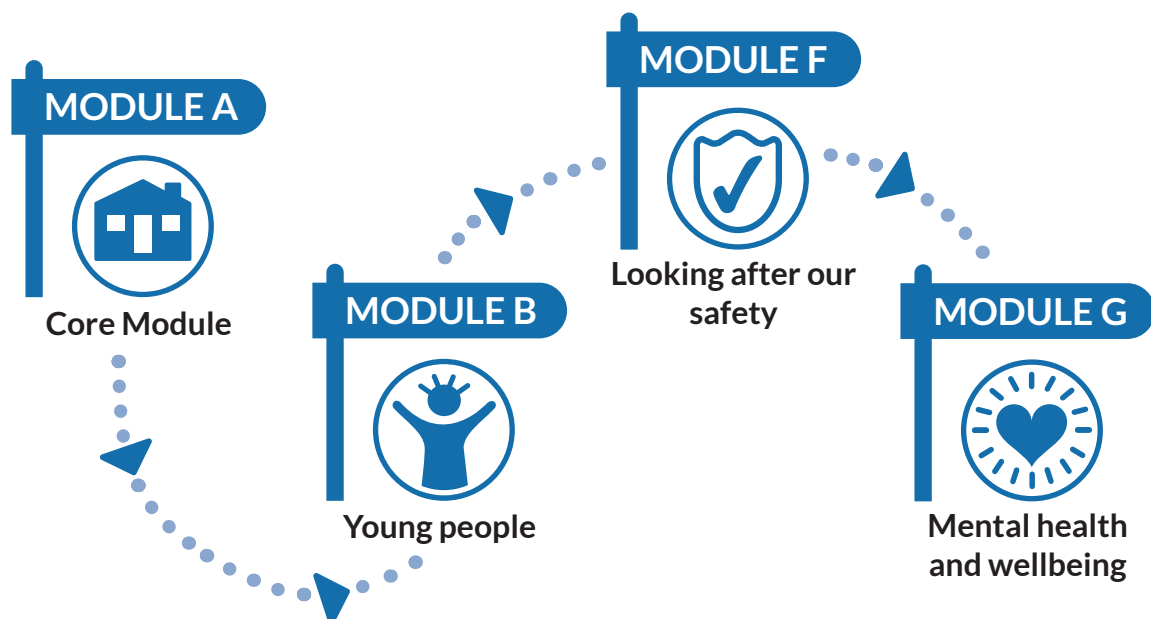
## Example 2

Traditional sexual and reproductive health (SRH) service providers who want to attract and serve a more diverse range of clients



MODULE A
Core Module

MODULE C
Gender, sexuality and social norms

MODULE D
SRHR and HIV

MODULE B
Young people
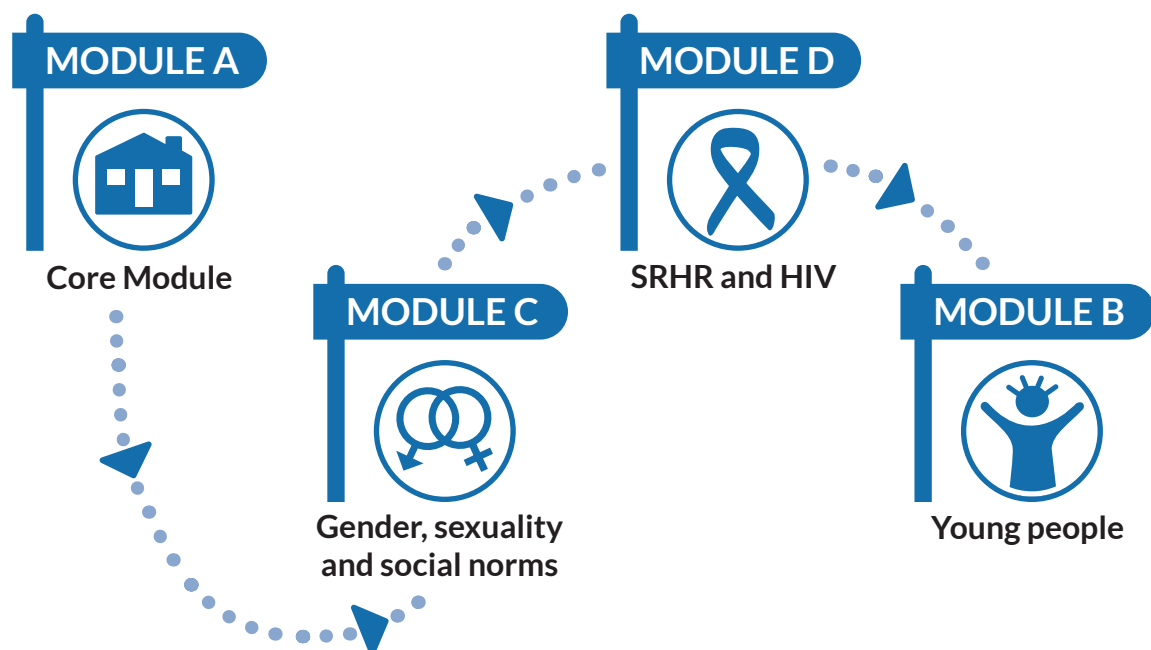
Sessions include suggestions, tips and reminders for facilitators, and list the time and materials needed. References to useful resources are also provided. These can be sourced in advance and either distributed to participants or a reference copy shared during the workshop. You may have relevant country-specific documents and materials that can also be used.

The annex section contains materials referred to throughout the guide. These can be photocopied and used as handouts to support the learning.

# Planning the training

We suggest that you read through the entire guide in preparation for the training. If there is to be more than one facilitator, you will need to meet to decide which sessions each of you will lead. Consider the following tips:

- **Facilitators should be competent and experienced in leading workshops and feel comfortable with the content.** Reading through the supporting documents in advance and exploring the links contained in each session can help ensure this. Facilitators may feel more comfortable with certain sessions than others. Play to each other's strengths and base your decision on who shall lead individual sessions on these.

- **Check your own attitudes** towards the training content and be aware of how they may influence your tone and delivery. If your feelings about a particular topic would prevent you from being able to facilitate in an accurate and non-judgemental way consider whether you are the right person to run that session.

- **Consider having a young person as a co-facilitator, for example a representative from a young key population group,** especially if they are confident about the content. This will bring a strong community perspective to the training and contribute to building participants' skills and experience. Working as a team of co-facilitators also really helps when it comes to taking care of all the logistics involved, such as reading the atmosphere in the room, facilitating energisers and taking notes.

- **The content of each session can be adjusted** to suit the level of participants' knowledge and experience in each setting. During your planning process, different facilitators may be able to suggest how to adapt sessions while keeping the content and learning points intact.

- **Choose a venue that is safe and appropriate for the group.** Consider its location and any connections, for example, whether it is linked to an authority, such as the police or military, or aligned to a religious group or political party. These might affect how much  participants can relax and share with one another. The space should be one where participants can take part comfortably and feel safe to share their views and experiences without being overheard by non-participants.

# In the planning process, check what you need to provide

For example, you may need to provide a room and/or breaks for breastfeeding and for prayer, or you may need a wheelchair ramp. If possible, hold the training away from participants' usual workplace to avoid distractions and interruptions. Ideally, seat participants in a u-shape or semi-circle (with or without tables). This helps everyone to feel included and participate on an equal footing and gives facilitators a better view of everybody in the room.

- **Share the agenda** and set some trigger warnings for sensitive issues.

- **Name tags** make it easier for you and the participants to get to know one another. Ask people to write down the name and pronoun by which they prefer to be called.

- **Schedule enough time for lunches and breaks.** They are also important learning and bonding spaces. Proper closure is important, especially after difficult or sensitive topics. You can introduce a short relaxation technique (such as a stretching or deep-breathing exercise) during or at the end of a session as needed, and use a closing circle to relieve any distress that has arisen before people depart.

- **Consider using a translator for all or part of the training** to help young people in all their diversity communicate freely and comfortably in their first language. The translator could be someone from the group or be brought in from the outside, depending on what helps participants feel most at ease. Make sure the translator understands and maintains respect and confidentiality.

- **Make sure that you have everything you will need before the training starts,** including equipment, handouts and supporting documents.

- **Participants should be selected appropriately and receive advance information** on what to expect. It is important to ensure that young people are among the participants. They should be supported before, during, and after the training, and their meaningful involvement ensured.

- **One of the activities is a panel discussion with young key populations.** In advance of this, participants should be told what the session involves and that their input will be treated in confidence and with respect. This principle should also be conveyed to the whole group and ensured by the facilitator during the session. A film on stigma and discrimination from your country could be shown, if available.

- **Agree the best schedule and timings for your audience and setting** and communicate these with participants in advance.

# Training principles

- Ground each session in participants' own context by getting them to reflect on and share their experiences. Use the resources in the room.

- Adopt a sex-positive approach, which accepts that sex and sexuality are part of life for all human beings and that open expressions of sexuality, free from taboo, shame and judgement, are important for every person's well-being.

- Establish a safe space and encourage open and honest dialogue. No question is a silly one! Agree with the group that any statements and experiences shared within the confines of the training should remain there. Make sure that confidentiality and privacy is understood and maintained throughout the training.

- Young co-facilitators, and/or young guest speakers in specific sessions, should represent the groups your participants are likely to be working with and should be relevant to the topic being discussed.

- Be prepared for participants to find the training emotionally draining or upsetting at times. Sometimes the content and the level of sharing can be overwhelming. Appoint someone with the skills, experience or personality suited to supporting any individuals who may need to take time out or talk privately. This applies to facilitators too! Be aware of your own emotional reactions and those of your co-facilitators and be prepared to support each other as needed.

- Remember, your well-being during a workshop is as important as that of the participants, so bear the following in mind:

  - The breaks are not only for participants, they are also for you!

  - Plan rigorously, but act flexibly. This will allow you some freedom to deal with unexpected outcomes from the group.

  - Anticipate the fact that individuals may want to approach you to discuss or disclose personal matters related to the topics you have been discussing in the group. Schedule some designated time for this but not every day, so that you also have a chance to rest and recover.

- Encourage participants to lead icebreakers and energisers; they often have fun ideas and it makes everyone feel more involved.

- Encourage critical and in-depth reflection to help participants identify aspects of their own practice and behaviour that may be stigmatising.

- Ensure that everyone takes responsibility for their own learning during the workshop, reading ahead of the sessions if necessary or reflecting on content and discussions at the end of the day.

- Remain practical and responsive to the specific needs of participants. You may need to build flexibility into the agenda to respond to the learning needs and dynamics of the group as they evolve during the training.

- Finally, have fun!

# Making our sessions inclusive for people with disabilities

We have already emphasised that evidence-based and accurate HIV and SRHR information and services should be accessible for young people in all their diversity. While this is an important general principle, there are some special considerations to bear in mind in relation to young people with disabilities. In addition, we and the implementing-partner staff or service providers we are training may ourselves be living with disabilities. Below are some strategies for making activities more inclusive. These recommendations do not aim to be in-depth guidelines; if you are interested in learning more about this topic, there are some useful resources on the next page.

## What language should I use?

Generally, use 'person-first' language, which focuses on the individual rather than the disability (for example, 'young people with learning disabilities also have sexual and reproductive rights'). However, some people prefer an 'identity first' language and might identify themselves as a disabled person. Ask people about their language preferences and use the terms they prefer.

## What about disclosure of disabilities?

Some disabilities are visible, such as certain physical impairments, while others might not be, such as hearing impairment and intellectual or psychosocial disabilities. It's important to maintain the confidentiality of all members of the group, whether they are living with a disability or not. Let all participants introduce themselves in the way they feel most comfortable with. Ensure everyone knows they do not have to reveal anything about themselves unless and until they are ready to share it.

## What can I adapt when I'm facilitating a session?

There are several aspects you can think about when planning and running activities:

- Consider the accessibility of the venue to ensure there's enough room for everyone and that people using a wheelchair or other mobility supports can reach the place easily and comfortably.

- Pay special attention to the ground rules to make your sessions a safe space that recognises and embraces the diversity of all participants.

- Invite group members to tell you if there is anything you can do to enable them to participate fully. Do this before, during, or after the session, depending on people's preference.

- If your activity has a strong physical component, be sure to offer alternatives for people using mobility supports or consider substituting it with a different activity that suits all members.

- Use clear language when giving instructions and introducing new concepts. You can ask the group, 'Am I explaining myself well?' Repeat information in different ways, using diverse levels of language if necessary.

- You can add visual aids and props to make your message clearer.

- Check the group's energy and focus-levels regularly. Avoid lengthy sessions and add breaks if necessary.

## Useful resources

1. **Americans with Disabilities Act (ADA) National Network, Guidelines for Writing About People With Disabilities** www.adata.org/factsheet/ADANN-writing

2. **Advocates for Youth, Sexual Health Education for Young People with Disabilities – Research and Resources for Educators** www.advocatesforyouth.org/resources/fact-sheets/sexual-health-education-for-young-people-with-disabilities

3. **International Planned Parenthood Federation (2017), Training manual for sensitizing intermediaries on sexual rights of young people with learning disabilities** www.ippfen.org/sites/ippfen/files/2017-12/KMS%20training%20manual%20for%20intermediaries.pdf
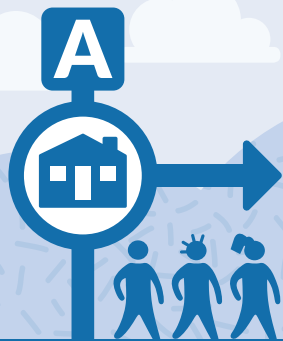
# CORE MODULE FOR ALL USERS

## SESSIONS IN THIS MODULE

| SESSION TITLE | TIME | PAGE |
|---|---|---|
| A1 Training introduction | 90 minutes | 15 |
| A2 Expectations and participation | 45 minutes | 16 |
| A3 Reflection and debrief | 15 minutes | 18 |
| A4 Recap | 20 minutes | 19 |
| A5 Testimonials and personal commitment | 60 minutes | 20 |
| A6 Evaluation, reflection, appreciation and close | 40 minutes | 22 |

# A1

# TRAINING INTRODUCTION

## Time
90 minutes

## What
This session welcomes participants and introduces your work on SRHR and HIV integration with young people in all their diversity.

## Why
Giving participants an opportunity to introduce themselves allows everyone to get used to each other and the training environment, and switch off from their everyday lives.

## Preparation
- Laptop and projector for presentation, or flip chart

## Activities

### 1 Welcome

🕐 10 minutes

- Participants are welcomed by an appropriate representative of the host organisation or facility, or a young person.

### 2 Icebreaker: Getting to know you

🕐 20 minutes

- Ask participants to introduce themselves by saying their name, the name of their organisation or health facility, and the work they do there.
- Ask them to describe what they would do if they were able to have one superpower or if they ruled the world (this can be fun or serious). For example: 'My name is Imran and I provide SRH services to young people. If I ruled the world, I would remove stigma experienced by people living with HIV.'

### 3 Introduction

🕐 30 minutes

- Introduce the training to participants. If there is more than one facilitator, the lead facilitator should provide the introduction.

### 4 Presentation

🕐 30 minutes

- Give a presentation on your work on SRHR and HIV integration with young key populations.

# A2

# EXPECTATIONS AND PARTICIPATION

**Time**
45 minutes

**What**
This session explores participants' expectations of the training and what actively taking part means to each of them.

**Why**
It is important to set realistic expectations of the training from the start. This encourages everyone to feel responsible for their own learning and recognise that the success of the training is as much about the quality of their participation as the effectiveness of the facilitation.

**Preparation**
- Different coloured Post-it notes
- A flip chart labelled 'Expectations' and 'Contributions'
- A flip chart labelled 'A' and 'B'

## Facilitator's notes

### Objective

To explore our expectations of the training and what we can contribute and reflect on what participation means to us.

## Activities

### 1 Exercise: Our expectations and contributions

20 minutes

- Ask participants to write their expectations of the training on Post-it notes of the same colour (one expectation on each Post-it note). On different coloured Post-it notes, ask them to write what they can contribute, such as particular skills, knowledge or expertise.

- Now group together the expectations and contributions that share similar themes and place on the flip chart labelled 'Expectations' and 'Contributions'. Explain to participants which of these themes will be addressed. If some will not be covered, make this clear to them as well.

- Finally, check that participants feel comfortable about expressing their feelings, and remind them about confidentiality during the training.

| Expectations | Contributions |
|---|---|
| | |

## 2  What participation means to us

⏱ 15 minutes

■ Ask participants to think individually of a workshop or training where either:

  ■ (A) They experienced a well-facilitated and positive participatory process or

  ■ (B) Their opinions were used in a tokenistic or superficial way.

■ Then ask them to write down brief phrases summarising what stands out from that experience, which made it either positive or negative for them. If they need any suggestions, here are a few:

| | | | |
|---|---|---|---|
| Gender | Power | Talking | Silence |
| Language | Group dynamics | Sexual orientation | Characteristics of facilitator |
| HIV status | Education | Social class | Age |

■ Ask for a show of hands from those who answered A, then from those who answered B. Pair up the participants who answered A, then pair up those who answered B. Ask them to discuss with each other what they have written down and whether there are any common themes that emerge. Suggest they share a short summary of their experience if they want to.

■ In a plenary (whole group discussion), write up the themes in columns headed 'A' and 'B' on a flip chart.

| A | B |
|---|---|
| | |

## 3  Group contact

⏱ 10 minutes

■ Wrap up by helping participants develop a group contract for the training, agreeing the kinds of behaviours that we should expect from ourselves and each other. These might include arriving on time, mobile phones on silent, respecting different opinions, having fun, and helping others to participate while being actively engaged as individuals. However, try to encourage participants to come up with their own ideas first rather than suggesting them directly yourself.

# A3

# REFLECTION AND DEBRIEF

## Time
15 minutes

## What
This session introduces reflective practice. It provides a short assessment of the quality and style of the training, and the key learning points. It also introduces the recap.

## Why
A reflection and debrief helps to consolidate what was discussed and learnt during the training period, and iron out any issues before moving on. It flags any concerns with the pitch, speed or format of the training. Giving participants an opportunity to take the lead in some sessions encourages them to take responsibility for their own (and each other's) learning.

## Preparation
- Flip chart paper and pens
- Any other available materials participants would like to use – imagination is key!

## Facilitator's notes

Each day or period of training should finish with a short evaluation, reflecting on what has been learnt.

## Activities

### 1 Introduction

15 minutes

- Explain the purpose of reflection and ask the group to think about what was good about the training (structure, speed, pitch of information, logistics, etc.). Then ask them what could be improved.

- Make a note of their answers and decide what can be changed. Some things might be easier to change than others.

- Explain that future training periods (if applicable) will start with a 20-minute recap summarising the previous session's content and learning.

- Ask participants for volunteers to present the recaps, and note their names.

- Explain that they can present in any way they like – the more fun, imaginative and energetic the better! As a guide, they should try to include:

  - What did we talk about?
  - What are the implications for our organisation or programme?
  - Based on what we learnt, what action could we take to improve SRHR and HIV integration?

# A4

# RECAP

## Time
20 minutes

## What
A participant-led activity on what happened in the previous training period and what we learned. Obviously, this is only relevant for longer workshops taking place over multiple days or meetings.

## Why
Reminding participants of key messages, after they have had time to process the previous content, helps to consolidate their learning. Recapping creatively – using songs, pictures, drawings and games – starts off the day on an energetic note.

## Preparation
- Flip chart paper and pens

# Activities

## 1 Group discussion

⏱ 20 minutes

- Invite participants to lead a recap of the previous training's key messages. Remind them of the time limit (they might not need all of this). Ask:
  - What happened yesterday/the last time we met [as appropriate] for this training?
  - What did we learn?
- After the session has been delivered, thank the presenters and remind the group who is presenting the next recap (if relevant).

# A5

# TESTIMONIALS AND PERSONAL COMMITMENT

**Time**
60 minutes

**What**
A relaxed session where participants make a commitment based on their experience of the training. **Note that, while this is included in the Core Module, the session itself takes place at the end of the training.**

**Why**
It inspires participants in a fun way to make a personal commitment to translating their learning from the training into practical implementation.

**Preparation**
- Flip chart paper and pens
- Large Post-it notes
- PA photographer, video equipment or mobile phone camera

## Facilitator's notes

### Objective

To document the diversity of participants and their commitments to integrating SRHR and HIV interventions for young people.

## Activities

### 1 Individual commitment statements

15 minutes

- Write out the statements (below) in large letters on separate sheets of flip chart paper and pin them up in different parts of the room. You can add other statements if you wish. Ask participants to individually complete one or more of the statements.

> Integration is important because...

> I think this area of work has potential in my country because...

> Meeting the needs and rights of young people is important because...

> The one new thing I have learnt in this training has been...

> Integrated SRHR and HIV interventions for young people will make a difference in my country or context by...

> I am dedicated to working with young people in all their diversity because...

## 2 Sharing commitment statements with the group

🕐 25 minutes

■ Read out the statements again and after each one ask for a show of hands from participants who completed it. Then ask if anyone wants to volunteer to share their statement.

## 3 Documenting commitments

🕐 20 minutes

■ This should be fun! If possible (depending on time and budget) arrange a photographer in advance to take professional portrait photographs of participants holding up their statements (in bold and legible handwriting!) on flip chart paper – and perhaps a group photo at the end.

■ You could also encourage participants to stand by a statement they would like to talk about and use a mobile phone camera or other video equipment if available to record them.

■ Another idea is to ask participants to write their statements on large Post-it notes and stick them to the flip chart sheet whose statement they have completed. These can then be grouped into common themes, discussed with the group and documented in the evaluation. They can be kept anonymous if participants prefer.

■ Alternatively, you or the participants themselves can write their statements on flip chart paper to include in the workshop evaluation.

### Key messages

■ To be successful will take the personal and professional commitment of everyone involved.

■ We all must take responsibility for translating the learning from this training into actions that will contribute to the success of READY and similar initiatives that aim to integrate SRHR and HIV for young people in all their diversity.

### Facilitator's tips

■ You can do this activity in many different ways. The main thing is to keep it quick and light-hearted but meaningful. The session should be fun, reflective and action oriented.

# A6

# EVALUATION, REFLECTION, APPRECIATION AND CLOSE

**Time**
40 minutes

**What**
A wrap-up session. **Note that, while this is included in the Core Module, the session itself takes place at the end of the training.**

**Why**
It is important to appreciate the contribution of participants and recognise that they left behind their families and regular jobs to travel to the training. Also acknowledge and congratulate all involved in making the training happen.

**Preparation**
- Old newspapers to make a ball
- Flip chart paper and pens
- Evaluation forms

## Facilitator's notes

### Objective

You will have your own ideas for closing the training, but if you need some suggestions these activities may help you.

## Activities

### 1 Workshop evaluation

15 minutes

- Revisit the expectations participants discussed at the beginning to make sure that they have been met. No new questions or issues should be raised during this activity. It is a symbolic finale to allow participants to leave with a sense of closure.

- Then distribute evaluation forms for participants to complete. Remind everyone of the importance of honest evaluation. It helps to improve the training each time it is delivered.

- Allow enough time for these to be completed – some people take longer than others. Then collect the forms.

### 2 Reflection

15 minutes

- Make a ball out of old newspapers, large enough to be thrown around from one participant to another. Write the following questions in large letters on a flip chart and put it where it can be clearly seen from anywhere in the room:

  - What one thing would improve the content of this training if it were to be held again?

  - What was the best or most exciting thing about the content of this training?

- What one thing would improve the facilitation of this training if it were to be held again?
- What was the best thing about the way this training was facilitated?

■ Ask participants to form a circle and tell them that you will throw the ball to one of them. As they catch it, ask them to pick one of the questions on the flip chart to answer. Then ask them to throw the ball to someone else who will answer one of the questions.

■ Repeat until all participants have answered a question. Make sure that no one gets the ball a second time.

## 3   Closing activity: Circle of appreciation

10 minutes

■ Remain in the circle and ask participants to say one thing they appreciated about someone in the circle this week. Ask them not to choose someone who has already been spoken about, nor the facilitator. It is important to hear from everyone in the closing session!

■ The facilitator starts and ends the circle of appreciation. To start, make your first comment about any of the participants.

■ Decide in advance if this kind of wrap-up is appropriate in your country context. Adjust it as you see fit, or replace it with another activity that you think would work better.

■ Finally, close the training by thanking everyone. Whatever the activity, it should be one that only allows for positive reflection. This is not the time to raise challenges, issues or criticisms – there have been opportunities for that already.

# YOUNG PEOPLE

## SESSIONS IN THIS MODULE

| SESSION TITLE | TIME | PAGE |
|---|---|---|
| B1: Who are young people? | 85 minutes | 25 |
| B2: Young people's sexual rights and evolving capacity | 70 minutes | 29 |
| B3: Interactive session with young key populations | 60 minutes | 34 |
| B4: Meaningful youth participation | 100 minutes | 36 |

# B1

# WHO ARE YOUNG PEOPLE?

**Time**
85 minutes

**What**
This session introduces definitions of 'child', 'adolescent', 'youth' and 'young person'.

**Why**
Definitions can vary in different settings according to the legal context and social expectations.

**Preparation**
- Post-it notes
- Flip chart paper and pens
- A line drawing of a young person's body (boy and girl) on a flip chart

**Resources**
Evans, R. (2012), What is childhood and what do we mean by 'young person'? www.ippf.org/resource/what-childhood-and-what-do-we-mean-young-person

FHI (2008), Youth participation guide: assessment, planning, and implementation www.unfpa.org/sites/default/files/resource-pdf/youth_participation.pdf

Frontline AIDS (2012), Good Practice Guide: Family centred HIV programming for children www.frontlineaids.org/resources/good-practice-guide-hiv-programming-for-children/

UNICEF, Adolescent Participation and Civic Engagement www.unicef.org/adolescence/participation

## Facilitator's notes

### Objective

To introduce definitions of the terms 'child', 'adolescent', 'youth' and 'young person', and challenge traditional ways of thinking about young people.

## Activities

### 1  Polling booth / Post box

🕐 40 minutes

- Ask participants to think back to their own adolescence and consider the following questions but emphasise that this is for their own private thoughts, not for sharing with the group. Allow time for reflection after each question:
    - Who helped shape your attitudes towards your first sexual experience?
    - What did you learn about your sexuality and/or body from school?
    - Can you remember what it was like to go to a SRH service provider as an adolescent or young person?
    - What do you think it would be like for a young gay person, someone selling sex, or someone facing early marriage to go to an SRH provider?
- Now explain that we are going to use an anonymous polling booth or post box.
- Ask participants to write down on a piece of paper their answers to the following questions:
    1. When did you hear about sex for the first time?
    2. What did you understand about the word sex?
    3. Have you ever had sex? If so, what was your age the first time?

- After this, collect the anonymous responses in a box and highlight some of the most common answers. Follow this with a 'buzz session' discussion on:
  - What influences young people to have sex?
  - If young people have a problem related to SRH, what do they do and why?

*Note: This is a very powerful session, which is designed to help participants accept that sexuality is part of everyone's life and can become easier to discuss when we learn from personal reflection.*

## 2 Exercise: Understanding adolescence and youth

🕐 30 minutes

- Lay out the line drawing of the young person's body on the floor or table.
- Ask participants to write words frequently used in their communities to describe young people or being young on separate Post-it notes and stick them on to the drawing.
- When everybody has finished, group the Post-it notes into themes. Notice if the themes indicate any differences between young men and women, or questions about gender identity or sexual orientation.
- Explain how negative and gendered labelling affects young people and the expectations that adults have of them. Ask how the labelling changes for young key populations.
- Discuss:
  - How is an adolescent or young person distinguished from a child and an adult in your community?
- Say that there are many differences among rural and urban communities, minority groups, and genders in understanding the phase of life between childhood and adulthood. While there are international age-related definitions of adolescents and young people, it is important to be aware that there are also cultural constructs and these can vary from place to place. The expectations placed on adolescents and young people can be diverse and impact significantly on their SRHR.
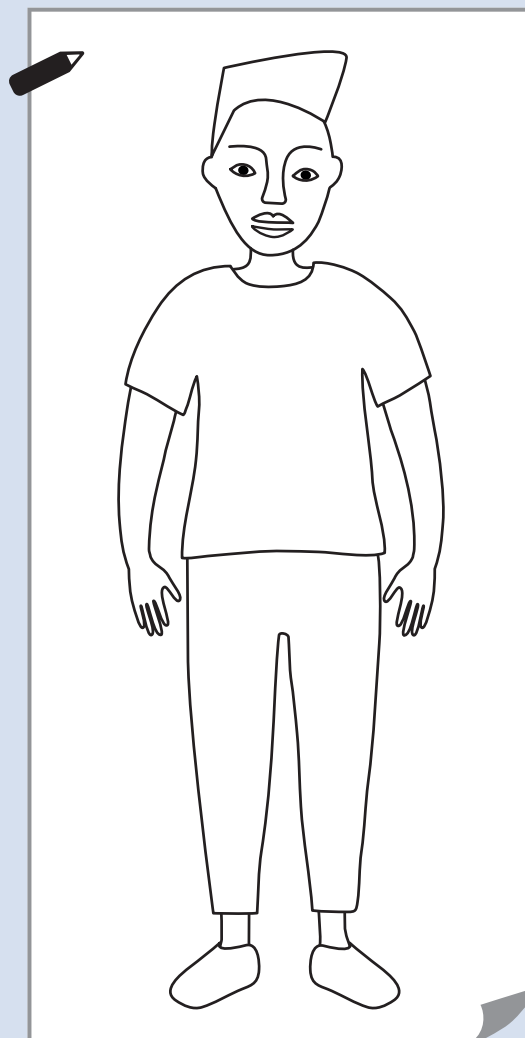
## 3 Exercise: A dynamic concept of youth

**15 minutes**

- Write 'Youth' and 'Adult' on a flip chart with a line between the two words.
- Ask participants:
    - What are the differences between them?
    - Are all the young people and adults you know like this?

**Some of these ideas may come up:**

| YOUTH | ADULT |
|---|---|
| Not adult / adolescent | Adult/grown up |
| Dependent | Independent |
| Social identity is emerging | Arrived |
| Ignorant and vulnerable | Identity is fixed |
| Risky behaviours | Knowledgeable |
| Less responsible | Powerful and strong |
| Rebellious | Powerless |
| Reliant | Considered behaviour |
|  | Responsible |
|  | Conformist |
|  | Autonomous |

| ADULT | YOUTH |
|---|---|
| Not adult / adolescent | Adult/grown up |
| Dependent | Independent |
| Social identity is emerging | Arrived |
| Ignorant and vulnerable | Identity is fixed |
| Risky behaviours | Knowledgeable |
| Less responsible | Powerful and strong |
| Rebellious | Powerless |
| Reliant | Considered behaviour |
|  | Responsible |
|  | Conformist |
|  | Autonomous |

- Now interchange the column headings 'Youth' and 'Adult'.
- Ask:
    - Do you know any young people and adults like this?
- Discuss whether we can properly think of 'youth' and 'adult' as separate categories of people. In reality, we cannot say that all young people are the same, just as we cannot say that all adults are the same.
- Explain that a dynamic concept of youth takes into account many factors, including:
    - Social status (e.g. class, gender, ethnicity, race, geographical location)
    - Cultural formation (e.g. youth subcultures)

- Unequal provision, opportunities and outcomes
- State regulation according to social status (e.g. indigenous/ tribal young people and the police)
- Diverse life experiences and cultural norms for growing up
- Young people having multiple dimensions
- Ask:
    - What else would a dynamic concept of youth include?
    - How might society's ideals, images and expectations of young people affect their health-seeking behaviours?

# Key messages

- All adults have their own perceptions and expectations of young people. Together with negative and gendered labelling, these can have an enormous impact on the way we design and implement our programmes. It is important to be aware of our assumptions and recognise that young people are not all the same.

- While there are international age-related definitions of adolescents and young people, it is important to be aware that there are also cultural constructs and these can vary from place to place. There are also religious and political definitions of these groups. It is important to have a dynamic concept of youth that takes into account multiple factors.

- Before we can successfully address young people's SRH vulnerabilities successfully, we first need to explore how we ourselves see young people. Some of us may envy young people and wish we were young again. Others may stereotype them.

- Often, young people are seen as risk-taking pleasure seekers who only live for the present. Do we view them like this or as social agents for change? Do we, or the societies we live in, have ambivalent attitudes towards young people? For example, we may view or treat them in some ways as 'small adults', yet at the same time as immature, inexperienced and untrustworthy.

- Stereotyping may discourage young people from asserting their rights to complete and accurate SRHR information, hampering their ability to make responsible decisions about their life.

- Young people are often given work inside and outside of the family that involves a lot of responsibility. Although, at a household or community level their value is often recognised, their legal rights can be unclear and differ widely.

- Around the world, the age of criminal responsibility varies widely, from as young as the age of 6 up to 18, with a median age of 12. Yet laws do not give adolescents and young people the corresponding ability to make decisions about their own health. Some can marry while they are still children (under the age of 18) and access health services. But many girls who are sexually active, whether married or not, have no right to make decisions about their own health, access to SRH services or contraception, as they are below the age of legal consent.

- Our assumptions about young people can discourage us from accepting their sexualities and their SRHR. This may powerfully influence our policy and practice in relation to young people and their sexual health.

# B2

# YOUNG PEOPLE'S SEXUAL RIGHTS AND EVOLVING CAPACITY

### Time
70 minutes

### What
This session moves the general discussion about human and sexual rights into the specific area of the human rights of children and adolescents' human rights.

### Why
It is important to consider what is different or more challenging about ensuring that young people's human and sexual rights are realised.

### Preparation
■ Flip chart paper and pens
■ Handout 4

### Resources
Frontline AIDS (2019), REAct User Guide www.frontlineaids.org/resources/react-user-guide/

IPPF (2011), Keys to youth-friendly services: understanding evolving capacity www.ippf.org/resource/Evolving-capacity

## Facilitator's notes

### Objective

To understand young people's sexual rights and how the concept of their 'evolving capacity' applies to programmes and services.

*Note: It is important that the facilitator understands the UN's Convention on the Rights of the Child and its human rights charter and how they work in the context where the training is taking place. For example, some countries do not speak of reproductive rights; the facilitator needs to use the right words that are appropriate to the context.*

## Activities

### 1 Introduction and discussion

🕐 10 minutes

■ Explain to participants that children and adolescents enjoy the same human rights as adults. In some rights documents their rights are further emphasised. For example, the ICPD Programme of Action calls on governments to provide adolescents with access to sexual and reproductive information and education, and recognises that reproductive and sexual health services 'must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent' (paragraph 7.45). Young people aged 18 and under are covered by an additional human rights convention that adults are not: the Convention on the Rights of the Child (CRC). The CRC is an important document for working with young people's rights because it introduces a number of concepts that only apply to rights for under-18s. A particularly important concept is that of evolving capacity.

## Talking points

**Evolving capacity** is about individual development and autonomy. It refers to the way that each young person gradually develops the ability to take full responsibility for their own actions and decisions. This happens at a different pace for each individual person. At any given age, some young people will be more mature and experienced than others. Context and personal circumstances will almost certainly influence each individual's development.

Evolving capacities is a concept that was first introduced into international law in the (almost) universally-accepted CRC. There are several articles within the CRC that further explain evolving capacities. You could write these three on a slide or flip chart for participants to see:

**ARTICLE 5:**

Young people's evolving capacity to exercise their own rights must be taken into consideration by those who provide guidance and direction to young people.

**ARTICLE 12:**

Young people must be able to freely express their views, which should be given weight in accordance with their evolving capacity.

**ARTICLE 14:**

Young people must be afforded freedom of thought, conscience and religion.

■ Explain that, quite often, the best interests and the evolving capacities of young people – both concepts found within the CRC – are seen as being in opposition. However, the two are not mutually exclusive, nor are they contradictory. What is in the 'best interests' of a young person is only apparent once the views of young people, as well as the contexts of their lives, are considered. In some instances, this may mean they need to be protected or guided, and in other instances it may mean they are able to decide the best course of action for themselves. In other words, it is all about achieving a balance between protection and autonomy, just as we must achieve a balance between rights and responsibilities.

■ Ask participants:

■ What is your understanding of what we mean by young people's 'best interests' and young people's 'evolving capacities'? Discuss in a pair or small group before feeding back.

■ Do you have any questions? Any observations on other groups' contributions?

## 2 Exercise: Evolving capacities in practice

**40 minutes**

- Write 'Agree' on a sheet of flip chart paper, 'Disagree' on a second sheet, and 'Not sure' on a third. Place each sheet in different corners (or one in the middle) of the room. Explain to the group that they need to take a position based on the statements being read out.

- Use the case studies below and read aloud the first part of Case Study 1. Ask participants to stand next to the sign most appropriate to how they feel about the scenario. Then read out aloud the second part of the case study and tell participants they can change their position if they wish. Discuss why participants chose their position, and whether and why the extra information changed their mind. Repeat with each of the case studies.

- There are no easy answers to these case studies. Each scenario not only raises issues about a young person's right to choose and make their own decisions but also about the need to protect them.

**Agree**

**Disagree**

**Not sure**
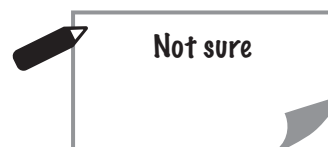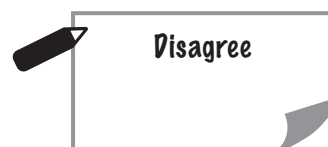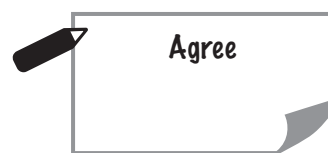
## Handouts

## Case Study 1

### Part 1

You are an outreach worker. You have met a 16 year old who has been having a sexual relationship for two years with an adult who is 20 years older than them. He/she is being paid for sex by the adult. The young person has clearly stated that he/she is happy for this situation to continue.

Do you think this young person is capable of deciding to continue the relationship?

### Part 2

The young person has been living on the streets for four years following the death of his/her mother. During this time, he/she has supported their two younger siblings, who are still in school.

Would you change your response as a result of this new information?

*Note: You can also change the age of the street child (e.g. reduce it to 14) to see if people change their position. If they do, ask what would be the 'right' age for this child to make their decision and why. This helps to emphasise the importance of separating age from the capacity and abilities of the individual, as well as their circumstances. You could also change the gender and see what difference that makes.*

## Case Study 2

### Part 1

You are a service provider. A young woman aged 17 has come to you for a pregnancy test. The test is positive, and she is certain that she wants to keep the baby. One week later she returns saying that she does not want to keep the baby, and she wants an abortion that same day. There are parental/guardian consent laws around such services for those aged under 18.

Do you think this young woman is capable of deciding to terminate her pregnancy?

### Part 2

The young woman explains that her change of mind is as a result of her boyfriend not agreeing to marry her, as he had promised.

Would you change your response as a result of this new information?

## Case Study 3

### Part 1

You are a service provider. A 22-year-old man visits your clinic requesting a vasectomy.

Do you think this young man is capable of deciding to have a vasectomy?

### Part 2

The young man explains in a very articulate manner that he has no desire to marry or have children, and he is happy to think of spending his life as a single man.

Would you change your response as a result of this new information?

## 3 Feedback and discussion

🕐 20 minutes

Cases like these are difficult as they challenge our attitudes and beliefs as well as what is legal, acceptable, just and ethical. The important thing is to be able to recognise cases where there are different interests at play and to know the tools you can use to help you think through what to do, such as the key pointers for assessing capacity.

Discuss the following key pointers for service providers to assess capacity and involve young people in SRHR decision-making:

- Recognise that young people have valuable insights into their health and well-being that adults do not possess.

- Learn more about the family, friends and environment in which the young person lives.

- Make sure privacy and confidentiality are guaranteed, and make sure the young person knows it.

- Make the young person comfortable.

- Look for evidence that the young person has made autonomous decisions about their healthcare already.

- Have organisational guidelines in place to assist healthcare professionals in asking the right questions and gathering adequate information to assess a young person's decision-making capacity.

- Have organisational guidelines in place to assist healthcare professionals in interpreting laws relating to the provision of services to young people.

## Key messages

- Children and adolescents enjoy the same human rights as adults, but the way in which these rights are fulfilled will differ.

- Young people of 18 years and under are covered by the Convention on the Rights of the Child which introduces a number of concepts that only apply to rights for this age group. One of them is 'evolving capacity'.

- The concept of 'evolving capacity', when applied to SRHR and young people, can be complicated and there are no clear-cut right or wrong answers. This forces us to think about everything that we do through a rights-based lens, otherwise we end up with programmes, policies and services that do not reflect the realities of young people's lives.

# B3

# INTERACTIVE SESSION WITH YOUNG KEY POPULATIONS

**Time**
60 minutes

**What**
This session involves a panel discussion where young people from key populations are invited to debate topics specific to their needs.

**Why**
It is only by listening to and hearing the voices of young people from key populations that we can properly support them in designing and delivering activities, including advocacy interventions. In READY, all activities should involve young people.

**Preparation**
- Chairs (table optional)
- Microphones, if a large room

## Facilitator's notes

### Objective

To hear directly from young people from key populations to understand the kinds of stigma and discrimination they have encountered and the impact this has had on their lives, especially on their health and sexual and reproductive lives.

## Activities

### 1  Exercise: Panel discussion

60 minutes

- Host a panel discussion with invited young people from key populations on the kinds of stigma and discrimination they have encountered and the impact this has had on their lives, especially their health and sexual and reproductive lives.

- The panel could be conducted like a television chat show with celebrity guests. A young person should interview the panellists using the questions on the next page.

- Refer back to the discussion on evolving capacities, and run the session in line with the guidance given in the sections on the consent process and creating a safe environment for young people.

- The exercise will enable topics, such as the impact of double standards, gender-based violence, stigma and discrimination, to be discussed.

- Wrap up the session by asking volunteers from the group to say what they have learnt, or will do or think differently, because of the panel discussion. Thank everyone, especially the young people, for their open and honest participation. Then close the session.

**Interview questions**

- What do you think makes young people vulnerable to HIV in our country today?

- How can HIV prevention activities (services, campaigns and information) be designed to suit young people's needs?

- Can you describe your experiences of dealing with the police and the education system, and of accessing the health system? To what extent did they meet your needs?

- If you feel comfortable to do so, can you describe how HIV has affected you in different ways (directly or indirectly)?

- What is your message (or wish) either to policy-makers, programme managers, the people in this room or the READY programme?

- What single piece of advice would you give to the president/prime minster to improve things for young people in our country?

## Facilitator's tips

**For meaningful and safe participation of young people, make sure:**

- The experience is kept simple and light.

- The panellists have help with translation if they need it – be sure to arrange a translator if appropriate.

- The session is set up to recognise that young people have valuable insights into their health and well-being that adults do not possess.

- The panellists have given informed consent in writing after thorough discussions about the pros and cons of taking part, both now and in the future (e.g. once they are in a serious relationship or pursuing professional opportunities).

- The panellists are adequately supported, either by friends and family and/or an institutional representative accompanying them to the session. To do this, learn more about the family, friends and environment in which the panellists live. Bear in mind that some caregivers are not ready to be open about their own or the young person's HIV status.

- Ensure that privacy and confidentiality are guaranteed, and that the panellists are aware of this. You could do this by referring to the group contract agreed at the start of the workshop.

- Make sure the panellists feel comfortable. One way to protect the panellists is by having a mediator (the lead facilitator) filter questions from the audience back to the panel, and vice versa. In that way, if something inappropriate is asked and/or one of the young people's answers needs clarification, filtering can be provided respectfully by the facilitator. Let the young people know they can also skip answering any questions.

# B4

# MEANINGFUL YOUTH PARTICIPATION

## Time
100 minutes

## What
This session enables participants to understand the concept of meaningful youth participation and assess how meaningfully they involve young people in their own projects or organisations.

## Why
It is important to be aware of the values and assumptions we may have towards working with young people in case we have need to adjust our opinions to work effectively in partnership with young people.

## Preparation
- Flip chart paper and pens
- Handout 8
- Definition of youth participation on flip chart paper, and written or printed on separate cards
- Post-it notes

## Resources
IPPF (2008), Participate: The voice of young people in programmes and policies www.ippf.org/resource/participate-voice-young-people-programmes-and-policies

## Facilitator's notes

### Objective

To understand youth participation and youth–adult collaboration and assess the level of youth participation in our own project, organisation or health facility.

## Activities

### 1 What is youth participation?

20 minutes

- Brainstorm definitions of youth participation with the group and write their responses on a flip chart.
- Ask:
  - What different ways can young people participate in an organisation, project or facility?
  - What different roles can they play?
  - Why should young people participate?
- Explain that usually there are many more ways for young people to become involved in an organisation, project or facility than people have tried out so far. We can start thinking creatively about the opportunities organisations can create for young people to participate. These could include:
  - Decision-making roles
  - Research
  - Monitoring and evaluation
  - Advocacy and awareness-creation campaigns
  - Peer education
  - As staff, consultants and trainers

■ Then share these definitions of youth participation (write them on flip chart paper in advance):

"Adolescents partaking in and influencing processes, decisions and activities."

Roger Hart, in Children's Participation: From Tokenism to Citizenship

"Adults work in full partnership with young people on issues facing youth and/or on programmes and policies affecting youth."

Advocates for Youth

■ Explain that **youth participation** is increasingly viewed as youth–adult collaboration, as the emphasis has shifted from prevention (using peers for behaviour change) to **power sharing**. Youth participation has moved beyond peer education to governance, advocacy, monitoring and evaluation.

## Talking points

■ Emphasise that participation is not achieved by any of these means singly but by all of them because different young people will be interested in becoming involved in different ways. While one young person might be happy to attend board meetings regularly, another might only want the chance to give their views anonymously on services from time to time.

■ Different levels of youth participation require different levels of responsibility from young people and adults.

■ Some forms of youth participation are forms of tokenism – in other words, they are just a gesture but do not lead to meaningful involvement – and are not considered genuine youth participation.

■ Young people have different timetables and obligations than adults and may want to participate in different levels.

■ Be clear on the required commitment and accompanied responsibilities in youth-adult partnerships, from both adults and young people.

■ Social norms related to age and gender can create barriers to young people's meaningful participation. This is particularly true for young women, lesbian women, gay men, bisexual people and trans/gender non-conforming young people.

■ Youth participation implies a shift in power within the structure of an organisation, project or health facility.

■ Youth participation should be supported by training due to young people's and adults' different experiences and knowledge.

**2** **Levels of youth participation**

🕐 20 minutes

- ■ In advance, write or print out on separate cards the text from the definitions section of Handout 8, showing the different levels of youth participation. Then break into small groups and ask participants to arrange the cards in order from low to high levels of participation.

- ■ In small groups, ask participants to identify examples from their existing outreach work, programme management and institutional governance that might fit these different levels of youth participation. Ask them to write these on Post-it notes and place on the appropriate card.

- ■ As a large group, discuss and agree the order of the cards. Where are most of the Post-it notes?

- ■ Emphasise that in the implementation of our work with young people we want to see more examples at the higher levels to ensure that we are moving towards genuine and meaningful youth participation.

**3** **Personal values relating to participation**

🕐 60 minutes

- ■ Write 'Agree' and 'Disagree' on two sheets of flip chart paper and place them at opposite sides of the room.

- ■ Then read out the statements on the following page, asking participants to move to the appropriate sign depending on whether they agree or disagree with it Or they can take a provocative opinion (that may not necessarily be their own) for a lively debate.

- ■ Ask participants to be honest with themselves. You do not have to use all the statements, only as many as time permits.



Agree



Disagree

- ■ After each statement, ask participants why they agree or disagree. If there is enough time, you could also encourage discussion among the 'Agree' and 'Disagree' groups of participants for each statement.

- ■ Explain that it is important to be aware of our values and where we stand on these issues in case we have to adjust our opinions to work effectively in partnerships.

    - ■ Distribute the 'Fifteen tips for good practice' section of Handout 8. Ask participants in small groups to go through the list and choose the ones they find most interesting or challenging.

    - ■ Round off with a plenary (whole group discussion) about how we can support each other to implement good practice in youth participation.
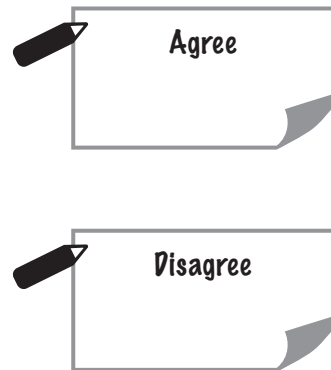
# Handouts

**Statement 1**
Adults should always make the final decision regarding the SRHR of young people

**Discussion**
Young people are experts on their own lives. Informed decision-making should be encouraged, whereby the role of adults is to ensure that young people are well equipped with the skills and knowledge they need to make their own decisions about their SRHR.

**Statement 2**
Young people don't have the skills to develop effective SRHR and/or HIV programmes.

**Discussion**
Examples exist of young people of various ages successfully developing programmes and advocacy actions on SRHR and HIV. Given encouragement and capacity-building, young people can be as effective as anyone in programme development. Remember, they are the experts on their own lives!

**Statement 3**
Young people should be respectful of their elders and do as they are told.

**Discussion**
Many cultures expect young people to be respectful and unquestioningly obedient to people older than them. This is a hierarchical social structure aimed at maintaining power for adults. It is in the interests of young people to develop critical analysis skills and decide for themselves what course of action would be best for them. While being respectful is always appreciated, actions should be based on informed decisions rather than unquestioning obedience.

**Statement 4**
Young participants in a programme planning consultation should be fully paid for their activities.

**Discussion**
It is important to remain aware that young people often do not have their own income. It is good practice to reimburse them for any out-of-pocket expenses they incur when participating in our programmes.

**Statement 5**
A young sex worker can be on the advisory board of a project.

**Discussion**
For programmes aimed at reaching young people who sell sex, it is advisable to ensure that they have an equal say on programme-advisory or other decision-making bodies. Global evidence on effective programming suggests that the target populations must be involved at all levels of programmes.

**Statement 6**
Condoms should be provided to under-15s.

**Discussion**
Young people, regardless of age, are engaging in sex. Providing condoms to ensure that sex is safer is the responsible action to take.

**Statement 7**
Youth participation is donor driven.

**Discussion**
While in some parts of the world youth participation may be donor driven, it is important that programme implementers understand the importance of youth participation in itself, rather than simply viewing it as part of a donor agenda to be ticked off the checklist.

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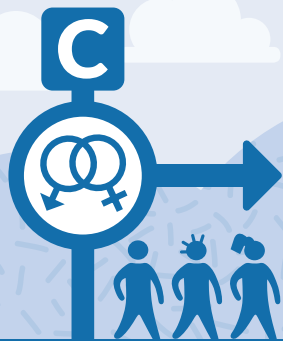
# GENDER, SEXUALITY AND SOCIAL NORMS

## SESSIONS IN THIS MODULE

| SESSION TITLE | TIME | PAGE |
|---|---|---|
| C1: Gender and social norms | 100 minutes | 41 |
| C2: Understanding sexuality | 110 minutes | 46 |
| C3: Stigma and discrimination | 40 minutes | 51 |
| C4: Consent | 150 minutes | 54 |

# C1
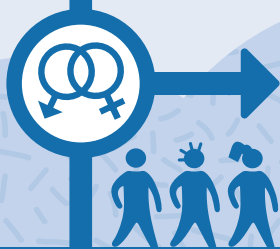
# GENDER AND SOCIAL NORMS

## Time
100 minutes

## What
This session explores what we mean by gender and how it affects the way men, women transgender and gender non-conforming people are perceived and valued in our society.

## Why
Considering some of the ways that our society expects men and women to behave helps us to challenge these expectations and think about how they impact on the work we are doing.

## Preparation
■ Flip chart paper and pens

## Resources
BRIDGE website – specialised gender and development research and information service www.bridge.ids.ac.uk

UN Women website www.unwomen.org

WHO, Gender, equity and human rights www.who.int/gender-equity-rights/en/

## Facilitator's notes

### Objective

To understand that gender is a concept constructed by society or a community.

## Activities

### 1  Exercise: Where do you stand?

🕐 25 minutes

■ Write 'Society' and 'Biology' on two sheets of flip chart paper and stick them on opposite walls. Then ask participants to stand in a straight line in the centre of the room.

■ Read aloud one statement at a time (see below). After each statement, ask participants to move a step towards the walls labelled 'Society' or 'Biology' depending on whether they think the statement is socioculturally or biologically based.

Society    Biology

**Statements**

1. Girls are gentle; boys are not.

2. Having sex with her husband is a woman's duty.

3. Women can get pregnant; men cannot.

4. Men are good at logical and analytical thinking.

5. Real men don't cry.

6. Women can breastfeed babies; men cannot.

7. Women are creative and artistic.

8. Women have maternal instincts.

9. Men's voices break at puberty; women's voices don't.

10. Men have a greater sex drive than women.

11. Women like to dress up and wear make-up.

12. Men should be the wage earners of a family, not women.

13. In a heterosexual relationship or marriage, the man has to be older than the woman.

Can you give other examples of how we learn gender roles?

## Key messages

- Until recently, our sex was considered to be unchangeable. Now it can be changed through medical intervention (known as 'sex reassignment surgery').

- Gender is socially constructed, which means that it is determined by our social, cultural and psychological surroundings and environment. It is not innate in the same way that our biology (sex) is believed to be. It refers to how societies view women and men, how they are distinguished, and the roles assigned to them. People are generally expected to identify with the gender that has been assigned to them, from their sex at birth (known as 'gender assignment'), and to act in ways deemed appropriate to this gender.

- Gender is variable and can change from time to time, culture to culture, and sub-culture to sub-culture.

- The way girls and boys are socialised to be 'feminine' or 'masculine' is called gendering. People who do not conform to stereotyped gendering are often subjected to stigma and discrimination.

- It is important to distinguish between what society has constructed/created for each gender and what is biological. For example, the idea that men are strong and should not cry is created by society, whereas a woman giving birth is biological.

- SRH decisions can be influenced by a person's gender. For example, in a heterosexual relationship, it may be the man who has the power to decide whether, when and how many children to have.

  - In general, cis-gender (a term for people whose gender identity matches their sex assigned at birth) women can get pregnant (and cis-gender men can't), but there are many cis-gender women who do not get pregnant for many reasons (e.g. because they are outside of the reproductive years or choose not to have children). While the ability or inability to have children, and the decision to have or not to have them, may be out of their hands it may have gendered implications for their status as 'women'.

## 2 Plenary discussion: Where do we stand?

**25 minutes**

■ In a plenary (whole group discussion), ask groups to reflect on their responses to the statements in the 'Where do we stand?' exercise. Then facilitate a discussion about the sociocultural (and legal) factors that affect the sexual and reproductive lives of young people. Ask:

■ How do our social expectations of what men and women should 'be' and 'do' (gender norms) affect their SRH and HIV vulnerability?

■ How do these expectations affect young people's sexual and health-seeking behaviours?

## Key messages

■ Gender norms restrict women's decision making, power and control over their bodies, which reduces their ability to protect their sexual health and limits their access to services. These norms help to sustain a system of gender inequality in which men have greater decision-making power, access and control over resources than women. No country in the world has achieved gender equality.

■ People who fall outside the norm of heterosexual and marital relationships are often excluded from society and therefore from important aspects of life, for example, education, health services, employment and legal redress. This makes them more vulnerable to HIV and other kinds of sexual and reproductive ill health, such as other STIs, unwanted pregnancy and unsafe abortion.

■ Stigma and discrimination against those who do not conform to society's expectations are often compounded by factors, such as their legal status. Together, these things act as barriers that prevent people from accessing health information and services, and practising safer sex or safer injecting.

■ Special efforts need to be made to address the realities of those who fall outside of sociocultural gender and sexual norms to ensure they can access life-saving information and services. We can achieve this by first becoming aware of the many ways in which sexual and gender norms affect everyone's sexual behaviour, health-seeking behaviour and access to services.

**3** **Exercise: Group work on factors that shape sexual and health-seeking behaviours**

🕐 25 minutes

■ Explain you are going to explore in more depth how sexual and gender norms shape sexual and health-seeking behaviours, and therefore vulnerability to HIV and other SRHR issues.

■ Break into groups and ask each to represent a character from the list below. Adapt the characters and number of groups to suit your setting.

**Handouts**

**A 17-year-old college girl who is HIV positive.** Her boyfriend does not know her status and wants to have sex with her. She would like to have sex with him too.

**A 21-year-old female garment factory/migrant worker with a boyfriend.** While they used condoms at the start of their relationship, they have not done so recently as they have been together now for six months and their relationship is getting more serious.

**An affluent 21-year-old, heterosexual male university student who uses drugs.** He often pays for sex when going out with his friends to 'have a good time'.

**A 15-year-old, self-identified homosexual boy who is out only to his best friend.** Other boys often make jokes about hijra and kothi or panthi (South Asian terms for cultural transgender identities). He has had sex once with a young boy who also lives on the same street.

**An 18-year-old young man who has sex with both men and women.** He lives with his extended family, who assume he is heterosexual. He is attracted to and looks for validation from older men, who assume a more dominant role.

**A 14-year-old schoolgirl who has a steady boyfriend and several older male sexual partners who give her gifts and money.** Her boyfriend sometimes gets jealous, so she doesn't use a condom with him to show that he is special to her.

**A young, transgender woman.** Although she is accepted by her community, she faces harassment on the streets.

- Ask groups to answer these questions for their character:
    - What kind of sex is this person having and where are they having sex?
    - Where are they going to get information on sex?
    - What information on sex are they getting?
    - How do these factors affect their vulnerability to HIV and sexual and reproductive ill health?
    - How would you address the gaps in their information and access to services?

## **4** Plenary discussion: Factors that shape sexual and health-seeking behaviours

🕐 25 minutes

- In plenary, ask groups to present the key points from their group work on how sexual and gender norms shape the sexual and health-seeking behaviour of the characters they discussed.
- Then facilitate a discussion about how these factors increase young key populations' vulnerability to HIV and poor SRH.

# C2
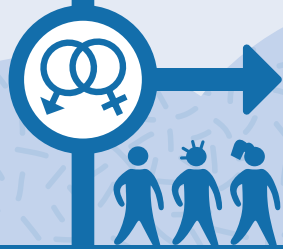
# UNDERSTANDING SEXUALITY

## Time
110 minutes

## What
This session explores the assumptions we make relating to gender, sexuality and intimacy and will help participants to understand the concepts of sexuality and the continuum of sexual orientation and gender identities.

## Why
Growing up is a time of great fluidity and change. Understanding the assumptions we make around young people's gender roles and sexuality, and seeing gender identities and sexual orientation as a continuum, helps us to deliver effective community mobilisation and services to improve young people's SRHR.

## Preparation
■ A colourful drawing pinned to the wall showing different scenes from your story character's life.

## Resources
Frontline AIDS (2019), Sexuality and Life-Skills Toolkit
www.frontlineaids.org/resources/sexuality-and-life-skills-toolkit/

Handout 5: Sex and sexuality

# Facilitator's notes

## Objective

To understand sexuality as more than a physical act, and become confident in discussing sexuality and the continuum of sexual orientation and gender identities.

# Activities

## 1 Preparing a sexuality story (in advance)

■ Before the session starts, prepare a sexuality story showing four stages of a young person growing up. The suggested stages (see below) can be developed to also include first love, a first kiss, the first time the character has sex and so on.

■ Choose a name for the young person that is specific to your culture and could be for a male or female character (for example, Jo(e) in English or Kiran in a South Asian context). Make sure that throughout the story you never use the pronouns 'he' or 'she', or 'him' or 'her'. Only use the name you have selected.

■ Ask for some local help to tailor the story to your context. The exercise works best if it is specific and relevant.

■ As you write the story, make sure you include the following four stages:

■ **Stage 1: Jo is at home in the village**
Jo is a good child, helpful in the home, really interested in school work and a good student. Jo has hobbies, such as playing football with the other children, tending the garden and collecting firewood. (Make sure you choose hobbies that could be for either a girl or a boy.)

- **Stage 2: Jo moves to a bigger town or city to go to high school**
  Jo's favourite subjects are maths and literature. Jo does well in school and wins a scholarship to go to university. (You can add more details here, if you like.) Jo also discovers a social life, with music and dancing, and falls in love for the first time with best friend, Katherine (choose a culturally-specific female name). It is quite awkward since they are both teenagers and don't know how to express their feelings, but they vow to keep in touch when Jo goes off to university.

- **Stage 3: Jo moves to the capital city and excels at university**
  As a recent graduate, Jo gets a really good job in the city working for an agricultural production company and is active in the local community/church life. Jo also falls in love with the captain of the football team, Frank (choose a culturally-specific masculine name).

- **Stage 4: Jo is happily married with three children**
  Jo has two girls and a boy and has settled in the city.

■ Once you have prepared the story, you could draw illustrations for each of the four parts of the story to put up on the wall.

## 2   Story time

🕐 5 minutes

■ Read the story to the group, making sure you don't use a pronoun (no 'he' or 'she', 'his' or 'her').

## 3   Discussion

🕐 15 minutes

■ Ask the group to think about the story and raise their hand if they think Jo is:

- Male?
- Female?

■ There will be some confusion as participants begin to realise that they are interpreting different signs of gender throughout the story. They might also be perplexed as to how Jo could have been attracted to both a female and a male. Some members of the group are bound to try to catch you out saying that you gave it away in one direction or the other!

■ Then ask:

- Why did you think Jo was female?
- Why did you think Jo was male?

## Key messages

- Sexuality is about much more than who a person has sex with.

- Sexuality can be fluid and change over time.

- Sexuality can be viewed on a continuum from 100% heterosexual through to 100% homosexual, with everyone fitting somewhere within that continuum.

- Sexuality is experienced and expressed differently for different individuals and may change at different times in their life.

**See Handout 5 for definitions of sex and sexuality (page 125).**

## Facilitator's tips

This exercise is designed to cause confusion – of the constructive kind! So be ready to let the group become confused but then guide them back to the main considerations about sexuality, gender, intimacy and sexual orientation. It is also important to highlight here the value of respecting individual sexuality, the diverse forms of identities, orientations etc., rather than becoming judgemental with negative thoughts/feelings/attitudes towards those who do not conform to stereotyped social norms.

## 4 Heads, hearts, bodies, actions

90 minutes

■ Ask the group to draw the outline of a person on a large sheet of paper or on the ground. They should add in and label the brain, the heart, the face, the genitals, the hands and feet. Explain that these are symbols of our thoughts, feelings, public appearance, biological sex and actions
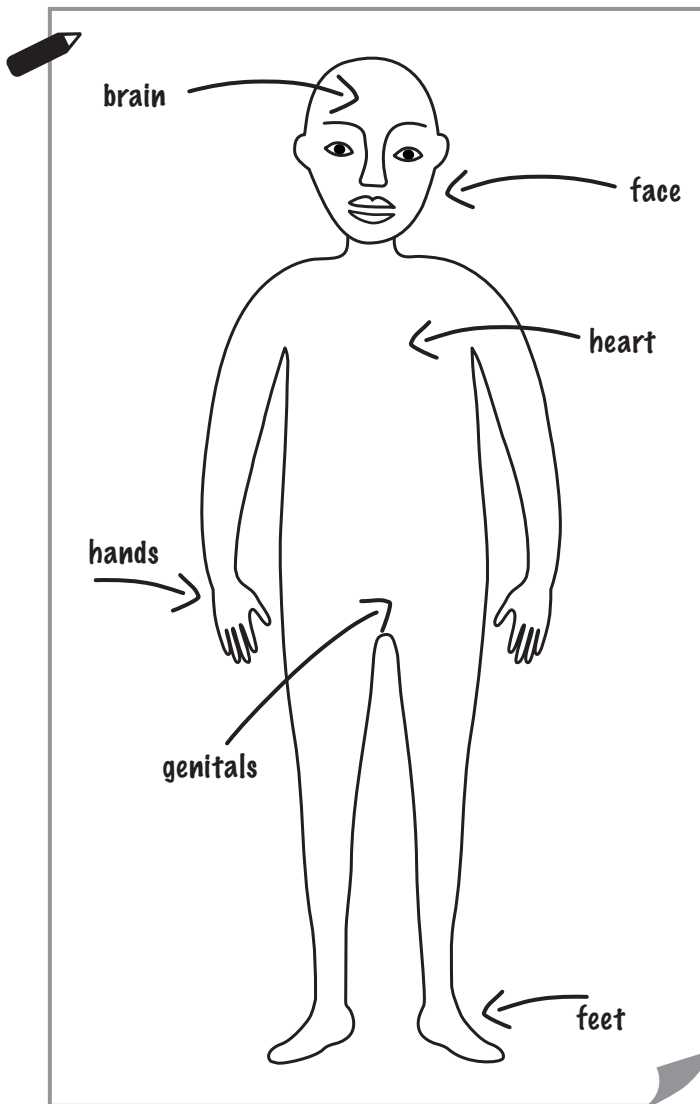


■ Ask them to discuss and agree on the following (they may choose more than one answer):

■ Which of these do we think most affects how we think about ourselves and who we are? Why?

■ Which of these do we think most affects who we fall in love with? Why?

■ Which of these do we think most affects who we are sexually attracted to? Why?

■ Which of these do we think we use to show other people who we are? Why?

■ Which of these do we think most affects how other people identify us? Why?

■ Ask the group:

■ What do we think may happen if our thoughts, feelings, public appearance, biological sex and actions do not 'line up' in the way society expects of us? Can we think of any examples of this in our community? How might this make us feel? What might be the consequences?

■ Draw a long line and label one end 'Same', one end 'Different' and the middle 'Both'.

| Same | Both | Different |
| --- | --- | --- |

■ Explain this represents the range of human sexuality and attraction, and that all of us are included somewhere along this line. Some of us may feel strongly attracted to people of a different sex/gender than us (heterosexual, straight); some of us may feel strongly attracted to people of the same sex/gender as us (homosexual, gay, lesbian); some of us may feel attracted to both (bisexual). Our position on the line may stay unchanged throughout our lives, or it may change.

## Facilitator's tips

This topic may be seen as sensitive or controversial in your local context. Some forms of appearance that don't fit local gender norms may be considered socially unacceptable and treated harshly. Some sexual behaviours among consenting adults may even be punished as crimes. We have a duty of care to ourselves and our participants to deal with this topic in a responsible way that does not put anyone at risk. Equally, we have a responsibility to provide accurate information, and be as inclusive and supportive as possible.

# C3

# STIGMA AND DISCRIMINATION

## Time
40 minutes

## What
This session explores stigma and discrimination and how they differ. It also delves into the impact of stigma and discrimination on individuals and communities.

## Why
Stigma and discrimination are a key barrier to SRHR and well-being. Young people from key populations may experience stigma and discrimination at many levels in relation to multiple aspects of their identity (for example, sexual behaviours and HIV status). Stigma and discrimination also create barriers for delivering successful SRHR and HIV interventions, impacting on access to and uptake of services and the quality of the services available. Being aware of our own attitudes, values, and behaviours helps us to understand how stigma and discrimination affect the young key populations we work with.

## Preparation
- Flip chart paper and pens
- A film on stigma and discrimination, if available (particularly if produced locally or regionally). For example, the Ugandan film Call me Kuchu. Available at: www.callmekuchu.com

## Facilitator's notes

### Objective

To think about our own experience of being stigmatised or of stigmatising others.

## Activities

### 1 Discussion: Differences between stigma and discrimination

5 minutes

- Ask participants what experiences come to mind when you say the word 'stigma' and then when you say the word 'discrimination'. Alternatively, ask them to brainstorm the differences between stigma and discrimination.

> **STIGMA** is a process of devaluation. In other words, if one is stigmatised one is discredited, seen as a disgrace and/or perceived to have less value or worth in the eyes of others.

> **DISCRIMINATION** is an action which involves treating someone in a different and unjust, unfair or prejudicial manner, often on the basis of their belonging, or being perceived to belong, to a particular group. It is often viewed as the end result of the process of stigmatisation in the eyes of others.

## 2   Exercise: Our own experience of being stigmatised

🕐 10 minutes

■ Ask participants to sit on their own. Then ask:

  ■ Think about a time in your life when you felt isolated or rejected for being seen to be different from others, or when you saw other people treated in this way

■ Explain that they do not have to find examples of HIV stigma; just any form of isolation or rejection for being seen to be different.  Then ask them to share with someone with whom they feel comfortable:

  ■ What happened?

  ■ How did it feel?

  ■ What impact did it have on you?

■ Invite the participants to share their stories in plenary if they would like to – it is not compulsory.

### Facilitator's tips

■ Take as your starting point the assumption that everyone has stigmatised someone else and/or themselves (for a variety of reasons, including those relating to sex and sexuality, HIV, race or gender).

■ Model stigma-free behaviour to participants through open-minded facilitation and by accepting different opinions (in this session and throughout the training).

## 3   Exercise: Our own experience of stigmatising others

🕐 10 minutes

■ Ask participants to sit on their own. Then ask:

  ■ Think about a time in your life when you isolated or rejected someone because they were different. What happened?

  ■ How did you feel?

  ■ What was your attitude? How did you behave?

■ Invite them to write down any thoughts, feelings or words they associate with stigma. Then ask each participant to read their list aloud and write the points on a flip chart.

**4** **Wrap up**

15 minutes

- Explain that everybody has felt ostracised or treated like a minority at different times in their lives. We have all experienced this sense of social exclusion. It is good to remember how that felt when we work with marginalised people, such as those involved with READY.

- Ask:
    - What are the differences between stigma and discrimination?
    - What impact can stigma and discrimination have on access to SRH and HIV services?
    - Can we ever get rid of it completely?

- Finally, ask participants to think of a time when they felt that they truly mattered and were included. What made this experience different from the experience of being stigmatised, marginalised or isolated? Invite a few contributions. What can we learn from this about how we can behave in inclusive, non-stigmatising ways, both as individuals and within our organisation or health facility?

## Key messages

- Stigma and discrimination are different. Stigma is a process of devaluation; discrimination is an action (that can often result from stigma). Stigma can be harder to pinpoint or articulate.

- The attitudes and behaviours that create stigma are often unconscious parts of our daily interactions, based on the social and cultural context we were brought up in. So we are all responsible for stigma.

- A person's HIV status, gender or sexual orientation is only one part of their life. One way to overcome stigma is to challenge ourselves to remember that people are complicated and made up of multiple identities. We need to be open to this if we want to adopt non-judgemental attitudes.

# C4

# CONSENT

## Time
150 minutes

## What
This session explores the concept of consent and the different ways people express and ask for consent.

## Why
Consent is integral to healthy and pleasurable sexual behaviour. It should be informed, uncompromised and freely given on the basis of equality.

## Preparation
- Flip chart and pens

# Facilitator's notes

## Objective

To define consent in the context of relationships and understand how it links to social and gender norms.

**Note:** *It is likely that one or more participants will have experienced some form of non-consensual activity, potentially on going, and may need support. Be ready with information about local services that can help them.*

# Activities

## 1 Let's talk about consent

60 minutes

- Tell the group that we are going to talk about how other people might touch you or talk to you in ways that you do not like. This could be a colleague, an older peer, a man or a woman.

- Tell the group that:
  - No one has a right to touch parts of your body in ways that you do not like.
  - No one has a right to approach you or talk to you in ways that make you feel uncomfortable.
  - Let's find ways to identify unwanted sexual attention and what we can do about it.

- Divide into two groups, either mixed or separated by gender.

- Ask each group to draw a body map: one group draws a feminine figure, the other group draws a masculine figure.

- Ask both groups to mark on the map:
  - Parts of our body (if any) that are OK for anyone to touch.
  - Parts of our body that are OK for certain trusted people to touch. (Who?)
  - Parts of our body that are private, which no one should touch unless we want them to and unless we give our consent for them to do it.
- Ask the group:
  - Why did you mark these parts as private? What does this mean? Did everyone agree? (Emphasise that everyone has the right to decide their own boundaries.)
  - Why do we think that a sense of privacy about our bodies and personal space becomes more important as we grow up?
  - How do we feel when our privacy isn't respected? What are the possible results?
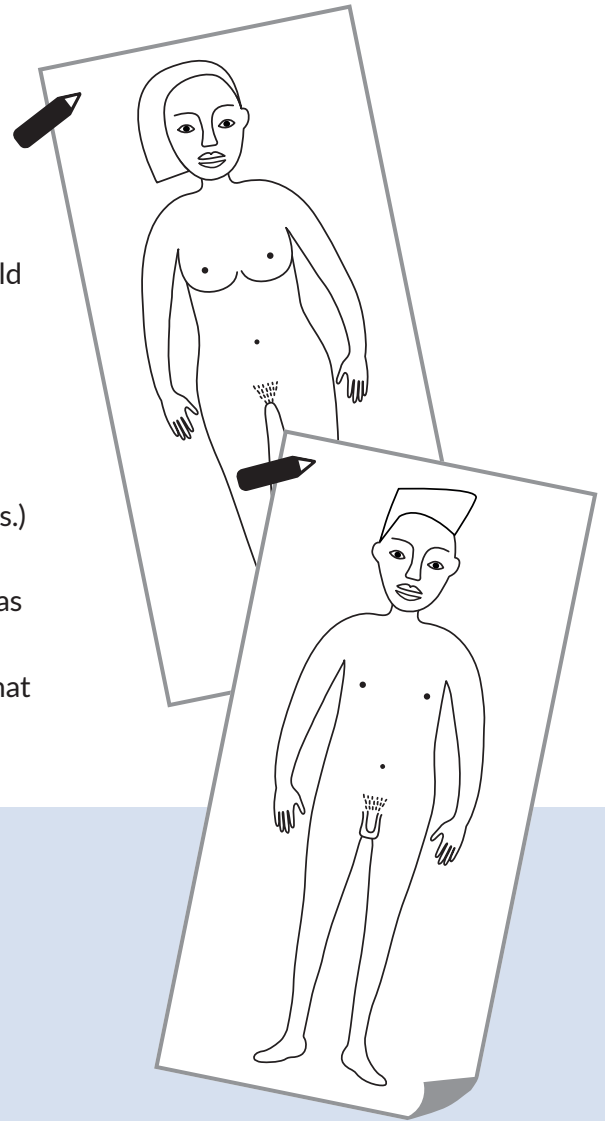
- Write the word 'consent' on a board or a flip chart.
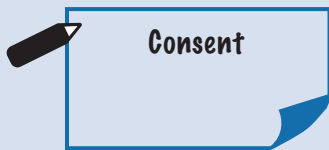
Consent

- Ask the group:
  - What is the first thing that comes to your mind when you hear the word 'consent'?
  - Write some of the answers on the board or flip chart. This activity will give you a sense of what the group already knows about this subject.
  - Present this definition of consent: 'Consent means actively agreeing to engage in romantic or sexual interaction with someone. Consent means letting someone know that their touch, sexual or romantic attention and interactions are wanted.'[1]
  - Go over each key part of this definition and ask the group to explain what it means in their own words. (For example, what does 'actively agreeing' mean? What is 'romantic or sexual interaction'?)

- Talk about the following:
  - Consent is not only for sexual activities. If someone is forcing us to do something we don't want to do (for example, disclose HIV status) we can always say no and ask for help if we don't know how to handle it.
  - Consent is for specific things. Go back to the body maps and make it clear that if someone says it's ok to touch their arm, it doesn't mean they're letting you touch other parts of their body, such as their private parts.
  - Consent can be expressed verbally when the other person says 'yes', but it also shows in their body language and in their enthusiasm.
  - Likewise, non-consent can be expressed both verbally and through body language.
  - An important way to check for consent is by asking, for example, 'Is it ok if I do this? Do you like this? Do you want me to continue?'

1. Adapted from Planned Parenthood, Sexual Consent (accessed May 2020). www.plannedparenthood.org/learn/relationships/sexual-consent.

## 2    What does consent look like anyway?

🕐 90 minutes

■ Tell participants we are going to talk about what consent looks like.

We already know that consent means actively agreeing to participate in romantic or sexual approaches, but how can we know we're offering free and informed consent, and how can we identify when someone is consenting or not to our approaches?

■ To do this, first define some elements of consent.

■ Present the following ideas[2] to the group (you can write them on a flip chart or just discuss them with the group):

**Freely given:**

It's a choice you make without pressure, manipulation, threats, or under the effects of drugs or alcohol.

**Always reversible:**

You can change your mind about what you want to do at any time, even if you've done it before.

**Fully informed:**

Your consent only counts if the information you are basing it on is correct and complete. For example, if someone says they'll use a condom and then they don't there isn't full consent.

**Enthusiastic:**

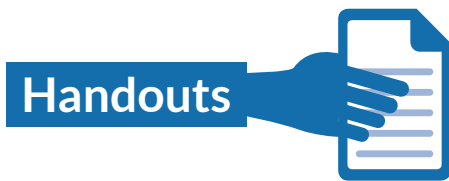This means the people involved are actively enjoying what they're doing such as kissing, holding hands, cuddling or having intercourse.

**Specific:**

It applies only to one thing. If you agree to kiss it doesn't mean you're consenting to have sex, for example.

2. Adapted from Planned Parenthood, Sexual Consent (accessed May 2020). www.plannedparenthood.org/learn/relationships/ sexual-consent.

■ Divide into five groups. Give each group one of the following scenarios and ask them to prepare a short role-play representing the situation.

**Handouts**

**Scenario A:**
Two young people have been seeing each other after school for some weeks now. They are getting to know each other slowly. One asks, "May I kiss you?" and the other says yes.

**Scenario B:**
A couple have been together for a few months and are sexually active. One does not feel like having sex that night and the other complains, "You don't love me!" The first person feels guilty and says yes to sex.

**Scenario C:**
A girl is 15 and she's dating a man who is 28. He is married but she doesn't know this. He always buys her presents and sometimes gives her money. Although she wants to spend more time with her friends, she's afraid he will get upset with her if she doesn't meet him when he wants to.

**Scenario D:**
A boy is 16 and has been living with HIV for a year. He hasn't told his parents because he's afraid of their reaction, but he has told his older brother and asked him to keep it a secret. One day his older brother tells their mother.

**Scenario E:**
Two young people are at a party and they've both had a lot to drink. One starts kissing the other, who is not responsive and seems to be feeling dizzy. The first person keeps touching and caressing the other without permission.

■ After each presentation, ask the following:
   ■ How are the characters feeling?
   ■ Is this an example of free and informed consent? Yes? No? How do we know?
■ After all the presentations are finished, ask the participants:
   ■ Why do you think consent is important?
   ■ What can we do to promote healthy relationships and consent?
■ Try to promote a space where everyone can feel safe expressing their own opinions about the subject.
■ Close the session by reminding the group that there are different elements to consent. Ask participants if they can name them.

# Key messages

**If your participants are working with younger adolescents, make sure to emphasise the following:**

- Unwanted sexual attention is a form of violence and it needs to be stopped. Sex without consent is rape.

- Younger adolescents' need for privacy in places, such as school and community groups, increases as they grow up and develop.

- Communicating assertively helps to maintain privacy and counter unwanted sexual attention and is key to keeping us safe. However, sometimes we can't act on this because we're in violent or abusive relationships. In these cases, it's essential to ask for help from trusted adults.

- For younger adolescents, it's always useful to highlight a message of respect for our own and other people's bodies and personal space. Even when working with parents and caregivers, it's important to mention they should not oblige their children to hug or kiss other older people.

- Different countries have different legal ages of consent for sexual activity. Sex between a person above the age of consent and someone below the age of consent may be considered rape in the eyes of the law, regardless of whether the younger individual consented or not.

- There are other scenarios where it is not possible for a person to give their consent, for example, if they are unconscious, very drunk, drugged or asleep.

## Key messages

**If your participants are working with older adolescents and young people, who may already be sexually active, raise the following discussion points:**

- Everyone, regardless of their gender or age, has the right to privacy and to the safety of their own body.

- Everyone has the right to be aware and in control of their sexual and romantic boundaries, and to decide what they're actively willing to engage with and under what circumstances.

- Consent is not only about assertively expressing what we ourselves are willing and able to do, it is also about paying attention to the other person's needs, body language and messages.

- Consent is part of healthy and pleasurable sexual behaviour with a partner. However, things such as alcohol and drugs, intimate partner violence, poverty, disability and power dynamics (e.g. older partners; the offer of money or expensive gifts) can affect our ability to give genuine consent on the basis of equality.

- Consent is influenced by social and gender norms, for example, the expectation that women and girls should always accept sexual or physical advances, or that men should always be the ones to initiate sexual or physical advances and should not take 'No' for an answer. These norms may make it difficult for people to recognise gender-based violence or intimate partner violence and to seek appropriate support, whether perpetrators or victims/survivors.

- Transforming social and gender norms involves working with men and boys, as well as women and girls, to understand and respond to gender inequality and power imbalances.

- Consent is not only about sexual or romantic touch or contact or agreeing to do certain activities. For young people living with HIV, it is also about having the right to give or withhold consent for their HIV status to be shared with others.

## Talking points

**The list below is adapted from 'The Importance of Sexual Consent' by Rights For Education:**[3]

- Sexual consent means an explicit agreement between people to have sex or take part in sexual or romantic activity. This means that, more than the absence of a 'no', it is the presence of an enthusiastic 'yes!'

- Subtle forms of pressure that lead to sex, such as emotional blackmail or bribery with gifts or favours, do not equal consent.

- Consent is not only for people who are dating. Even if they're in a long-term, committed relationship there should be an agreement between partners to engage in sexual activity.

- Without sexual consent, sex becomes sexual violence.

- Both women and men have the right to refuse sex whenever they want, as well as the right to engage in sexual activity if they want, as long as the other person consents.

- Sexual violence is a negative and traumatic experience that can have long-term physical and psychological consequences.

3. Accessed May 2020.
www.rightforeducation.org/2016/04/the-importance-of-sexual-consent/.
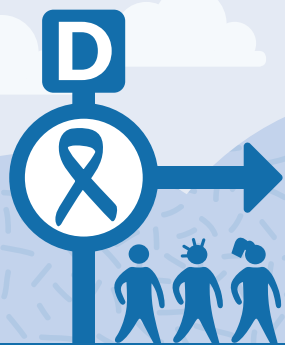
# SRHR AND HIV

## SESSIONS IN THIS MODULE

| SESSION TITLE | TIME | PAGE |
|---|---|---|
| D1: Know your epidemic | 30 minutes | 62 |
| D2: Integration of SRHR and HIV | 45 minutes | 63 |
| D3: Human rights and sexual and reproductive rights | 100 minutes | 67 |
| D4: Entry points to SRHR and HIV integration | 90 minutes | 71 |
| D5: Unplanned pregnancy | 60 minutes | 74 |
| D6: Role play on SRHR and HIV integration | 60 minutes | 78 |

# D1
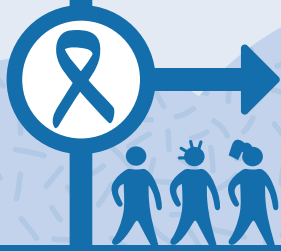
# KNOW YOUR EPIDEMIC

### Time
30 minutes

### What
A session that encourages participants to understand the HIV epidemic in their country and consider the links between HIV and SRHR needs and rates of infection.

### Why
Before moving on to discussing integration of HIV and SRHR, it helps to focus on your own context. It can highlight differences of opinion that will need to be addressed.

### Preparation
- Flip chart, paper and pens

### Resources
UNAIDS (2019), UNAIDS Data 2019 www.unaids.org/sites/default/files/media_asset/2019-UNAIDS-data_en.pdf

UNAIDS (2018), Knowledge is Power: Know your status, know your viral load www.unaids.org/sites/default/files/media_asset/jc2940_knowledge-is-power-report_en.pdf

## Facilitator's notes

### Objective

To increase our understanding of the HIV epidemic and general SRH situation in our country, based on the 'Know Your Epidemic' strategy.

## Activities

### 1 Know your epidemic

30 minutes

- Explain why the root causes of HIV and sexual and reproductive ill health are similar. Emphasise why it matters to address both in an integrated way.
- Brainstorm the following questions with the group and write up their responses on a flip chart:
  - What are the main factors contributing to the HIV epidemic in this country?
  - Are these similar to other SRHR issues, such as unintended pregnancies, gender-based violence, sexually transmitted infections (STIs)?
  - What other factors may be contributing (e.g. violence)?
  - Are specific groups of people more vulnerable to SRHR challenges in this country? Which groups?
  - Who gets the attention of your programmers?
  - What is the impact of HIV and SRHR on young people?
  - Why should we work with young people in all their diversity?
- Wrap up by explaining that certain people are more affected by HIV as well as being essential partners in an effective response. For example, men who have sex with men are at greater risk of HIV through having unprotected anal or oral sex. They are more vulnerable due to the criminalisation of same-sex behaviour and lack of access to user-friendly services. Similarly, young people who use drugs are at greater risk of HIV through sharing injecting equipment and their drug use may be taboo or criminalised. Services that just focus on harm reduction in relation to HIV may not address their other SRH issues.
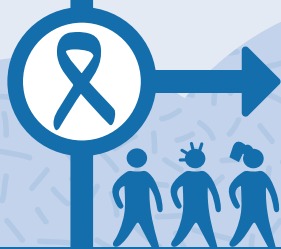
# INTEGRATION OF SRHR AND HIV

## Time
45 minutes

## What
This session makes sure that participants understand what 'integration' means in terms of a comprehensive, 'joined-up' approach to HIV and SRHR policy, programming and service delivery.

## Why
It is essential that participants understand how to programme HIV and SRH interventions in an integrated way.

## Preparation
- Handout 1
- Handout 2
- Flip chart paper and pens

## Resources
Frontline AIDS (2010), Good Practice Guide: Integration of HIV and sexual and reproductive health and rights www.frontlineaids.org/resources/good-practice-guide-hiv-and-sexual-and-reproductive-health/

Guttmacher–Lancet Commission (2018), 'Accelerate Progress – Sexual and Reproductive Health and Rights for All', Lancet, 391: 2642–92 www.thelancet.com/commissions/sexual-and-reproductive-health-and-rights

Integration Initiatives www.integrainitiative.org

Inter-Agency Working Group on SRH and HIV Linkages (2018), SRH & HIV Linkages Resource Pack www.srhhivlinkages.org

# Facilitator's notes

## Objective

To define 'integration', describe advantages and challenges of integrating SRHR and HIV programmes, and introduce key principles.

# Activities

## 1 Exercise: Integration and linkages

20 minutes

- Break into three groups, giving each an empty Venn diagram on a flip chart consisting of two circles overlapping in the centre.
- Assign each group a different kind of service delivery point.
- These could be a government health service provider, a private service provider or an NGO service provider. Ask them to discuss and write in the empty diagram which services are provided in an SRH clinic and which are provided in an HIV clinic. Then ask them to write in the overlapping area the services that can be provided in both.

SRH services    HIV services

Services provided by both
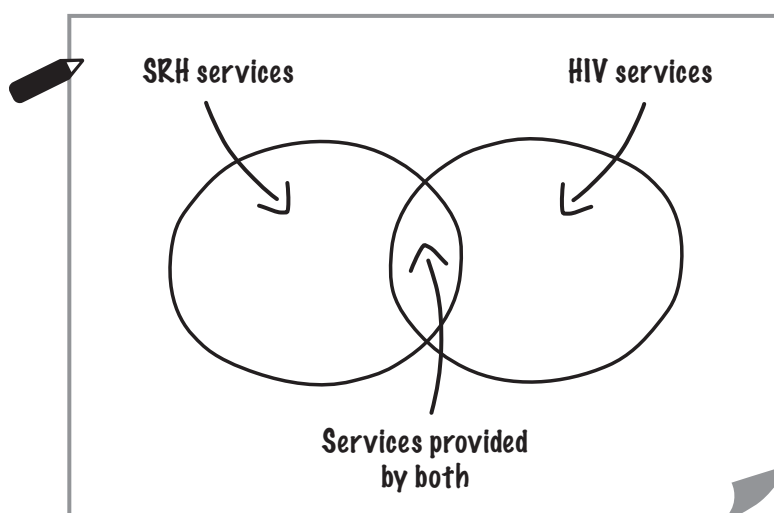
- Display the flip charts on a wall and discuss them together, comparing the service delivery points. Summarise the areas of integration and point out the linkages with other services that need to be made by referral. Examples could be care and support, income generation, a violence shelter, legal support.

- Refer to the Interventions Package in Handout 1.
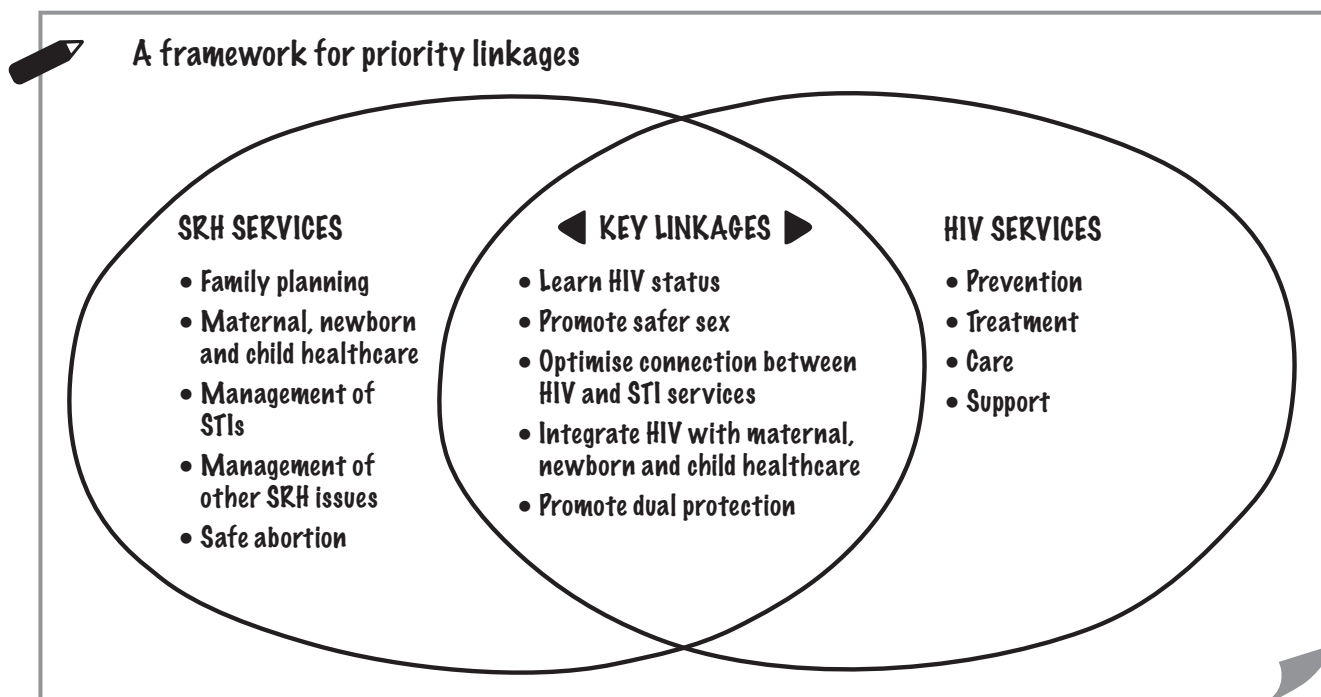
## A framework for priority linkages

### SRH SERVICES
- Family planning
- Maternal, newborn and child healthcare
- Management of STIs
- Management of other SRH issues
- Safe abortion

### ◀ KEY LINKAGES ▶
- Learn HIV status
- Promote safer sex
- Optimise connection between HIV and STI services
- Integrate HIV with maternal, newborn and child healthcare
- Promote dual protection

### HIV SERVICES
- Prevention
- Treatment
- Care
- Support

Source: Adapted from WHO (2005), Sexual and reproductive health and HIV/AIDS: a framework for priority linkages.

## 2 A framework for priority linkages

🕐 5 minutes

- Give participants Handout 1, highlighting anything not already covered in the first exercise above.

## 3 Group discussion: Integration

🕐 20 minutes

- In the three groups, ask participants to brainstorm (for 10 minutes) advantages and challenges to integration for:
  - Clients/young key populations (Group 1)
  - Healthcare providers/clinics (Group 2)
  - Health policymakers, such as the ministry of health or education (Group 3)
- Using the group responses, discuss (for 10 minutes) the rationale for integrating SRHR and HIV services. You can include any of the talking points below. Also provide examples of how integration works in different settings, including where integration is already happening. Explain that it is not a one-model-fits-all approach, and emphasise client-centredness.

# Talking points

**Programme evaluations have shown that integrated SRHR and HIV interventions improve access, increase uptake, and provide better care and increased efficiency (time and resources). More details can be found in the Good Practice Guide: Integration of HIV and sexual and reproductive health and rights (see Resources). However, integration can have its challenges too. Potentially, it can (or can be perceived to) overburden services and facilities, and can be a drain on already limited resources unless carefully planned and budgeted for. Staff may also need additional support and training.**

- Both SRHR and HIV mainly serve reproductive-age populations.

- Sexual and reproductive ill health and HIV share root causes, including poverty, harmful gender norms and inequality, cultural norms, and social marginalisation.

- Both SRHR and HIV interventions have common desired outcomes, such as improved quality of life, gender equality and a reduction in maternal, newborn and child mortality.

- Both SRHR and HIV interventions rely on community participation to address sensitive sexuality issues and sociocultural determinants of behaviour change.

- Most HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding.

- The risk of HIV transmission and acquisition can be increased by the presence of certain STIs.

- Both SRHR and HIV interventions are interested in addressing vulnerability, focus on behaviour change, and use similar behaviour change communication channels.

- In resource-poor settings, both SRH and HIV services are typically offered through decentralised public health services. However, due to feared and actual stigma and discrimination, many key populations tend to access healthcare provided by non-government organisations and trusted private healthcare providers.

# Integrated definition of SRHR[4]

Sexual and reproductive health is a state of physical, emotional, mental, and social well-being in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. Therefore, a positive approach to sexuality and reproduction should recognise the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall well-being. All individuals have a right to make decisions governing their bodies and to access services that support that right. Achievement of sexual and reproductive health relies on the realisation of sexual and reproductive rights, which are based on the human rights of all individuals to:

- Have their bodily integrity, privacy, and personal autonomy respected

- Freely define their own sexuality, including sexual orientation and gender identity and expression

- Decide whether and when to be sexually active

- Choose their sexual partners

- Have safe and pleasurable sexual experiences

- Decide whether, when, and whom to marry

- Decide whether, when, and by what means to have a child or children, and how many children to have

- Have access over their lifetimes to the information, resources, services, and support necessary to achieve all the above, free from discrimination, coercion, exploitation, and violence

Essential sexual and reproductive health services must meet public health and human rights standards, including the Availability, Accessibility, Acceptability, and Quality Framework of the right to health. The services should include:

- Accurate information and counselling on sexual and reproductive health, including evidence-based, comprehensive sexuality education

- Information, counselling, and care related to sexual function and satisfaction

- Prevention, detection, and management of sexual and gender-based violence and coercion

- A choice of safe and effective contraceptive methods

- Safe and effective antenatal, childbirth, and postnatal care

- Safe and effective abortion services and care

- Prevention, management, and treatment of infertility

- Prevention, detection, and treatment of sexually transmitted infections, including HIV, and of reproductive tract infections

- Prevention, detection, and treatment of reproductive cancers

4. From 'Accelerate Progress – Sexual and Reproductive Health and Rights for All: Report of the Guttmacher–Lancet Commission', Lancet, 391: 2642–92. https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736%2818%2930293-9.pdf
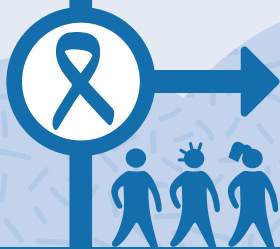
# HUMAN RIGHTS AND SEXUAL AND REPRODUCTIVE RIGHTS

## Time
100 minutes

## What
This session explores a rights-based approach to HIV and SRH programming, and participants' knowledge of, and attitudes towards, human rights and sexual and reproductive rights.

## Why
When we work with young key populations, it is important to understand and respect the human rights and international laws that are in place to protect them.

## Preparation
- Exclaim! poster (see Handout 3)

## Resources
Frontline AIDS (2010), Good Practice Guide: Integration of HIV and sexual and reproductive health and rights www.frontlineaids.org/resources/good-practice-guide-hiv-and-sexual-and-reproductive-health/

IPPF (2008), Sexual rights: an IPPF declaration www.ippf.org/resource/sexual-rights-ippf-declaration

IPPF (2011), Exclaim! Young people's guide to 'Sexual rights: an IPPF declaration' www.ippf.org/resource/exclaim-young-peoples-guide-sexual-rights-ippf-declaration

UNDP (2013), Practical manual: Legal environment assessment for HIV www.undp.org/content/undp/en/home/librarypage/hiv-aids/practical-manual--legal-environment-assessment-for-hiv--an-opera.html

# Facilitator's notes

## Objective

To define human rights and sexual and reproductive rights.

# Activities

## 1 An overview of human rights and sexual and reproductive rights

20 minutes

- Ask participants some open-ended questions to find out how much they already know about human rights and sexual and reproductive rights. For example, ask:
  - What does the idea of human rights mean to you?
  - Can you name or describe a human right?
  - Has anyone studied human rights previously?

This will help you to pitch your introduction to human rights at an appropriate level. If it is a new subject for participants, go into more detail. But if it is familiar to most people, cover the background quickly and move on.

- Then explain the following four principles of human rights (refer to the resources listed to help you):
  1. **Universal:** Human rights are applicable everywhere and at all times.
  2. **Interdependent and interrelated:** All rights are connected. For example, the right to education is linked to the right to health, and vice versa.
  3. **Accountability:** Countries and individuals have a responsibility to promote and respect human rights and to report violations.
  4. **Indivisible:** All rights must be fulfilled with the exemption of none.

- Issues relating to HIV and key populations cut across many human rights. HIV is often framed within the context of the human right to health. The accurate language is the 'human right to the highest attainable level of health', where health is defined as not only the absence of disease but also a complete state of physical and mental well-being (as noted in the founding constitution of the World Health Organization in 1946).

- The information in this session can feel boring and people may have different levels of interest in the detail. You don't want to lose their attention. Make sure that you illustrate the points with real-life examples to show how the topic is relevant to participants.

## 2 Sexual and reproductive rights

🕐 5 minutes

- Using the Exclaim! poster in Handout 3, introduce the sexual and reproductive rights of young people and talk through the ten sexual rights from the *IPPF Declaration on Sexual Rights* on Handout 2.

## Key messages

- Governments have three levels of obligation: to respect, protect and fulfil human rights (civil and political, and economic, social and cultural rights).

- Given the resource and knowledge restraints faced by many countries, the International Covenant on Economic, Social, and Cultural Rights recognises that the fulfilment of economic and social rights can only be achieved over time, and calls for the progressive realisation of rights. Progressive realisation of rights means that there will be continual progress on the status of these rights. It does not mean that governments can wait until a certain level of economic development is reached before they have obligations in terms of the rights of their citizens.

## 3 Exercise: Working with case studies

**60 minutes**

- Break into five groups and ask participants to discuss one case study each on the next page and answer the questions in their group (30 minutes).

- In plenary (whole group discussion), ask:

  - Briefly (3–4 minutes for each group) summarise your case study and responses to the questions (3 - 4 minutes for each group, 20 minutes in total).

- Explain that it is often easier to understand rights by looking at violations.

Then ask the whole group:

- Are the situations in the case studies familiar to you?

- Do you have an example of how your project has addressed (or could address) sexual rights issues through policies and activities? (10 minutes)

- Ask if anyone has any thoughts or concerns about how their programme delivery would be affected by any of the issues suggested by the case studies.

## 4 Conclusion

**15 minutes**

- Remind participants that in order to effectively address young people's SRHR, it is important to think about their own values and the rights of other people whose lives and lifestyles may be different to their own. (This may have already come up in the discussion.)

- Explain that emotional factors and perceived injustices are often the factors that motivate older adults who work with young people and advocate on their behalf. Explain that clarifying a concept, such as human rights, is a step towards social change because it challenges social, cultural and religious norms, beliefs and expectations. If these are not interrogated, the needs and rights of young people, especially those from key populations, will be ignored, neglected and violated.

- Emphasise the importance of understanding the concepts of access to justice – including barriers, challenges and opportunities – and legal literacy in relation to young people's human rights. Depending on the local/national context, you can publicise any existing support platforms that provide help when rights are violated.

## Key messages

- Sexual and reproductive rights are human rights.

- If those who are most vulnerable, such as young key populations, are not aware of their human rights, they cannot take appropriate steps to access them and reduce negative health outcomes, such as HIV infections and unsafe abortions.

- Community activists, service providers and policy-makers play a significant role in ensuring that young key populations are aware of their human rights and are able to access services.

- People can demand and claim the realisation of their human rights. Governments have an obligation to protect, respect and fulfil human rights for all.

# Handouts

**Case Study 1**

A couple who are both 15 years old would like to have sex but do not know about contraception or where to get advice. They are too afraid to discuss it with anyone.

**Discussion**

- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

**Case Study 2**

A young girl who is living with HIV is told by a service provider that she should not have sex or attend school.

**Discussion**

- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

**Case Study 3**

A young sex worker has no information about where to find safe abortion services. She visits a 'doctor' who performs an illegal and unsafe abortion. She suffers a severe haemorrhage and dies.

**Discussion**

- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

**Case Study 4**

A young boy cannot go to the local clinic to get tested for HIV because he fears that people he knows might see him and that the nurse might tell his parents.

**Discussion**

- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

**Case Study 5**

A young girl is denied contraceptive services because she is not married.

**Discussion**

- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

# D4
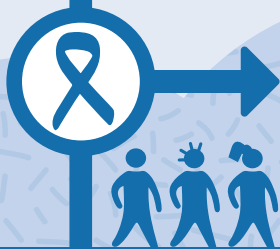
# ENTRY POINTS TO SRHR AND HIV INTEGRATION

## Time
90 minutes

## What
This session explores family planning and contraceptive methods and the opportunities for broader SRHR and HIV integration in group work.

## Why
This could be a new area for any participants who have mainly worked within HIV programming. The session demonstrates the variety of family planning methods available and their benefits. You can model a rights-based approach to contraception and the right to choose if, when, and how many children to have.

## Preparation
- Flip chart paper and pens
- Handout 7

## Facilitator's notes

### Objective

To provide an overview of family planning methods and interventions and opportunities for SRHR and HIV integration, including a rights-based approach.

## Activities

### 1 Overview of family planning

60 minutes

- Provide participants with an overview of contraceptive methods, emphasising the importance of thinking of clients as individuals with multiple needs and providing them with a choice of methods.
- Explain that service providers need to enable clients to assess their own risks and understand the concept of dual protection.

**2** **Group work**

🕐 30 minutes

■ Break into five groups and provide each of them with one of the scenarios below. They all depict a young person from a key population group who comes to a clinic for a certain service. Ask the groups to list what other services this person might need.

■ Discuss participants' responses to the scenarios in a plenary. Then return to the groups and ask participants to refer to Handout 7. Ask them to choose the 'best' contraceptive option for the client, giving their reasons, as well as the second- and third-best options eligible to them. Discuss these responses in a plenary.

■ The detail in the case studies, such as status and number of children, is important to the discussions. The emphasis of the feedback should be on eligibility, client choice and dual protection.

---

**Scenarios**

■ A 16-year-old sex worker comes in for a sexually transmitted infection (STI) check-up.

■ A 22-year-old garment factory or migrant worker comes in for an abortion.

■ A 14-year-old boy comes in with an anal fissure.

■ A 24-year-old woman with three children keeps coming in for contraception but still experiences unintended pregnancies.

■ A 17-year-old university student who uses drugs comes in for an HIV test.

---

## Talking points

**Challenges of dual protection:**

■ It can be difficult to know if your partner is HIV negative due to a lack of youth-friendly HIV counselling and testing services, or their reluctance to take a test or disclose their status due to fear of stigma and discrimination.

■ Delaying or abstaining from sex can be particularly challenging for young people who wish to explore their sexuality and experience sexual relationships.

■ In a long-term relationship, using condoms with an additional contraceptive method can be seen as a sign of infidelity or lack of trust in your partner.

■ Although using condoms, or using condoms plus another contraceptive method, is the most robust guidance to give during individual safer sex counselling, it is important to explore the multiple barriers and risks involved.

## Talking points

**Community role in family planning and HIV:**

- Discuss rights and fertility intentions with everyone, and the rights component of SRHR.

- Include messages around family planning and dual protection in community awareness-raising and information, education and communication materials.

- Promote condoms and other non-clinical contraceptives as part of outreach and home visits (community-based distribution).

- Make referrals to clinics for clinical contraceptive methods (injectables, implants, intrauterine devices/IUDs, sterilisation).

- Provide information on reduced efficacy of some contraceptives if taking tuberculosis treatment, antiretrovirals and methadone.

- Advocate for key population-friendly family planning services, and document cases of denied access or coercive treatment.

## Key messages

- Family planning is important in preventing unintended pregnancies and enabling couples to choose if, how many, and when to have children.

- The more choices available in a country, the higher the rate of contraception use there.

- Unless service providers ask the right questions, they will not know the extent of the health service needs of the client.

- People's contraceptive choices and ability to use condoms are influenced by issues related to social and cultural practice, gender relations and family life.

- Dual protection means preventing unintended pregnancy and STIs (including HIV). It is part of the first and second prongs in comprehensive vertical transmission prevention (see Handout 7).

- Interventions include using male or female condoms:

  - Correctly and consistently in every sexual encounter

  - Plus an additional modern contraceptive.

- Most HIV infections occur in regions where there are high fertility and HIV prevalence rates among women, especially in sub-Saharan Africa.

# D5
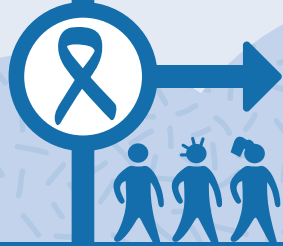
# UNPLANNED PREGNANCY

## Time
60 minutes

## What
This session explores the options for young people facing an unplanned pregnancy in the local context.

## Why
Young people need to have accurate information about all the choices that are available to them in their local context.

## Resources
Frontline AIDS(2018) Ungagging abortion: Safe abortion in the context of HIV
www.frontlineaids.org/resources/ungagging-abortion-safe-abortion-in-the-context-of-hiv/.

IPPF (2015) How to talk about abortion: A guide to rights-based messaging. www.ippf.org/sites/default/files/ippf_abortion_messaging_guide_web.pdf

## Facilitator's notes

### Objective

To provide information about the choices young people have if they are facing an unplanned pregnancy, to think about the advantages and disadvantages of these choices, and learn how to reduce the negative impacts of teenage pregnancy for young women and men. This session will also identify community-support resources that can help young people in dealing with an unplanned pregnancy.

## Activities

### 1  Drama

60 minutes

- Divide into four single-sex groups. Ask each group to act a short role-play to show a situation where someone like them has an unplanned pregnancy or gets a young woman pregnant. Try to make up different situations.

**Discussion points:**

- What choices do the young man and woman and the families have now? What support do they need? Where can they find it?

  - Get into four single-sex groups and give two groups the title 'abortion' and two groups the title 'continue the pregnancy'.

  - Ask one group with each title to prepare a role-play to show the choice working out well and the other groups to show it working out badly.

  - Perform the role-plays. Perform the good and bad role-plays for one choice first and discuss them. Then perform the other choice and discuss.

- Ask the group:
    - What are the good and bad points about this choice?
    - If a person makes this choice, what can everyone do to make sure that it works out as well as possible?
    - What have people learned from the session?
- Summarise the main learning points. For example, if abortion is the choice, the young woman, man and families would have to find enough money to get a safe abortion. Proper post-abortion care is also extremely important. If the girl has the baby, she should be able to go back to school, the father of the baby and their families should be able to support the girl and raise her self-esteem.

## Key messages

- The choices for coping with unplanned pregnancy are to:
    - End the pregnancy by having an abortion
    - Have the baby and look after it
    - Give the baby to a relative to take care of
    - Give up the baby for adoption

**These options will depend on local laws, norms and practices.**

- Young women and men facing unplanned pregnancies need to think carefully about the advantages and disadvantages of these choices from the point of view of their own lives, health and future, and those of the baby and their own values.

- Many girls and women would not seek an abortion if they were better supported by their family, health workers and communities. This includes:
    - Having trusted relatives or friends to talk with about their pregnancy
    - Having information, services and supportive environments for young people to help them to make good choices about their sexual life
    - A reduction in stigma and discrimination against pregnant girls
    - Opportunities to return to school after delivery or to find work

*Note: This is a sensitive topic, but young people need to have accurate information about abortion and about the choices that are available to them in their local context.*

# Key messages

## Abortion

- People may feel very strongly about abortion, based on their religion or personal values. However, women will find ways to end a pregnancy even if they cannot do it safely and legally. Globally, many girls and women die or are injured every year because of unsafe abortion.

- Women use different methods to cause unsafe abortion, including drugs, herbs, and objects inserted into the mouth of the womb. These methods are ineffective and/or dangerous and may cause death, infertility or serious injury.

- Whether an abortion has been legal or illegal, safe or unsafe, post-abortion care is essential. Young women should go to a health worker at once if they have continuous bleeding, smelly liquid coming out of their vagina, pain in their lower belly, fever or shaking after an abortion. They may need further treatment, counselling and information on sexual and reproductive health and contraception.

- In some countries, women can have a legal abortion if continuing with the pregnancy will harm the mental or physical health of the woman or child. This usually requires doctors to give permission. The abortion is safe if done by a qualified practitioner in a health facility.

- We must acknowledge that abortion happens, and when it happens unsafely it has significant harmful consequences for the individual girl or woman involved and for public health generally.

- To destigmatise abortion it is important to provide accurate information about the circumstances (if any) under which access to safe abortion services is legal in the country. This requires us to understand both the legal and cultural context in which we are carrying out this training. Bringing in local expertise from organisations like IPPF or Ipas, or from the Ministry of Health as appropriate, is often the best way to deal with these issues in a locally-acceptable way.

- Post-abortion care is legally obtainable, regardless of whether a woman has miscarried spontaneously or had an abortion legally or illegally. We need to help participants understand why it is an essential life-saving service, where it is available, and to destigmatise this.

# Key messages

### Having a baby

- Pregnant young women may decide to have the baby. If the couple love each other, they may decide to stay together or to get married. If not, the father should still support the young woman and the child (note: the father may not be a young man; and the woman may not be his partner).

- Counsellors, peer educators and parents/caregivers can help young people to see that it is not the end of the world to have an unplanned child, although it may be difficult at first.

- Young women who become pregnant when they are still at school should be encouraged to continue with their schooling.

- Encourage the young woman's parents and the baby's father to care for her; ensure she has loose clothing, good food and not too much work.

- Help her to attend the antenatal clinic to keep herself and the baby healthy.

- Support her to access HIV treatment, including prevention of vertical transmission services if she is living with HIV.

- Help her to deliver her baby in a health centre or hospital in case there are any problems, for example, obstructed labour.

- Help her to care for herself and her baby after the birth.

- Suggest positive choices and try to build her self-esteem. Do not blame her.

# D6
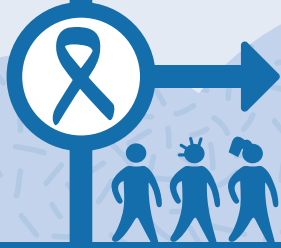
# ROLE PLAY ON SRHR AND HIV INTEGRATION

## Time
60 minutes

## What
This session enables participants to use role play to demonstrate what they have learnt about approaches to sexuality and SRHR and HIV integration through role play.

## Why
The role plays help to consolidate learning and move it on to more practical applications.

## Preparation
- A small stage at the front of the room for the performances
- Chocolate, or some other 'award' or Oscar, for the best performance!

## Resources
Frontline AIDS (2010), Good Practice Guide: Integration of HIV and sexual and reproductive health and rights
www.frontlineaids.org/resources/good-practice-guide-hiv-and-sexual-and-reproductive-health/

## Facilitator's notes

### Objective

To reinforce learning about positive and negative approaches to sexuality and to use role plays to understand how entry points to integration play out practically.

## Activities

### 1 Role play

15 minutes

- Break into six groups, ideally with four to five participants in each group. Present one of the three scenarios on p.80 to two groups at a time, asking one of the pair to take a positive approach and the other to take a negative approach.

- Explain that the groups have 10 minutes to prepare for their performance, and that each performance should take 3 to 5 minutes (30 minutes in total).

### 2 Performances and debrief

45 minutes

- After the performances, take a vote for the best individual actor to receive an 'Oscar'.

- Conduct a short debrief to draw out:

    - Entry points for integrated services/referrals

    - Quality of services provided

    - Attitudes of providers, including the receptionist, or other aspects of the environment if that has been included in the performances

- Finally, present an award (or Oscar!) for the best group performance.

## Key messages

- Reinforce that any SRHR concern can be framed either positively or negatively. Sometimes an individual may experience both positive and negative attitudes from different service providers during any one visit to a clinic; for example, a judgemental receptionist and empathetic provider.

- Remind participants of the importance of listening to young people and appreciating them as whole people with multiple needs.

- Positive or negative SRHR messages can come from many different people:
  - Service providers and other clinic staff in their attitudes towards clients and their SRHR concerns
  - Clients themselves in their own attitudes towards the situations they face (for example, internalised stigma)
  - Communities surrounding the clinic (for example, protestors outside a clinic providing safe abortion services)
  - Families and friends of clients

# Handouts

**Scenario 1**
A young woman, aged 19, who sells sex is brought into a clinic by her friend to see a healthcare provider because she was raped the night before.

**Discussion**
Points could include the range of services offered, such as post-rape care, counselling, HIV counselling and testing, post-exposure prophylaxis and emergency contraception. They could also include the provider's attitude in terms of empathy or stigma relating to the woman's age and the fact she engages in sex work as a source of employment. Ask what other services could be offered and how they should be provided in the context of violence.

**Scenario 2**
A young man, aged 15, comes to a clinic asking for condoms.

**Discussion**
Points could include the range of services offered, such as condoms and other contraceptive methods, and counselling about relationships, delaying sex, intimacy, and choosing partners. They could also include the provider's attitude to the young man's sexuality in terms of age of consent, stigma and so on.

**Scenario 3**
A young woman living with HIV, aged 22, who is three months pregnant, attends a clinic for her antenatal screening.

**Discussion**
Points could include choices about antenatal care, and a range of services, such as vertical transmission counselling, family planning, adherence to antiretroviral therapy and treatment literacy. They could also include the provider's attitude on the right of a young woman living with HIV to have children.
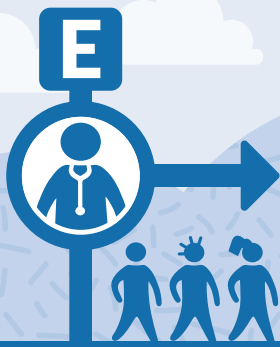
# SERVICE DELIVERY

## SESSIONS IN THIS MODULE

| SESSION TITLE | TIME | PAGE |
|---|---|---|
| E1: A sex-positive approach to services | 25 minutes | 82 |
| E2: Service delivery role play | 40 minutes | 84 |
| E3: Site visit | 1 day | 87 |
| E4: Solutions and strategies | 45 minutes | 90 |
| E5: Sources of technical assistance | 30 minutes | 92 |

# A SEX-POSITIVE APPROACH TO SERVICES

**Time**
25 minutes

**What**
This session explores what sexuality means to participants, and the impact of negative and positive approaches to sexuality on adolescent sexual health services.

**Why**
Understanding the language we use to deliver sexual health information messages helps us to deliver effective and meaningful SRHR services and campaigns. Our opinions and attitudes can have a profound effect on service and programme outcomes.

**Resources**
Frontline AIDS (2019), Sexuality and Life-Skills Toolkit
www.frontlineaids.org/resources/sexuality-and-life-skills-toolkit/

## Facilitator's notes

### Objective

To describe and understand a positive approach to sexuality.

## Activities

**1** **Exercise: Positive and negative approaches to sexuality**

25 minutes

■ In a group, ask participants to brainstorm all the reasons why people have sex. Some suggestions could be:

Pleasure and fun

Reproduction

Cultural duty

Intimacy

Expected gender roles
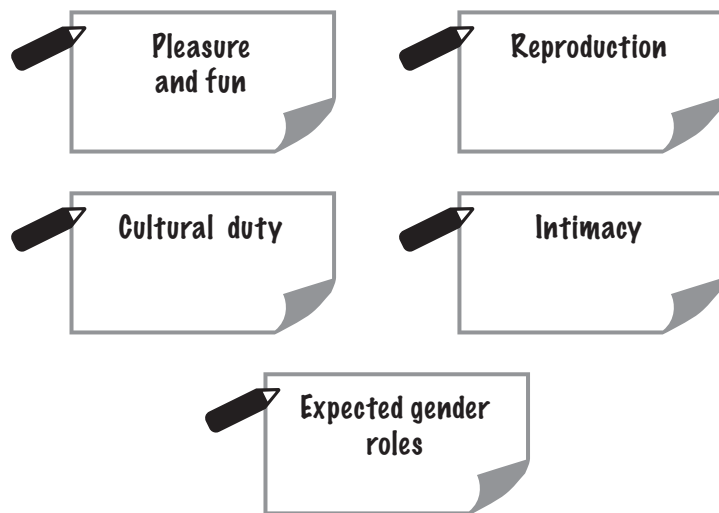
Make sure that pleasure and fun are included in the list. Did anyone mention STIs or HIV on the list? These aspects of health and prevention aren't among the reasons why people have sex, and yet they are often the only aspect of sex that is addressed in messaging and education about sexuality.

- Then ask participants to use this list to help them think about different approaches to talking about sex, health and sexuality. Emphasise the impact that a particular approach can have on the motivation of young people to learn about and discuss sexuality. For example, ask:

  - How do young people respond when a teacher, peer educator, or health service provider says that having sex before marriage is very bad, or that it is very risky and unhealthy because it can cause HIV or unwanted pregnancy?

- Explain that a negative approach is one that is judgemental in that it defines sexuality as being about 'good' sex and 'bad' sex and, linked to that, defines individuals as 'good' people or 'bad' people. A negative approach does not have respect for others and their culture or encourage personal opinions. Young people do not get complete information and are afraid to ask questions.

- If there is time, ask participants to develop a positive and a negative message about the same topic to make sure they have properly understood the difference between the two approaches. Some suggestions for topics are:

  - Sex before marriage

  - Using a condom

  - Prevention of vertical transmission of HIV

## Key messages

- Any SRHR topic can be framed in a positive or negative way. For example, we now take a positive approach to 'people living with HIV' compared to the negative messaging in the 1980s and 1990s of 'people dying from AIDS'.

- Approaching sexuality and related topics positively might conflict with what you personally believe and feel. It is important that you leave your personal ideas behind and give open, honest and complete answers to young people.

- If your personal feelings are getting in the way of your work, it is only professional to be aware of your limitations in communicating with young people. If you can, find ways to overcome these.

- If it is difficult for you to do your work because of your personal feelings, it is better to ask to work with another group or on another topic. Your personal feelings or attitudes might be inappropriately influencing the information you are giving. From a rights-based perspective, everyone is entitled to receive information to enable them to make their own informed decisions about sexuality.

# E2

# SERVICE DELIVERY ROLE PLAY

## Time
40 minutes

## What
This session enables us to reflect on what can happen when our personal opinions and assumptions affect how we deliver services.

## Why
We all have opinions and make assumptions about people in our communities, although we may not be aware of them. It can be difficult for us to identify and confront our own behaviours and to understand and accept the impact these can have on how we deliver services.

## Preparation
- Chairs arranged at the front of the room for observing the role play (like a stage).

## Facilitator's notes

### Objective

Enhance understanding of the underlying assumptions that service providers have and how these affect service delivery to young people in all their diversity, including young people from key populations.

## Activities

### 1 Exercise: Romeo and Juliet role play

40 minutes

- Ask four participants to volunteer to take the roles of Romeo (a male client), Juliet (a female client), a male service provider, and a female service provider.

- Ask the service providers to wait outside while you explain the role play to Romeo and Juliet:

> Romeo and Juliet are a young married couple who do not want to have children. Romeo has been using condoms for the last six months but wishes to stop using them. Juliet is reluctant to start using other contraceptives and would prefer Romeo to continue using condoms. This has caused some tension in their relationship. They each visit a male and female service provider to discuss the problem.

- Ask the other participants to observe the role plays and to note down any differences or similarities they see in how the service providers behave with Romeo and Juliet.

- Invite one of the service providers back into the room while the other remains outside. Ask the first service provider to role play a consultation with, separately, Romeo and then with Juliet. Then invite the second service provider to come in and repeat the process, role playing one consultation with Romeo and another with Juliet.

- As a group, discuss how the male and female service providers respond similarly or differently to the needs of the young man and the young woman. Think about how social expectations of young men and women influence how SRHR information and services are provided.

- Ask:

  - How does the way SRHR information and services are provided reinforce gender stereotypes?

  - How does it reflect or neglect the real needs of the clients?

- If there is time, introduce two new, hidden aspects of Romeo and Juliet's lives (make sure you tell Romeo and Juliet about these in advance). If you have less time, you can introduce only one:

- Romeo had a boyfriend before he was married to Juliet and still meets him regularly to have sex.

- Juliet often sells sex to support the household income.

- Ask participants:

  - How would these hidden aspects of their lives affect the service delivered to them?

  - How could service providers find out about these hidden aspects to ensure they receive the most useful services?

- Conclude by asking one or two participants how they feel about what has been discussed, and whether they would see it as a large or a small problem in their own context and why.

## Talking points

- Young people who visit SRHR services may be heterosexual, bisexual or homosexual, or can be questioning their sexual orientation. They may be sexually inexperienced, or they may have more or different experiences to those of the staff members they encounter.

- There are many ways that people experience sexual desire (a longing for sexual expression or a feeling of sexual attraction). There is no one 'normal' way to experience it.

- A person's level of sexual desire may change over a short time, or over the course of their life. People may experience sexual desire until the end of their lives, although their physical response may change with age.

- The social environment can also influence the expression of desire. For example, couples may lack privacy or people may feel shy or nervous.

- What determines whether a person experiences desire for the same sex, the opposite sex or both is not well understood. These desires cannot be changed by religion, therapy or medication.

## Facilitator's tips

Usually, the service providers in the role play will end up offering information and services based on their own organisational or facility focus; for example, HIV-focused staff will most likely talk about HIV testing, condoms being the best barrier method against sexually transmitted infections, including HIV, and so on. It is important to point this out in case participants do not pick up on it, and to identify opportunities for integration and expanding the range of SRHR and HIV services offered.

# E3

# SITE VISIT

### Time
1 day

### What
A visit to a site where HIV and SRHR services are being delivered alongside each other in a clinical or outreach setting to a particular young key population group, such as young men who have sex with men, transgender people, sex workers, and people who use drugs.

### Why
It is important to put theory into practice and give participants a chance to see in action what they have learnt in the workshop, so they can replicate this in their own workplace.

### Preparation
- Consent forms for media/ photographs
- Copies of Handout 9
- Organise transport and logistics
- Source a gift or equivalent to say thank you to the host organisation / facility
- Confirm timings with host facility/organisation and ensure there is no disruption to their service delivery. Bear in mind that, even on a quieter day, facilities will always have activities going on.
- Flip chart paper and pens for debrief

## Facilitator's notes

### Objective

To learn what SRHR and HIV integration means by seeing actual programme delivery in action.

## Activities

### 1 Site visit briefing

40 minutes

- Brief participants on the need to be minimally disruptive during their site visits. Explain that there will be clients present. Any information that participants might be given or overhear should be treated as confidential and with respect.

- Discuss with the group acceptable standards for taking photographs. Photographs can be disruptive and breach client anonymity if they are used on websites or personal social media sites.

- Tell participants there will be specific time set aside for questions. To minimise disruption, decide how and when these questions can and should be asked.

- Prepare questions and/or discuss key points for observation/discussion with the group before they go (see Handout 9 for examples).

- Ask for a volunteer rapporteur to report back in the debriefing.

- It is better for host organisations/facilities if participants visit different sites to those they are already familiar with.

- Co-facilitators should split up and attend different sites (if possible). Step back as leaders for these visits – let the participants direct their own learning.

- If it is not possible (because of location, transport, etc.) to visit a site and return within the same day, there may be a need to organise overnight accommodation for participants.

## 2 Site visit

- Visits to two or three sites could be arranged, depending on the size of the group. Remember to consider transport logistics. Also think about the level of disruption to the site's services. For example, would the timing of the visit prevent services from being delivered during a busy time? Is there a quieter time?

- Sites need time to prepare for the visit. They should be told in advance about it and know what to expect.

- Consider minimising the number of participants who enter the facility/outreach setting at any one time (some facilities can be very small). Ask the facility manager to brief the group together and then arrange for a site tour so participants can understand how the service works at the site.

- Remember, it is neither necessary nor ethical for participants to observe actual clinical procedures. This is not a clinical training, and there is no learning benefit to being present in a procedure room. It may be acceptable for a few participants to be present at a group counselling session. However, the reason for their presence should be discussed in advance with the clients and their permission sought.

## 3 Site visit debriefing

🕐 60 minutes

- In a plenary (whole group discussion) or in smaller groups ask participants to discuss the questions from Handout 9. They should have used these questions during their visits, either to guide their observation of how the site functions or to steer their discussions with site personnel.

- If participants have broken into smaller groups, bring the discussion back into a plenary and write the main observations on a flip chart under the headings 'Strengths', 'Gaps', and 'Integration'. Try to answer any questions that arise, or tell the group you will find answers by the next session.

- Then ask:
    - Have the visits given you ideas for doing anything differently in your workplace?
    - What action points will you take forward?

| Strengths | Gaps | Integration |
|-----------|------|-------------|
|           |      |             |

## Facilitator's tips

- Make sure the discussion is open and constructive, as representatives from host organisations may be present. Host organisation(s) could be offered the chance to reply to the points and observations made about their site. Participants should be respectful of the privilege of being hosted at a site.

# E4

# SOLUTIONS AND STRATEGIES

### Time
45 minutes

### What
This session enables participants to address any issues that remain unclear and sum up how they would take forward plans, strategies and actions in their own project, organisation or facility.

### Why
It is important to resolve any remaining issues and consolidate participants' learning at the end of the training.

### Resources
Frontline AIDS (2014), Safeguarding the rights of children and young people: Guide to facilitating a workshop www.frontlineaids.org/resources/safeguarding-the-rights-of-children-and-young-people/

## Facilitator's notes

### Objective

To sum up important strategic and operational aspects in our particular country context.

## Activities

### 1 Challenges to SRHR and HIV integration and youth participation

20 minutes

- Brainstorm some of the cultural, religious or attitudinal challenges that might arise as participants try to put some of the key concepts into practice (e.g. participation, meaningful engagement with young key populations). Ask:
  - What would stop you setting up integrated programmes in your area, project, facility or site?

### 2 Paired sharing about legal age minimums

25 minutes

- Refer to the session on evolving capacity to revisit the laws and policies, particularly in relation to the age of consent, that might influence young people's ability to access integrated services, and the willingness of providers to enable this.
- Ask participants to break into pairs and briefly share the legal age minimums in their country for:
  - Sex
  - Marriage
  - Access to contraception if married and unmarried
  - Drop-in centres
  - Needle and syringe programmes
  - HIV counselling and testing

■ Give a few examples, and discuss the impact of these age barriers on young people's access to SRHR and HIV services. Highlight any contradictions in legal age minimums, for example, where the age of consent for sex is 16 but the minimum legal age to access HIV testing is 18.

## Key messages

■ Legal age barriers and social norms affect young people's access to SRHR and HIV services.

■ Although we may encounter policy and other obstacles to effective implementation, the expertise of participants and their organisations/facilities (and other potential partners) can be used to find strategies or solutions for overcoming these.

## Facilitator's tips

■ This session is designed to be flexible and particular to each training. Different issues exist in different countries, and issues that are context-specific will arise during the discussions, group work and site visits. Prior to this session, co-facilitators should discuss the most important issues to focus on and plan accordingly.

# E5

# SOURCES OF TECHNICAL ASSISTANCE

**Time**
30 minutes

**What**
This session identifies who can help participants to fill in the technical gaps identified during the training.

**Why**
Ideas for improving and developing our work are often agreed on during training, without identifying what technical expertise is already available and what needs to be sourced. Assign tasks and timelines to individuals or teams while everyone is still together in the group.

## Facilitator's notes

### Objective

To identify where technical assistance is needed as well as who might provide it.

## Activities

### 1 Group discussion

30 minutes

- In small groups or a plenary, brainstorm (or consolidate if already discussed) key areas where technical assistance may be needed.

- Identify who may be able to provide that technical assistance and what (if any) additional resources are needed.

- Prioritise into short- and medium-term actions.

- For each area identified, allocate a potential source of technical assistance. These could include a partner in this country, a partner in another country, and/or other organisations such as Frontline AIDS.

## Facilitator's tips

- Frame the session constructively, so we identify areas to be strengthened rather than failures. This should be a collaborative effort to ensure that our work with young people will be as effective as possible. Remember that, although some organisations or facilities represented in the group may be stronger than others, all will have an offer as well as a need in terms of technical assistance.

# LOOKING AFTER OUR SAFETY

## SESSIONS IN THIS MODULE

| SESSION TITLE | TIME | PAGE |
|---|---|---|
| F1: Violence and its impact | 90 minutes | 94 |
| F2: Supporting survivors of abuse and rape | 60 minutes | 98 |
| F3: Creating a safe environment for young people | 60 minutes | 100 |

# F1

# VIOLENCE AND ITS IMPACT

## Time
90 minutes

## What
This session explores different forms of violence, how it manifests, and the impact on individuals, family and communities.

## Why
All forms of violence are wrong and it is important to recognise what we can do to prevent it in our communities.

## Preparation
- Flip chart paper and pens

## Resources
Frontline AIDS (2018), To prevent HIV we must end gender-based violence www.frontlineaids.org/to-prevent-hiv-we-must-end-gender-based-violence/

5. WHO 'Definition and typology of violence' (accessed May 2020). www.who.int/violenceprevention/approach/definition/en/.

## Facilitator's notes

### Objective

To reach a common understanding of what violence is and how it impacts on SRHR, HIV and health-seeking behaviour.

## Activities

### 1 What is violence and how does it affect us?

90 minutes

- Tell participants we are going to talk about violence, the different ways it is shown, and how it may affect us in our relationships. Mention that this can be a difficult topic for many of us. We need to listen to each other carefully, supportively and without judging.

- Write the word 'Violence' on a flip chart, board or piece of paper and show it to the group.

> VIOLENCE

- Ask the group: what do you think violence is?

- Write down the answers and summarise them with the group.

- Present a definition of violence. For example:

> "Violence is the intentional use of physical force or power, threatened or actual, against oneself, another person or against a group or community, which either results in, or has a high likelihood of resulting in, injury, death or psychological harm."

(Adapted from the World Health Organization's definition.[5])

**A**

- Discuss the key parts of the definition in turn with the group. For example, what does 'intentional' mean? What do we mean by 'threatened or actual'?

- Ask the group:

    - What do you think is interesting in this definition?

    - Would you add anything?

- Place five large sheets of paper around the room or activity space. Describe these sheets as 'stations' and assign one of the following topics to each: physical violence, verbal violence, sexual violence, economic violence, fear of violence.

- Divide participants into five smaller groups and assign each of them to a station.

- Give five minutes for each group to draw or write down their ideas around the given topic.

- When the time is up, ask each group to move to the next station.

**B**

- Again, give five minutes for each group to draw or write down their ideas around the concept. This means they will be adding their pictures or words to the ones that were put there previously.

- The groups will continue rotating in this way until everyone is back to their original station.

- Give the groups five minutes to discuss the following:

    - What's new on the sheet that was not there when we first started defining this type of violence?

    - How can we pull together the ideas to make a definition of this type of violence?

    - After they are finished, bring the whole group together and walk around the different stations so they can see the integrated work at each one.

**C**

- Open the group to a plenary (whole group) discussion. Make sure that:

    - The group reaches an agreed definition of each type of violence.

    - The group understands that all violence, no matter what type, is also linked to a fear of violence because violence causes alarm, distress and hurt feelings.

- The group understands that transforming the social and gender norms that underpin violence involves working with men and boys, as well as women and girls, to understand and respond to gender inequality and power imbalances.

- The group knows about locally available sources of support for those who have experienced violence.

**D**

- Once the definitions are agreed, use these questions to guide the discussion:

    - Is violence ever deserved? Why or why not?

    - What are the SRH consequences of violence for young people (e.g. HIV vulnerability)?

- What is the impact of violence or potential violence on young people's health-seeking behaviour (e.g. asking to use condoms, going for an HIV test)?

- What support can we offer, either directly or by referral, if we know or suspect that a young person is experiencing violence?

# Key messages

- Violence is a big problem in our communities and it can take many forms. No form of violence or abuse should be tolerated; it needs to be immediately called out or reported if necessary.

- Violence is often rooted in, and an expression of, unequal power (for example, between men and women). It is an extreme way to unfairly treat those of us seen as different in some way.

- All forms of violence are wrong, whether the person using violence against us is a stranger or someone known to us. In fact, if the person using violence is a family member, friend, or sexual/romantic partner it is worse because it is also an abuse of our trust.

- Witnessing violence (especially in the home) can be harmful in itself and can have some of the same long-term effects as direct experiences of violence.

- We or others who have experienced violence need support and understanding from each other. These issues are complex, so we may also need help from organisations or groups with skills and experience in preventing or addressing violence and abuse within the family, relationships or community.

- Intimate partner violence is any form of violence that is inflicted by a spouse or sexual partner. Anyone can experience intimate partner violence, but women – including adolescent girls and young women – are most at risk. This kind of violence greatly increases women's likelihood of contracting HIV, having an unwanted pregnancy, or having mental health problems. It can also be a barrier to accessing treatment and care.

*Note: Violence in all its forms is very common, and it is likely group members and/or we ourselves may have experienced it. It may also be the case that some of us have used it against others and may feel ashamed of this. Be prepared with information about local sources of support (for example, counselling, shelters and online resources).*

# A definition of gender-based violence[6]

## Gender-based violence includes:

- **Physical violence:** when someone uses their physical power on others. This includes hitting, kicking, choking, pushing, grabbing you too hard or other actions that hurt or frighten you. It's violence even if it doesn't leave a bruise or mark.

- **Verbal violence:** using words to hurt the other person. This includes yelling at you, insulting you or calling you names. This type of violence should be taken as seriously as other types of violence. It's also verbal abuse if someone starts threatening you or making hurtful jokes about you.

- **Sexual violence:** forcing you to have sex (rape) or to do sexual things when you don't want to, including things like forcing you to kiss or hug them. This type of violence also includes when someone stops you or tries to stop you from using birth control or condoms when you want to. Sexual violence can happen to boys and men as well as girls and women. It can lead to consequences such as HIV, STIs and unwanted pregnancy.

- **Economic violence:** denying and controlling another person's access to resources, such as money, time, transport, food, clothing, medicines or other material goods, which they need to live a healthy and dignified life.

- **Fear of violence:** this is when someone uses threats and other types of violence to cause fear in a person to gain control. It may also include making you doubt yourself or cutting you off from contact with friends, family or other sources of support.

- Every type of violence against us is harmful to our mental health.

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6. Adapted from WAVE and UNFPA (2014), Strengthening Health System Responses to Gender-based Violence in Eastern Europe and Central Asia: A resource package. https://eeca.unfpa.org/sites/default/files/pub-pdf/WAVE-UNFPA-Report-EN.pdf

# F2

# SUPPORTING SURVIVORS OF ABUSE AND RAPE

**Time**
60 minutes

**What**
An activity to explore the best ways to support those affected by abuse or rape.

**Why**
It's important to be alert to signs of potential abuse or rape, and to be prepared to give appropriate support.

**Preparation**
- Information about local sources of support and advice.

## Facilitator's notes

### Objective

To understand how we can best support young people in cases of abuse or rape.

## Activities

### 1 My role and responsibilities

60 minutes

- Ask participants to imagine that a young person has approached them and told them about an incident that happened to her/him involving sexual abuse or rape.

- In small groups, talk about what you would do to help this young person.

- You can guide your discussion with the following questions:

    - How can I best support this young person right now? In the days ahead?

    - What are my responsibilities in this situation?

    - Who else do I need to involve?

- In the large group, ask participants to agree the steps they should take and put them in the right order.

- Ask participants what challenges they might face and how they could manage and overcome them.

- Round off the discussion by asking participants to identify what changes they could make in their own organisation or health facility to give better support to young people affected by abuse or rape.

*Note: Remember that participants themselves may have had experience of abuse or rape, so be alert for signs of distress during the activity. Come prepared with information about local sources of psychosocial support, counselling and/or legal advice.*

# Key messages

- Abuse and rape are manifestations of unequal gender norms and unequal power. They are used to terrorise, intimidate or humiliate.

- Abuse and rape are never the fault of the victim; they are always the responsibility of the perpetrator.

- Abuse and rape may be carried out by family members or other trusted adults, such as teachers or faith leaders, or by strangers.

- Young men as well as young women can experience abuse and rape.

- A sudden change in behaviour or outlook may be a sign that abuse or rape has occurred. For example, an outgoing and enthusiastic young person becomes withdrawn and uninterested in activities they previously enjoyed.

- Those who have been abused or raped may feel unloved, dirty, guilty, angry or unable to trust others. Talking about these feelings can help them feel better, even if it happened a long time ago.

# F3

# CREATING A SAFE ENVIRONMENT FOR YOUNG PEOPLE

## Time
60 minutes

## What
This session explores working with vulnerable young people and how to keep them safe.

## Why
Any project working with young people, including young key populations, must have measures in place to support and protect them. It is through understanding vulnerabilities and risks, and the action we should take if our organisational policies and codes are violated, that we can operate a safe space for young people to realise their SRHR.

## Preparation
- Flip chart paper and pens
- Frontline AIDS policy on the protection of children and vulnerable adults (see Safeguarding the rights of children and young adults Annex 4)

## Resources
FHI (2008), Youth participation guide: assessment, planning, and implementation www.unfpa.org/sites/default/files/resource-pdf/youth_participation.pdf

Frontline AIDS (2014), Safeguarding the rights of children and young people: Guide to facilitating a workshop www.frontlineaids.org/resources/safeguarding-the-rights-of-children-and-young-people/

## Facilitator's notes

### Objective

To understand how to create and maintain a safe space while working with young people in all their diversity, including young people from key populations.

## Activities

### 1  Exercise: What would you do if?

45 minutes

- Break into seven groups (or as many scenarios as you would like to be discussed). Give each group a scenario from the following pages and ask participants the following questions:
  - How do you feel about this scenario?
  - What do you need to do to address it?
  - What measures are already in place to address it in your organisation?
  - What are the challenges of addressing it?
- Ask groups to present their discussions in a plenary and note the key points on a flip chart. Summarise using the discussion points below each scenario.

# Handouts

**Scenario 1**

A staff member of a youth programme is looking at pornography websites, including child pornography.

**Discussion**

Depending on the laws in your country, child pornography is usually illegal. Even if it is not, viewing it is certainly against Frontline AIDS' child protection and IT policies. This would entail disciplinary action that would most likely result in dismissal and possibly police action. If the staff member is a consenting adult watching adult pornography in their own time on their own equipment, this is not really an issue for the organisation. However, a discussion about the values of the organisation may be relevant.

**Scenario 2**

A peer educator from your programme is alone in a room with a girl/boy. Afterwards, the girl/boy complains that the peer educator touched her/him intimately.

**Discussion**

The designated child protection focal person (for example, a social welfare officer) would need to initiate an investigation. This would involve meeting with each of the parties to clarify and document the facts. It would also entail informing each party about the process as well as the extent of confidentiality (i.e. who would need to know). Although privacy is important, having a third person in a session may be something to consider to avoid sexual harassment/abuse or malicious accusations. We need to be careful to protect both the educator and the clients. Organisations and facilities should have child protection committees that would respond to the reports and, depending on the context and evidence, might need to report the case to the police.

**Scenario 3**

A young person who is living with HIV tells you that a staff member from your organisation has told their teacher and parents of their HIV status, even though the young person had not openly shared this information.

**Discussion**

Depending on the organisational policy, this could lead to immediate dismissal (if there is zero tolerance for breach of confidentiality) or other disciplinary action for the staff member once it has been ascertained that they have breached confidentiality. Reassurance must be provided to the young person about the action taken, along with counselling for the distress caused, and other staff assigned to them so they do not have to encounter the same staff member again (in the case of a service delivery setting). Special sessions on living with HIV and the impact of stigma and discrimination may be held for teachers at the young person's school, parents' groups and other community groups in the area.

**Scenario 4**

You notice that male staff members are making inappropriate and suggestive comments to a sex worker who comes to your office frequently as a member of your project planning committee.

**Discussion**

If the sex worker is an adult, this would be treated as harassment and dealt with in-house through a disciplinary procedure that might involve verbal and written warnings. If the sex worker is a young person, this would be dealt with under the child protection policy and would also result in disciplinary action based on the organisation's policy and code of conduct. Depending on the severity of the circumstances, the male staff members might face dismissal, as with any disciplinary action.

**Scenario 5**

A young man who uses drugs who has been a staff member in your team has stopped coming to the office. Your colleagues tell you that the police have been hanging around the office.

**Discussion**

When dealing with people from criminalised populations that may be harassed by law enforcement agencies, the organisation should have protection protocols in place. These might include maintaining a working relationship with the local police, ensuring that drug use does not take place on organisational premises and having referral linkages with legal support services.

**Scenario 6**

A staff member tells you that the young man who works on your project focusing on men who have sex with men has been called names by other staff members.

**Discussion**

This is a harassment issue, needing a response similar to the young sex worker case (see scenario 4)

**Scenario 7**

A young peer educator feels intimidated and bullied by an adult staff member into behaving in a certain way.

**Discussion**

Ask about and document the allegation, recording facts, not assumptions. Explain issues of confidentiality (who will need to know) and that this will need to be discussed with the adult staff member. Establish whether the allegation can be mediated between them, or should result in a disciplinary procedure for the staff member.

## 2 Understanding good practice

15 minutes

- Distribute the Frontline AIDS' policy on protection of children and vulnerable adults, along with the country-specific policy if one exists. Discuss the policy and the need for an organisational child protection policy to be in place.

- Ask:

  - How many of you have seen the child protection policy before?

  - Has the policy been explained to you?

  - Do you have any questions about it?

- Emphasise that a child protection policy that just sits on a shelf is no use. There must be a designated focal person for the policy who is ready to respond; many organisations and health facilities already have one and we should know who it is. Everyone should be familiar with the policy and the consequences of breaching it.

- Remind participants about the workshop guide on safeguarding the rights of children and young people (see Resources).
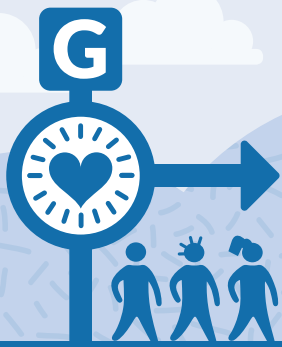
# MENTAL HEALTH AND WELL-BEING

## SESSIONS IN THIS MODULE

| SESSION TITLE | TIME | PAGE |
|---|---|---|
| G1: Mental health and psychosocial well-being | 105 minutes | 104 |
| G2: Mental health and SRHR | 90 minutes | 110 |
| G3: Mental health and HIV | 90 minutes | 114 |
| G4: Self-care and community care | 45 minutes | 116 |

# G1

# MENTAL HEALTH AND PSYCHOSOCIAL WELL-BEING

## Time
105 minutes

## What
This session introduces the concept of mental health and explores case studies relating to mental health challenges.

## Why
It is important that participants can relate the concept of mental health to their own context, and are able to identify everyday events where young people might need psychosocial support.

## Preparation
- Flip chart
- Markers, paper sheets, pencils, pens
- Cards with case studies printed out

## Resources
WHO (2014), Mental health: a state of well-being. www.who.int/features/factfiles/mental_health/en/

## Facilitator's notes

### Objective

To become familiar with the concepts of mental health and well-being, and identify issues that affect people's mental health. This session should also provide information about local mental health and psychosocial support services.

## Activities

### 1  Creating our own definition

45 minutes

**Before the activity:**

- Review the concept of mental health from WHO.
- Become familiar with these key messages:
  - Mental health is as important as physical health, no matter our age, gender or other characteristics.
  - Not feeling OK all the time is OK! Our emotions and feeling are ways to cope with stress and frustration. Looking for help when you feel overwhelmed is a brave act.

**During the activity:**

- Write the term 'Mental health' at the centre of the flip chart with big letters so that everyone can see them.
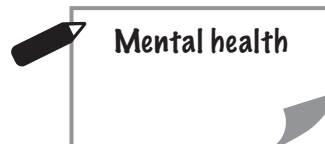
Mental health

- Introduce the activity:

> *We are going to talk about something called mental health, and ask the participants: Have any of you heard of this before? Can you share with the group where, when or how you heard about mental health?*

- Take a few responses from the group and mention that there are many definitions of mental health, but today we are going to create our own.
- Divide the group into smaller groups of three or four and ask them to discuss: *What is mental health for you?*
- Ask each group to write down their definition.
- Discuss each definition in plenary (whole group discussion) and take notes on the flip chart about key elements from each group that can relate to the WHO's concept. Some discussion points:
    - What do our definitions have in common?
    - What things are different in our definitions?
    - Present the WHO's definition to the group (see key messages) – how does this relate to our definitions?
- Finalise the activity by reinforcing the key messages. Recognising the importance of our mental health is the first step to taking care of it.

## 2 Finding psychosocial support

🕐 60 minutes

**Before the activity:**

- Read and become familiar with the situations and the concept of psychosocial support.
- Become familiar with these key messages:
    - Mental health and overall well-being is heavily influenced by our social and cultural context. What happens in our communities, neighbourhoods, and families can affect how we feel about ourselves.
    - Psychosocial support can also be described as love, care and protection and there are many sources of this, including family, friends, teachers, faith leaders, health providers, local support groups, community activists, counsellors in local clinics, school advisors, and therapists. It is important to have an idea of where to find help and services in the community.
    - It is useful to look at mental health on a continuum, whereby we recognise that we all move along it, or find ourselves at different points along it throughout the course of our lives – as we do with our physical health.
    - It is normal for all of us to experience negative feelings from time to time, which we can overcome with support from family, friends and others. But in some cases medical interventions may also be needed (e.g. for depression, post-traumatic stress disorder, suicidal ideation, or self-harm).
- Be aware that participants may have been through situations similar to the case studies, and keep an eye out for any distress arising during the group work or plenary (whole group) discussion. Come to the session with some brochures or information about local psychosocial and/or mental health support services or resources.

**During the activity:**

■ Introduce the activity by saying:

*Some events can make us feel good and powerful, and others can make us feel sad or frustrated. Sometimes it's for a short period of time, like a bad day, but other times the discomfort can last longer and affect our lives. Today we are going to discuss some cases, and explore how the characters might find the help they need.*

■ Divide participants into smaller groups and distribute one case per group.

■ Give some time for the groups to study their case and answer the questions.

■ Each group will read out loud their case to the rest of participants. In plenary, ask:

　■ What do you think about the case?

　■ How can this person manage or overcome this situation?

　■ Who could they ask for help?

■ Finish the activity with key messages and a debriefing, and by sharing some local places where mental health and psychosocial support can be found.

**!** **Modification**
If you judge that there is an atmosphere of mutual trust within the group - for example, if the participants already know each other and have worked together well in the past - you can encourage them to use their case studies as a basis for developing role plays for this activity.

# Key messages

## Mental health

■ Is a state of well-being in which every individual realises their potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to her or his community.[7]

### Psychosocial well-being

■ Is the state in which an individual, family or community has cognitive, emotional and spiritual strengths, combined with positive social relationships. This state of well-being motivates the development of life-skills that enables an individual to understand and engage with their environment and make healthy choices, leading to hope for the future.[7]

## Psychosocial support

■ Is a continuum of love, care and protection that enhances the cognitive, emotional and spiritual well-being of a person and strengthens their social and cultural connectedness. It enhances individual, family and community competencies and positively influences both the individual and the social environment in which people live.[8]

7. WHO (2014), Mental health: a state of well-being. www.who.int/features/factfiles/mental_health/en/.

8. Regional Psychosocial Support Initiative (REPSSI). www.repssi.org/PSS.aspx

# Handouts

## Case 1
Anni is a 13-year-old girl who is being bullied by older girls from another class. She told her family but they said the only thing that matters at school is her grades. She doesn't like to be at school anymore and has been failing maths lately. Her teacher has sent a negative report to her parents. She feels she isn't good enough and thinks it's better if she drops out.

### Discussion
- What is happening with Anni?
- How might she be feeling?
- What areas of her life are being affected?
- How can she find support?

## Case 2
Jay's partner broke up with him a few months ago. Since then, he hasn't shown up for football practice with his neighbourhood team. He is not replying to texts or talking to his friends. He left his part-time job at the local shop and has been hanging out with a group of boys who get together to drink alcohol every night.

### Discussion
- What is happening with Jay?
- How might he be feeling?
- What areas of his life are being affected?
- How can he find support?

## Case 3
Lee is the eldest of four children. Recently she has witnessed several occasions when her father has beaten, or threatened to beat, her mother. Now Lee is scared all the time, she doesn't want to go out or meet new people if it means leaving her mother or siblings in the house with her father. She has nightmares.

### Discussion
- What is happening with Lee?
- How might she be feeling?
- What areas of her life are being affected?
- How can she find support?

## Case 4
Mia is a 16-year-old girl who likes going to school and singing. Mia and her boyfriend Tomas, who has finished school and is currently unemployed, have been sexually active since last year. They use contraception on and off; normally condoms when they can get them. One day Mia finds out she is pregnant. Neither Mia nor Tomas feels comfortable with the idea of having a child. Neither one of them has told their parents, who are very religious, about the pregnancy.

### Discussion
- What is happening with Mia? What is happening with Tomas?
- How might they be feeling?
- What areas of their life are being affected?
- How can they find support?

### Case 5

Andrea and Tony have been dating for a couple of months. They kiss and touch each other but they have not had sexual intercourse. One afternoon while they are kissing at Tony's house he says he wants to try new things. Andrea says she prefers to wait until she feels fully ready. He insists repeatedly, and threatens to break up with her if she doesn't let him do what he wants. They have intercourse although she doesn't feel prepared or willing.

**Discussion**
- What is happening with Andrea?
- How might she be feeling?
- What areas of her life are being affected?
- How can she find support?

### Case 6

Nico is in his last year of high school and his group of friends are always making jokes about finding him a girlfriend. Nico doesn't feel comfortable telling them that he actually likes boys, and that recently he met Noel at his basketball team and both of them feel very attracted to each other. Nico doesn't know what to do because the message he gets from everyone around him is that what he is feeling is wrong.

**Discussion**
- What is happening with Nico?
- How might he be feeling?
- What areas of his life are being affected?
- How can he find support?

### Case 7

Ever since Julia can remember, she has had to take pills every day. Her maternal grandmother, who has taken care of her since Julia's mother passed away, has always told her that the pills are 'special vitamins'. Julia has started to wonder what is going on with her health, but no one will tell her. She finally confronts her grandmother, who reluctantly tells Julia that she was born with HIV and warns her not to tell anyone else.

**Discussion**
- What is happening with Julia?
- How might she be feeling?
- What areas of her life are being affected?
- How can she find support?

# G2

# MENTAL HEALTH AND SRHR

## Time
90 minutes

## What
This activity is a myth-busting and discussion exercise that reflects the intersections between mental, reproductive and sexual health.

## Why
There are numerous misconceptions about mental health and its links with sexual and reproductive health.

## Preparation
- Quiz prompts (statements) on cards
- A box
- Flipchart
- Markers
- Stopwatch

## Facilitator's notes

### Objective

To understand how sexual, reproductive and mental health influence each other, and the ways in which mental health and psychosocial well-being are affected by gender dynamics.

## Activities

### 1 The big quiz[9]

90 minutes

**Before the activity:**

- Become familiar with the facilitator's version of the quiz and go through some of the key statements (see below).

- Write the statements on folded cards or pieces of paper and put them in a box or bag (so participants can't see them).

> **! Alternative**
> If you don't have a box or bag, you can read the statements out loud in turn.

**Overview:**

- In each turn a representative from one of the teams draws a statement, goes back to discuss it with their group for 30 seconds (timed by you with a stopwatch so you give equal chance to the groups), then comes back to the centre. The participant answers on behalf of their team whether the statement is true or false and explains why.

9. Adapted from Population Council (2009), It's All One Curriculum: For a unified approach to sexuality, gender, HIV, and human rights. www.iwhc.org/wp-content/uploads/2013/11/2011pgy_itsalloneguidelines_en.pdf

**During the activity:**

- Introduce the activity by telling the group: 'Today we will have the big quiz contest.'

- Divide the participants into two groups and explain the activity.

- Give time to both groups to select a name for their team.

- As facilitator, you will act as the host of this competition. Flip a coin to decide which team goes first.

- For each round, the respective group answers if a statement is true or false and explains why. If they fail to respond correctly, including an explanation, the other team gets a chance to answer the question and win the point.

- End the game by adding up the points and declaring a winner.

- Reunite the participants into one big group again and debrief (take a few comments). Ask:

    - How did you feel during the game?

    - Can you mention something you learned in this game that impressed you or surprised you?

## Key messages

Mental health and sexual and reproductive health do not exist in silos. They are interconnected and affect our overall well-being. The following prompts demonstrate some ways in which people can be psychologically affected by aspects of their sexual and reproductive health, sexual orientation or gender identity. Many of these situations have their roots in stigma and discrimination.

- Lesbian, gay, bisexual, intersexual, trans and queer (LGBTIQ+) people are more likely than their heterosexual peers to report unmet mental health needs due to experiences of discrimination and violence. In unsupportive environments, disclosing sexual orientation or gender identity can result in losing family or community acceptance.

- Women and girls who have suffered from intimate partner violence (IPV) and other forms of gender-based violence (GBV) can develop trauma or other conditions, such as anxiety and depression[10], leaving them even more vulnerable.

- Young girls and adolescents may undergo harmful traditional practices, such as female genital mutilation, which may affect their self-image, confidence and sexuality. As well as the lifelong physical effects, survivors report emotional disturbances, such as post-traumatic stress disorder and severe depression or anxiety.[11,12]

- In settings where menstruation is still a taboo, girls and adolescents may be exposed to traumatic experiences, ranging from hurtful jokes made by friends, classmates and family members to being isolated while they menstruate. In such communities, girls and women report high levels of anxiety and trauma and added difficulties in managing their menstrual health with privacy and dignity.[13]

- Hormonal contraception, even when carefully prescribed by a trained healthcare provider, can have the side effect of increasing depression. There may also be stigma against adolescents and young people who access, or try to access, contraception.

- Post-natal depression[14] is another serious gender-specific mental health issue, linked to SRHR and to maternal and newborn health, but often left behind in service or support packages.

# Handouts

Cut out the statements and talking points below. The statements on the left are to be handed out, while the discussion points on the right are kept by the facilitator to guide the discussions.

---

**Statement 1**
All mental health issues require medication.

**False** [1]
Some mental health challenges will need medication and others won't. Your healthcare provider will determine this after an assessment. It is important to know that other things, such as therapy, counselling and psychosocial support, may be recommended instead or may complement medication if it is needed.

---

**Statement 2**
We have to keep our mental health issues private.

**False** [2]
Like any other health or life problems, these require care from our support networks: friends, family and other trusted adults such as educators or counsellors. People suffering from mental health problems must know they are not alone.

---

**Statement 3**
Anyone can suffer from mental health issues.

**True** [3]
Everyone may face mental health challenges at one or more points in their lives. This includes childhood, adolescence and adulthood.

---

**Statement 4**
Psychosocial well-being involves our relationships with ourselves, our family and our communities.

**True** [4]
Our relationships with others shape our psychosocial well-being and overall health. It is important that we take care of these relationships.

---

**Statement 5**
Intimate partner violence and gender-based violence happen because women have low self-esteem.

**False** [5]
This statement blames the victim. IPV and GBV happen because someone decides to exercise violence toward another person, and the responsibility rests with the perpetrator. However, it is true that the stress and trauma caused by IPV and GBV can have adverse impacts on the mental health and self-esteem of those affected by it.

---

**Statement 6**
Young people living with HIV might face mental health challenges and might require psychosocial support to live a healthy life.

**True** [6]
HIV is a chronic condition that has a big impact on the life of young people. But, like any other chronic health condition, it can be managed with access to appropriate medication, psychosocial support, and counselling.

---

**Statement 7**
The mental health of adolescents and young people is often not taken seriously.

**True** [7]
It is important to pay attention to what adolescents and young people are telling us about their mental health. We should listen and engage rather than dismissing the issue.

| Statement 8 | False 8 |
|---|---|
| All people living with HIV have depression or mental health problems. | Many people living with HIV live healthy and happy lives. Like anyone else, they need love, care and friendship. Like anyone else, at some point in their lives they might need mental health support because of challenges they are facing, which may be related or unrelated to HIV. The way that others treat people living with HIV may contribute to depression or other mental health problems. |
| Statement 9 | False 9 |
| All LGBTIQ+ people have depression or mental health problems. | Many LGBTIQ+ people live healthy and happy lives. Like anyone else, they need love, care and friendship. Like anyone else, at some point in their lives they might need mental health support because of challenges they are facing, which may be related or unrelated to their sexuality or gender identity. Being LGBTIQ+ is not a mental illness or disorder. The way that others treat LBGTIQ+ people may contribute to depression or other mental health problems. |
| Statement 10 | True 10 |
| Strict gender norms are harmful to people's mental health. | When people are not free to express themselves, they can experience stress or develop communication styles that reinforce unhealthy relationships. For example, young men are traditionally taught that they should not show their feelings (e.g. tenderness, doubt, fear or sadness), which is not healthy for them or for others around them. |
| Statement 11 | True 11 |
| Activists, educators and service providers must take care of their mental health. | In these roles, we are frequently exposed to other people's trauma and suffering, and this can affect our own mental health and the work we do every day. To be able to support others effectively, we must also look after ourselves. |

10. Mental Health Innovation Network (2018), The Lancet Commission on Mental Health and Sustainable Development: Evidence for action on mental health and global development. www.globalmentalhealthcommission.org/wp-content/uploads/2018/10/Lancet-Commission_policy-brief_MHIN2.pdf.pdf

11. Action Canada for Sexual and Reproductive Rights (2018), Mind your "business": how to make the connection between mental health and sexual health. www.srhweek.ca/wp-content/uploads/2018/02/SRH2018-Handbook-EN-Action-Canada-for-Sexual-Health-and-Rights.pdf

12. Knipscheer, J., Vloeberghs, E., Van der Kwaak, A. and van den Muijsenbergh, M. (2015), 'Mental health problems associated with female genital mutilation', BJPsych Bull. 39(6). p.273- 277. www.ncbi.nlm.nih.gov/pmc/articles/PMC4706216/.

13. Chhabi, R. et al. (2015). 'Chhaupadi culture and reproductive health of women in Nepal', Asia-Pacific Journal of Public Health, 27 (7), p.785-795. https://journals.sagepub.com/doi/10.1177/1010539515602743

14. WHO (2015), 'Maternal mental health'. www.who.int/mental_health/maternal-child/maternal_mental_health/en/ (accessed May 2020).

# G3

# MENTAL HEALTH AND HIV

**Time**
90 minutes

**What**
This activity presents different aspects of living with HIV or being affected by it that might require psychosocial support or counselling.

**Why**
To understand that HIV is a complex but manageable health condition.

**Preparation**
- Flipchart
- Coloured markers
- Old magazines
- Post-its, other stationery materials (scissors, tape, coloured paper)

## Facilitator's notes

### Objective

To understand the particular mental health challenges that young people living with and at higher risk of HIV may face, and identify the things that can improve these young people's quality of life.

## Activities

### 1 Posters and gallery walk[15]

90 minutes

**Before the activity:**
- Become familiar with the key messages (see page 115).

**During the activity:**
- Divide the participants into four groups. Each group will work on a different subject, as follows:
    - Group A: Being tested for HIV and getting results
    - Group B: Communicating to others about our HIV status
    - Group C: Adhering to treatment
    - Group D: Family and friends
- Each group will create a poster on their topic by answering the following questions (see handouts on page 115).

15. USAID (2015), Participatory Facilitation Techniques. www.fsnnetwork.org/sites/default/files/Facilitation%20Workshop%20Handout.pdf

| **Group A:** Being tested for HIV and getting results | **?** | ■ What might people feel when deciding whether to go for an HIV test or awaiting their test results?<br>■ What kind of help or support might someone like to have when receiving test results (whether they are positive or negative)? |
|---|---|---|
| **Group B:** Communicating to others about our HIV status | **?** | ■ What challenges face a person living with HIV when they want to communicate their status to important people in their lives?<br>■ What kind of support might they need? |
| **Group C:** Adhering to treatment | **?** | ■ What challenges face a person living with HIV in terms of taking their treatment consistently and correctly?<br>■ What kind of support might they need? |
| **Group D:** Family and friends | **?** | ■ What are the challenges for the family and friends of someone living with HIV?<br>■ How can they better support their loved one living with HIV? |

■ When the groups finish their posters, ask them to display them around the room (either posting them up on the wall, if permitted, with tape or blu-tack, or laying them out on the floor or tables) and invite the whole group to look at them.

■ Open a plenary discussion about the impressions of the participants.

# Key messages

■ Mental health issues are closely linked to HIV.[16] People affected by untreated mental health conditions may be more likely to engage in behaviours that can increase their risk of HIV (e.g. by not practising safer sex). Poor mental health can also increase a person's vulnerability to sexual abuse. People living with HIV may be affected by mental health issues relating to their HIV status and the challenges of living with a complex and stigmatised health condition.

■ Some people living with HIV have to deal with adverse circumstances, for example, being in an unsupportive environment, needing to keep their status a secret from family, friends and other networks, or struggling with treatment adherence.

16. WHO (2008), HIV/AIDS and Mental Health. http://apps.who.int/gb/archive/pdf_files/EB124/B124_6-en.pdf

# G4

# SELF-CARE AND COMMUNITY CARE

**Time**
45 minutes

**What**
In this activity participants will write short stories about what they do to improve their mental health.

**Why**
It serves to identify ways in which young people can take better care of themselves and their communities.

**Preparation**
- Paper sheets
- Pencils, pens

**Resources**
Frontline AIDS (2019), Sexuality & Life-Skills. Particular activities that can be useful when talking about mental health include p. 28: 'Feeling good about ourselves'; p. 41: 'Developing from a child to an adult'.
www.frontlineaids.org/resources/sexuality-and-life-skills-toolkit/

Frontline AIDS (2020), Supporting mental health of adolescents living with or affected by HIV.
www.frontlineaids.org/wp-content/uploads/2020/03/Supporting-mental-health-of-adolescents_final-web.pdf.

National Institute of Mental Health (2016), HIV/AIDS and Mental Health.
www.nimh.nih.gov/health/topics/hiv-aids/index.shtml

## Facilitator's notes

### Objective

To explore a range of psychosocial support strategies available to us.

## Activities

### 1 Storytelling time

🕐 45 minutes

**Before the activity:**

- Become familiar with the key concepts and messages (see page 117).

**During the activity:**

- Give each participant a piece of paper and a pen or pencil.

- Ask the participants to write a short story based on one of the following questions (they can take about 20 minutes to do it):

  - When you feel sad, stressed out, or you are going through a rough moment, what do you do to help yourself feel better?

  - When someone you know is feeling sad or stressed out, what do you do to help them?

- After the stories are written, ask them to choose a partner they feel comfortable talking with.

- Once every participant has a partner, ask them to read the stories to each other and discuss their reactions. Are there any common points or themes? This should take about 10 minutes.

- When they have finished sharing, start a plenary discussion by asking:
  - *Can you identify any unhealthy ways to cope with stress or challenges?*
  - *What healthier alternatives can we suggest?*
  - *What are some good sources for community care? How did you find them?*

Some suggestions on self-care may include: singing, dancing, listening to music, praying, thinking about things to be grateful for, spending time away from work with family and/or friends, watching a happy movie or reading a happy book. Some suggestions on community care may include: asking for help from your health provider, participating in the activities of your faith community, attending a support group.

## Key messages

### Self-care[17]

- This can be defined as a self-initiated act to establish and maintain physical and psychosocial health. Self-care will mean different things to different people, and what it looks like in practice will vary for each individual.

- Young people who live in difficult contexts, have gone through challenges with their mental health, and/or dedicate some of their time to activism can feel stressed, angry or frustrated. Many of us find it challenging to deal with our pain in healthy ways, and yet access to professional mental health assistance may be very limited due to economic and social barriers or the lack of appropriate specialist provision.

### Community care[18]

- This form of support means taking the focus of care from the self to turn to support networks in the community as a way to heal from trauma or exercise well-being. Through social activities and bonding, this allows community members to lean on each other and help one another.

17. CREA (2008), Self-Care and Self-Defense Manual for Feminist Activists. https://creaworld.org/publications/self-care-and-self-defence-manual-feminist-activists-2008-0

18. Leach, M. (3 January 2019), 'How community care makes self-care a social justice act'. https://thetempest.co/2019/01/03/social-justice/community-self-care/ (accessed May 2020).

### Resources (continued)

Remien, R. et al. (2019) 'Mental health and HIV/AIDS: the need for an integrated response', AIDS, 33 ( 9), p.1411-1420. https://journals.lww.com/aidsonline/Fulltext/2019/07150/Mental_health_and_HIV_AIDS__the_need_for_an.1.aspx

UNAIDS (2018), Better integration of mental health and HIV services. www.unaids.org/en/resources/presscentre/featurestories/2018/october/mental-health-and-hiv-services

WHO (2008), HIV/AIDS and mental health. http://apps.who.int/gb/archive/pdf_files/EB124/B124_6-en.pdf

# ANNEX

| HANDOUTS | | |
|---|---|---|
| **HANDOUT TITLE** | **MODULE** | **PAGE** |
| 1 Integration and Linkages | C2 | 119 |
| 2 Sexual and reproductive rights | C3 | 120 |
| 3 Exclaim poster | C3 | 122 |
| 4 Sexual rights, young people and evolving capacity | D2 | 123 |
| 5 Sex and sexuality | B2 | 125 |
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| 9 Site visit | E3 | 134 |

Handouts are intended for your own reference as well as to be given to participants during or after sessions. Photocopy them in advance if their use is suggested in the session notes.

# HANDOUT 1. INTEGRATION AND LINKAGES

## A framework for priority linkages
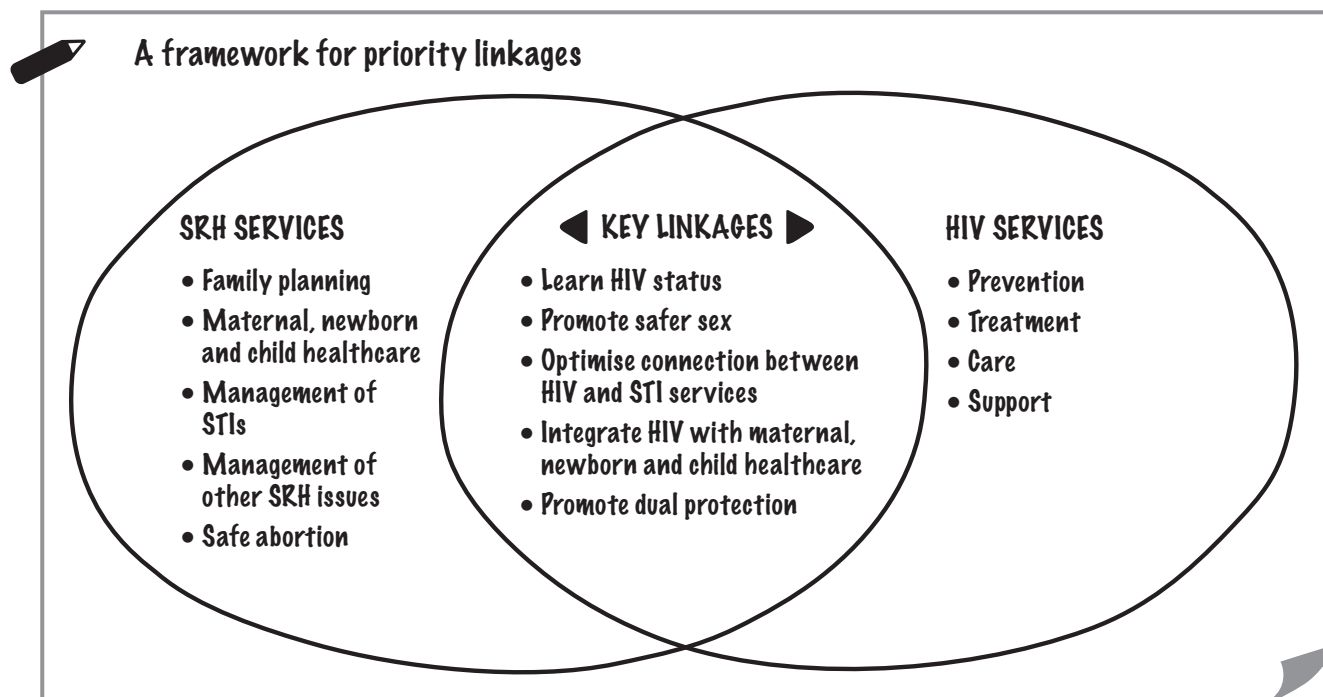
**A framework for priority linkages**

**SRH SERVICES**
- Family planning
- Maternal, newborn and child healthcare
- Management of STIs
- Management of other SRH issues
- Safe abortion

**◄ KEY LINKAGES ►**
- Learn HIV status
- Promote safer sex
- Optimise connection between HIV and STI services
- Integrate HIV with maternal, newborn and child healthcare
- Promote dual protection

**HIV SERVICES**
- Prevention
- Treatment
- Care
- Support

Source: Adapted from WHO (2005), Sexual and reproductive health and HIV/AIDS: a framework for priority linkages.

**Integration** refers to different kinds of SRH and HIV interventions and services that can be joined together to enhance outcomes (for example, referrals). It is based on the need to offer comprehensive services.

Different approaches to integration include:

- **One-stop shop provision of comprehensive and integrated services**, such as drop-in centres or clinics that offer HIV services (HIV counselling and testing, prevention, care and treatment) with SRHR services (family planning, STI, vertical transmission, maternal, newborn and child health, and safe abortion). An example is the Kenya AIDS NGOs Consortium's (KANCO) sex worker drop-in centre.

- **A referrals approach**, where an HIV service (community or clinic based) provides information and referrals for a SRH service. For example, the Network Support Model

in Uganda trains people living with HIV to improve access to prevention, care, treatment and support. It offers community-based palliative care, adherence counselling and HIV prevention. People living with HIV are selected as Network Support Agents who accompany and empower other people living with HIV to use existing government community-based wrap-around health services, including for family planning, vertical transmission and STIs.

- **Physical and functional integration** can include providing different services in the same room, the same provider for both services, the same facility but a different room, the same provider but in different rooms or at different times, or a combination of services received in one visit. These are all types of integration; there is no blueprint.

# HANDOUT 2. SEXUAL AND REPRODUCTIVE RIGHTS

## Sexual rights: an IPPF Declaration

**Sexual rights are human rights related to sexuality**

**ARTICLE 1:**     **Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender**

All human beings are born free and equal in dignity and rights and must enjoy the equal protection of the law against discrimination based on their sexuality, sex or gender

**ARTICLE 2:**     **The right to participation for all persons, regardless of sex, sexuality or gender**

All persons are entitled to an environment that enables active, free and meaningful participation in and contribution to the civil, economic, social, cultural and political aspects of human life at local, national, regional and international levels, through the development of which human rights and fundamental freedoms can be realized.

**ARTICLE 3:**     **The rights to life, liberty, security of the person and bodily integrity**

All persons have the right to life, liberty and to be free of torture and cruel, inhuman and degrading treatment in all cases, and particularly on account of sex, age, gender, gender identity, sexual orientation, marital status, sexual history or behaviour, real or imputed, and HIV/AIDS status and shall have the right to exercise their sexuality free of violence or coercion.

**ARTICLE 4:**     **Right to privacy**

All persons have the right not to be subjected to arbitrary interference with their privacy, family, home, papers or correspondence and the right to privacy which is essential to the exercise of sexual autonomy.

**ARTICLE 5:**     **Right to personal autonomy and recognition before the law**

All persons have the right to be recognized before the law and to sexual freedom, which encompasses the opportunity for individuals to have control and decide freely on matters related to sexuality, to choose their sexual partners, to seek to experience their full sexual potential and pleasure, within a framework of non-discrimination and with due regard to the rights of others and to the evolving capacity of children.

**ARTICLE 6:** **Right to freedom of thought, opinion and expression; right to association**

All persons have the right to exercise freedom of thought, opinion and expression regarding ideas on sexuality, sexual orientation, gender identity and sexual rights, without arbitrary intrusions or limitations based on dominant cultural beliefs or political ideology, or discriminatory notions of public order, public morality, public health or public security.

**ARTICLE 7:** **Right to health and to the benefits of scientific progress**

All persons have a right to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and access to sexual health care for prevention, diagnosis and treatment of all sexual concerns, problems and disorders.

**ARTICLE 8:** **Right to education and information**

All persons, without discrimination, have the right to education and information generally and to comprehensive sexuality education and information necessary and useful to exercise full citizenship and equality in the private, public and political domains.

**ARTICLE 9:** **Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children**

All persons have the right to choose whether or not to marry, whether or not to found and plan a family, when to have children and to decide the number and spacing of their children freely and responsibly, within an environment in which laws and policies recognize the diversity of family forms as including those not defined by descent or marriage.

**ARTICLE 10:** **Right to accountability and redress**

All persons have the right to effective, adequate, accessible and appropriate educative, legislative, judicial and other measures to ensure and demand that those who are duty-bound to uphold sexual rights are fully accountable to them. This includes the ability to monitor the implementation of sexual rights and to access remedies for violations of sexual rights, including access to full redress through restitution, compensation, rehabilitation, satisfaction, guarantee of non-repetition and any other means.

# HANDOUT 3. EXCLAIM! POSTER

**YOUNG PEOPLE HAVE THE RIGHT TO...**

EQUALITY

EXPRESS THEMSELVES

KNOW AND LEARN

PLEASURE

HEALTH

PRIVACY

CHOOSE

SAFER SEX

TAKE PART

ACCOUNTABILITY

**YOUNG PEOPLE HAVE THE RIGHT TO BE PROTECTED FROM...**

DISCRIMINATION

VIOLENCE

UNWANTED PREGNANCY

HARMFUL TRADITIONAL PRACTICES

PREGNANCY- RELATED DEATH OR DISABILITY

EXPOSURE OF PRIVATE INFORMATION

FORCED MARRIAGE

Source: IPPF (2008), Young people's guide to sexual rights: an IPPF declaration. International Planned Parenthood Federation.

# HANDOUT 4. SEXUAL RIGHTS, YOUNG PEOPLE AND EVOLVING CAPACITY

## INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, CAIRO, 1994

**What is it?**

The International Conference on Population and Development (ICPD) was convened by the United Nations in September 1994 in Cairo, Egypt. It drew some 11,000 delegates from 179 countries, including government officials, representatives from United Nations agencies, intergovernmental delegations, non-governmental organisations and the media. This was the largest ever conference on population and development.

**Why does it matter?**

From the negotiations in Cairo a consensus was reached by 179 countries, which committed to promoting a 20-year programme of action with set priorities and time-bound goals to guide national-level policymaking. It concretely addressed a diverse array of topics relating to population and development, including sexual and reproductive health, education, human rights, the environment, internal and international migration, and the prevention and control of HIV and AIDS.

The ICPD Programme of Action calls on governments to provide adolescents with access to sexual and reproductive information and education and recognises that reproductive and sexual health services: 'must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent' (paragraph 7.45).

## THE UNITED NATIONS CONVENTION ON THE RIGHTS OF THE CHILD

**What is it?**

A convention is an agreement between countries to obey the same law. When the government of a country ratifies a convention that means it agrees to obey the law written down in that convention.

The United Nations Convention on the Rights of the Child (UNCRC) was adopted by the United Nations General Assembly on 20 November 1989. At the end of 1993, 154 states had ratified the convention (i.e. given formal approval to it). This obliges them to report to the United Nations Committee on the Rights of the Child within two years of signing the convention explaining what progress they have made in meeting its goals.

**Why does it matter?**

The UNCRC has 54 articles in total. Articles 43 to 54 are about how adults and governments should work together to make sure all children and young people get all their rights.

**The UNCRC states:**

**ARTICLE 5:** Young people's evolving capacity to exercise their own rights must be taken into consideration by those who provide guidance and direction to young people.

**ARTICLE 12:** Young people must be able to freely express their views, which should be given weight in accordance with their evolving capacity.

**ARTICLE 14:** Young people must be afforded freedom of thought, conscience and religion.

**Evolving capacity** is about individual development and autonomy. It refers to the way that each young person gradually develops the ability to take full responsibility for their own actions and decisions. This happens at a different pace for each individual. At any given age, some young people will be more mature and experienced than others. Context and personal circumstances will almost certainly influence each individual's development.

# HANDOUT 5. SEX AND SEXUALITY

## SEX AND SEXUALITY

**Sex** refers to the biological differences between females and males present at birth. These include anatomical differences, such as the presence of a vagina or penis; genetic differences, as in a person's chromosomal makeup; physiological differences, such as menstruation or sperm production. Sex can also be used to describe physical acts of sex that includes, but is not limited to, penetrative penile–vaginal intercourse, oral sex, anal sex, masturbation and kissing.

**Sexuality** as a concept has been examined for many years. There are a number of definitions that cover the various components of sexuality. While there is no single agreed definition, the one below provides a basic and fairly comprehensive understanding of the concept.

Sexuality is a central aspect of being human throughout life and 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  these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical, religious and spiritual factors.

Sexuality is more than acts of sex. It is also different from gender, which refers to how societies view women and men, the differences between them, the roles assigned to them and the expectations placed upon them throughout their lives.

Sexuality is a complex and sensitive issue and includes personal and social meanings as well as sexual behaviour and biology. It includes roles and personality, gender and sexual identity, biology and behaviour, emotions, thoughts, feelings and relationships.

It is influenced by social, ethical, economic, cultural, spiritual and moral concerns. Sexuality is reflected in the total expression of who we are as human beings. It encompasses our values, attitudes, behaviours, physical appearance, beliefs, emotions and personality as well as the ways in which we have been socialised. It involves our sexual identity and orientation, begins at birth and lasts our lifetime.

The expression of sexuality is influenced by ethical, spiritual, cultural and moral factors. Everyone does not experience sexuality in the same way. Being aware of these differences helps us cater to individual needs and provide effective services to people. Sexuality encompasses many ideas and is subjective. Any definition of sexuality needs to reflect this diversity, which is why it will be longer and more complex than expected. The definition of sexuality has been evolving along with our understanding.

Multiple factors are influenced by, and influence, our sexuality. For example, we cannot assume that all people are motivated by the same reasons to have sex or be in a relationship – some people might make this choice in order to have children, others for companionship.

Sex positivity is an attitude that celebrates sexuality as an enhancing part of life that brings happiness, energy and celebration. Sex-positive approaches strive to achieve ideal experiences, rather than solely working to prevent negative experiences. At the same time, sex-positive approaches acknowledge and tackle the various concerns and risks associated with sexuality without reinforcing fear, shame or taboo of young people's sexuality and gender inequality.

## SEXUAL ORIENTATION AND GENDER IDENTITY

**Gender identity** refers to a person's internal sense of being male, female or something else. For many people, their gender identity often corresponds to their biological sex. A person who identifies as transgender has a gender identity that does not correspond to their biological sex.

**Gender expression** relates to how a person chooses to communicate their gender identity to others through clothing, hair, styles, mannerisms and so on. This communication may be conscious or unconscious. While most people's understandings of gender expressions relate to masculinity and femininity, there are countless combinations that may combine both masculine and feminine expressions, or neither, through androgynous expressions.

**Sexual orientation** describes whom we are romantically attracted to and love. A person's gender identity does not predetermine their sexual orientation.

It is important to understand that these concepts are all on a **continuum and they are all fluid**. This means that anyone could begin life at one point on a continuum and, depending on their circumstances, choices and bodies, they could change (or not) and move between the extremes on either side.

For example, there could be two people, A and B, who were born female (biological sex), have a masculine gender expression, and identify as bisexual (loving and desiring both sexes). Person A might live their life expressing this, while person B might grow up to realise that they were born in the wrong body and would rather be male (biological sex). Person C might have grown up to identify as heterosexual but may change to find others of the same sex attractive and perhaps try out a homosexual relationship.

People who change from one side of the gender identity continuum to the other are known as **transgender**. People who change from one side of the biological sex continuum to the other are known as **transsexual** (undergoing hormone replacement and/or surgery). People who are intersex are born with ambiguous genitalia, and often the doctor or parents decide for the infant which sex they should be. This choice could be wrong, so intersex people are advocating against doctors or parents making this choice for infants.

In order to counter the gender norms that are assigned to 'males' and 'females', there is also a movement to bring up children in a gender 'neutral' manner. This means not making distinctions between boys' and girls' clothes, colours, toys and activities (for example, blue for boys, pink for girls; cars for boys, dolls for girls; football for boys, playing house for girls).

A question that may be raised is that, if sex and sexuality are all fluid, then is it possible to change people of homosexual orientation to heterosexual orientation?

The key point here is that all of these points on the continuum are related to self-identification rather than labels that can be applied to us by others or by us to others. Just as you cannot force a person to fall in love with someone, you cannot force a person who identifies as homosexual to fall in love with or desire someone of the opposite sex, or vice versa. Attempting to do so is also a fundamental violation of people's human rights.

# HANDOUT 6. VIOLENCE AND ITS IMPACT

## DEFINITIONS

WHO defines **violence** as 'Intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation.'

World Health Organization (2002), World report on violence and health: summary

## GENDER-BASED VIOLENCE

'Is violence involving men and women, in which the female is usually the victim. It is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm. It includes that violence which is perpetuated or condoned by the state.'

United Nations Population Fund Gender Theme Group (1998), Violence Against Girls and Women: A Public Health Priority

## VIOLENCE AGAINST WOMEN

Refers to 'any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.'

Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993

## SEXUAL VIOLENCE

Is 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise, directed against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.'

World Health Organization (2002), World Report on violence and health

Young people, including young key populations, may be exposed to many forms of violence throughout their lives, such as:

- Psychological abuse, which includes suffering insults, humiliation, bullying, 'Eve-teasing' (an Asian term meaning harassment of young women), confinement and withholding of basic needs such as food.

- Physical abuse, which includes beating, kicking, pulling hair, biting, acid throwing and female genital cutting.

- Sexual violence, which includes economically coerced sex, date rape, marital rape, and gang rape, incest, forced pregnancy and child sexual abuse.

In addition to these interpersonal forms of violence there are also systemic forms of violence, such as corporal punishment, state-sanctioned violence and structural violence.

> **!**
>
> **Note:**
> Be sensitive to the possibility of bullying, harassment and power inequalities that can result in violence in same-sex relationships as well.
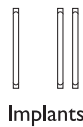
Types of gender-based violence include:

- Physical violence
- Emotional, psychological and socioeconomic abuse
- Sexual assault and abuse
- Harmful traditional practices

# HANDOUT 7. ENTRY POINTS TO INTEGRATION

**More effective**
Less than 1 pregnancy per 100 women in one year

## How to make your method more effective

**Implants, IUD, female sterilization:** After procedure, little or nothing to do or remember

**Vasectomy:** Use another method for first 3 months
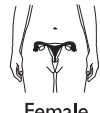
Implants    IUD    Female Sterilization    Vasectomy

**Injectables:** Get repeat injections on time

**Lactational Amenorrhea Method (for 6 months):** Breastfeed often, day and night

**Pills:** Take a pill each day

**Patch, ring:** Keep in place, change on time
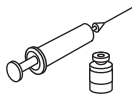
Injectables    LAM    Pills    Patch    Vaginal Ring

**Condoms, diaphragm:** Use correctly every time you have sex

**Fertility awareness methods:** Abstain or use condoms on fertile days. Standard Days Method and TwoDay Method may be easiest to use.

Male Condoms    Diaphragm    Female Condoms    Fertility Awareness Methods

**Withdrawal, spermicides:** Use correctly every time you have sex

Withdrawal    Spermicides

**Less effective**
About 30 pregnancies per 100 women in one year

## Four prongs of prevention of vertical transmission of HIV

**1**
- Primary prevention of HIV among women of reproductive age.

**2**
- The prevention of unintended pregnancies among women and girls living with HIV.
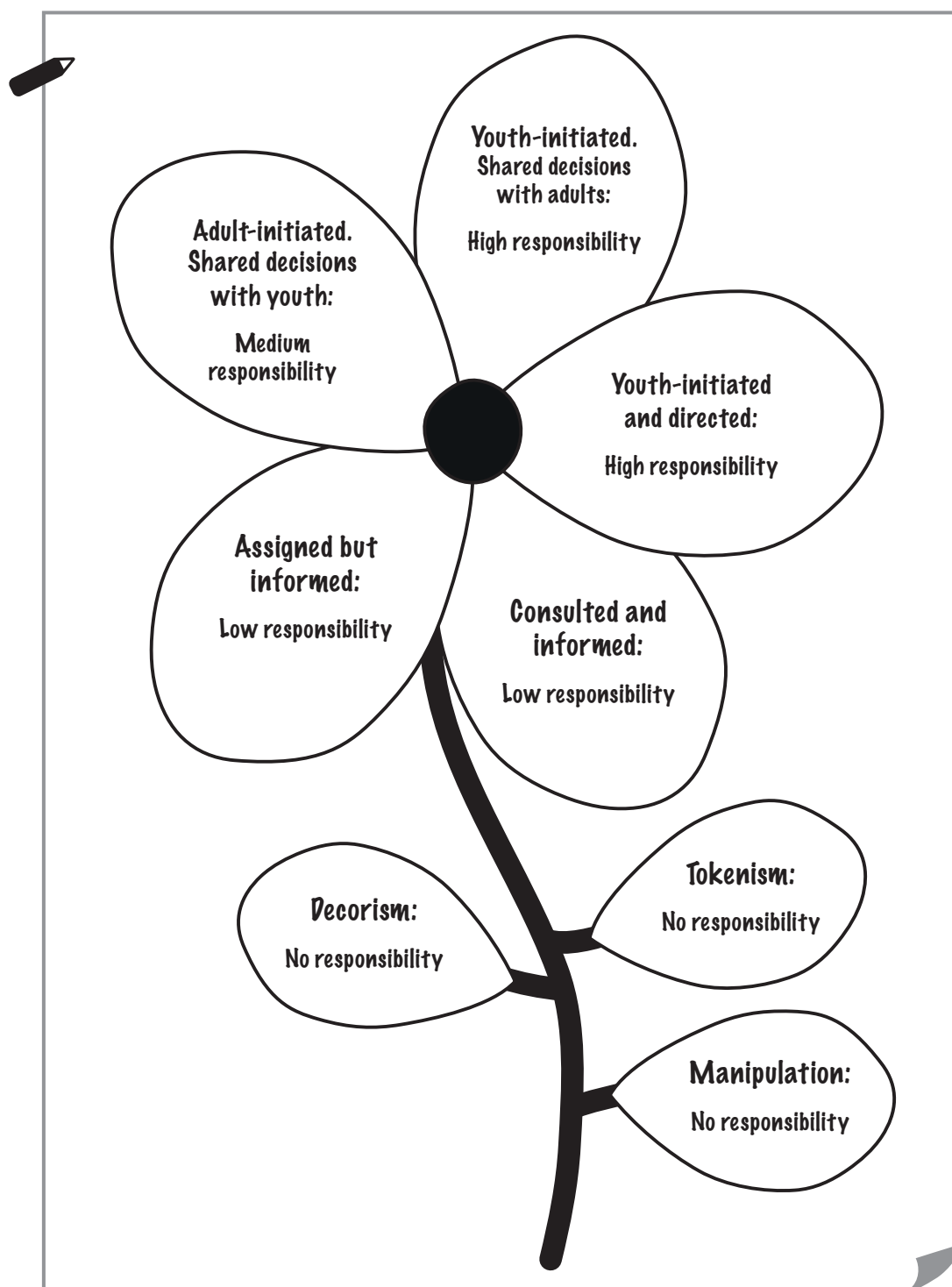
**3**
- HIV testing and counselling for all pregnant women, with fast referral to antiretroviral treatment (ART), care and support; ART prophylaxis; safer delivery; use of cotrimoxazole for HIV-exposed infants and safer infant feeding.
- Testing of partners and safer sex promotion, as risk of HIV transmission is very high if partner is recently infected.

**4**
- Long-term ART for mothers and children living with HIV.
- Ensure that mothers and children get long-term support with nutrition, prevention of infections, treatment and care.

# HANDOUT 8. MEANINGFUL YOUTH PARTICIPATION

Youth-initiated.
Shared decisions
with adults:

High responsibility

Adult-initiated.
Shared decisions
with youth:

Medium
responsibility

Youth-initiated
and directed:

High responsibility

Assigned but
informed:

Low responsibility

Consulted and
informed:

Low responsibility

Decorism:

No responsibility

Tokenism:

No responsibility

Manipulation:

No responsibility

Source: CHOICE for Youth and Sexuality has developed the Flower of Participation, inspired by Roger Hart's ladder of participation.

# Levels of youth participation – definitions

## Manipulation

- This takes place when young people don't have any understanding of the issues and therefore don't understand their actions. An example is when a four-year-old AIDS orphan shakes the hand of the President of the United States to make them invest more in orphans.

## Decoration

- This looks like manipulation, but young people might understand their actions. However, they are still being used to support adults' causes indirectly, and adults do not pretend that their cause has been inspired by young people. An example is young people singing to the delegates at the opening of a conference on youth.

## Tokenism

- Young people are given a voice, but have little say on the subject or the style of communicating it, and are given little or no opportunity to formulate their own opinions. This can happen when children are given seats on conference panels or when young people are included in a delegation but are not allowed to say anything.

## Assigned but informed

- Young people understand the aim of the project, they know who made the decisions concerning their involvement and why, and they have a meaningful role. They volunteered for this project after the project was explained to them. An example is a community activity that is planned by adults but young people join in the activity.

## Consulted and informed

- The project is designed and run by adults, but young people understand the process, are consulted, and their opinions are treated seriously.

## Adult-initiated, shared decisions with youth

- Although projects are initiated by adults, decision-making is shared with young people.

## Youth-initiated and directed

- Young people work together cooperatively in large groups, and design and run their own projects with some adult support as needed.

## Youth-initiated, shared decisions with adults

- Young people ask adults to join in an activity that is initiated by young people.

# Fifteen tips for good practice in youth participation

1. Provide training and support for young people, e.g. assertiveness training, negotiation and communication.

2. Provide training and support for adult decision-makers to help them engage with young people and listen to their views.

3. Provide young people with jargon-free information that is accessible to them.

4. Ensure hard-to-reach groups of young people are aware of, and encouraged to be, part of projects. Consider their specific access needs.

5. Ensure meetings are accessible, at times and locations young people can comfortably manage.

6. Offer a variety of options so young people can choose different ways to engage.

7. Make participation voluntary and don't expect long-term commitment.

8. Allow adequate time for projects; results will not be achieved immediately.

9. Value the input of young people. Take their views seriously and give clear feedback on the impact of their contribution.

10. Ensure there is clear and transparent communication about the limits to their involvement and the expectations of them.

11. Make sure there is the necessary financial commitment to the project, including reimbursing the costs of young people's participation (e.g. transport) and agreeing a policy on paying for their time (e.g. if asking them to attend a meeting or take part in a consultation).

12. Set up systems for reviewing and continuously improving the process of involving young people.

13. Have fun in the project; build in opportunities for socialising.

14. Recognise young people's contribution and input, e.g. by providing a certificate of achievement.

15. Provide support to project staff to develop their skills in working with young people.

# HANDOUT 9. SITE VISIT

**Participants should have guiding questions to inform discussions, observations, questions and answers during the visit.**

**For example:**

- What SRHR interventions/services are being implemented?
- What HIV interventions/services are provided?
- What SRHR and HIV interventions are integrated?
- How are young people involved in the services?
- What gaps/barriers exist as challenges?
- What are the opportunities and entry points for integration?
- What are the opportunities for youth leadership?
- How is sustainability (financial and human resources, commodities) being ensured?

- What is the level of community involvement, and in which activities?
- How is the programme addressing stigma and discrimination in the community and among service providers?
- How are human rights addressed and upheld?
- What is in place to support someone who experiences gender-based violence?
- Does the facility/organisation have a child protection policy? Have all staff and volunteers signed a code of conduct? What training is given to staff and volunteers on child protection and other safeguarding issues? How does the facility/organisation measure and assure the quality of the services they provide and refer their clients to?

Add more questions to the list, as appropriate.

# NOTES

# READY

## RESILIENT & EMPOWERED ADOLESCENTS & YOUNG PEOPLE

READY is a movement of youth-led and youth-serving organisations, which aims to build resilient and empowered adolescents and young people. We know this is vital because HIV is the leading cause of death among young people (aged 10-24) in Africa and the second globally.

Young people all over the world can join the READY movement to demand their right to a healthy life whatever their circumstances, sexual orientation, gender identity or expression. Young people helped create the READY movement in order to expand our READY portfolio. Today, they remain at its core.

www.frontlineaids.org/our-work-includes/ready/

**READY Movement**

fb.me/READYMovement

@READY_Movement

@readymovement

www.yplusnetwork.org/ready-movement/

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