Sexual and Reproductive Health Facilitators' Training Manual

Youth 2 Youth Initiatives
for sexual and reproductive health

DSW

Published by:
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Layout and Design:
SALT Concepts, Uganda

Recommended Citation:
DSW, 2014, SRH Facilitators'Training Manual

About DSW

DSW (Deutsche Stiftung Weltbevoelkerung) is an international development and advocacy organisation founded in 1991 as a non-profit foundation in Hannover, Germany. DSW focuses on development programmes, advocacy, and awareness raising. Headquartered in Hannover, DSW also maintains four country offices in Ethiopia, Kenya, Tanzania, and Uganda, as well as liaison offices in Berlin, Germany, and Brussels, Belgium.

DSW empowers young people and communities in low- and middle-income countries by addressing the issues of population dynamics and health as a way to achieve sustainable development. Our focus is on achieving universal access to sexual and reproductive health services and information, which is fundamental to improving health and effectively fighting poverty. Our motto: "Empowering people for a healthy future!" DSW is politically and religiously independent. It relies on private donations and financial support from other organisations, foundations and agencies to carry out its project work.

DSW

DSW focuses on development programmes, advocacy, and awareness raising.

Youth 2 Youth for sexual and reproductive health

Our Youth-to-Youth Initiative

Developed in 1999 and currently implemented in Ethiopia, Kenya, Uganda and Tanzania, DSW's Youth-to-Youth (Y2Y) Initiative offers an innovative and integrated response to the multi-faceted needs of young males and females in developing countries. It aims at empowering young people between 10 to 24 years in developing countries to improve their sexual and reproductive health as well as their socio-economic situation. (www.youth-to-youth.org)

- The Youth-to-Youth Initiative enables young people to become agents of change within the framework of a network of self-led youth clubs. Youth club members participate in peer education, SRHR, life skills, club management and leadership trainings. The acquired knowledge and skills help them to successfully manage their clubs and to pass on quality youth-friendly SRHR information on issues such as family planning, HIV & Aids, contraceptives and a responsible lifestyle to their peers.
- Furthermore, youth clubs engage in community outreach activities designed to raise awareness, change attitudes and strengthen community life. These activities include youth-led edutainment (music, drama, dance) shows, environmental work and community services as well community dialogue and advocacy meetings targeting local decision-makers and community members.
- Moreover, trained peer educators or health staff also offer SRH or family planning counselling services, HIV and Aids testing and counselling or home-based care services. Referral systems between youth clubs and health facilities are set up to ensure that young people with SRH-related problems are referred from clubs to health service providers for respective treatment.
- Enhancing the social and economic development of young people:Trainings provided to young people on entrepreneurship, business, and resource mobilisation skills enable them to develop, set up and maintain income generating activities. Club members share their knowledge and learn how to sustain youth club activities in a sustainable way, how to secure small loans and strengthen their socio-economic situation.

Foreword and acknowledgement

This SRH Facilitators' Training Manual is designed to empower young people with knowledge and skills needed to take informed decisions on their Sexual and Reproductive Health (SRH) and to become confident change agents in their local communities. It constitutes a key tool of DSW's efforts to facilitate quality peer education in the framework of its Youth-to-Youth Initiative as well as other peer education-based projects.

Since more than two decades, DSW has gained valuable experiences in organising and conducting intensive trainings for trainers and youth peer educators on Sexual and Reproductive Health and Rights (SRHR), including issues like reproductive anatomy, life skills, contraceptives and family planning as well as HIV &Aids. In order to facilitate these trainings DSW has developed a respective SRH training manual. Over time, this manual has been revised on a regular basis. The aim of each revision was to update information, methods and content and to better meet the needs of youth in low and middle income countries that lack access to SRHR education, related information and life skills.

The result of the latest revision process that included various international DSW staff is this comprehensive document - the Sexual and Reproductive Health Facilitators' Training Manual that is designed to ultimately strengthen, improve and effectively facilitate SRH-related knowledge and skills gain of young people at various levels. It can be used in the context of trainings for Trainers, peer educators or peer learning group facilitators respectively. Its modular structure enables training facilitators to use the Manual in a flexible way, e.g. to select particular modules and facilitate a training tailored to particular learning needs.

We also owe our gratitude to all young people in Ethiopia, Kenya, Uganda, and Tanzania as well as in other parts of world who engage in peer-to-peer education

TheSRH Facilitators' Training Manual promotes a participatory learning process that is inspired by concepts of experiential learning. Accordingly, trainees discover learning contents themselves, learn with all their senses, connect their experiences to the learning topic, participate actively in session, and thus become part and parcel of the learning process.

Without the dedicated coordination of Emmanuel Curuma and DSW's international manual review team the revision of this Manual would not have been possible. Many thanks also go to James Kotzsch, Siegrid Tautz as well Karolin Rizzo for their valuable input and efforts.

We also owe our gratitude to all young people in Ethiopia, Kenya, Uganda, and Tanzania as well as in other parts of world who engage in peer-to-peer education and actively share SRH-related knowledge and skills with their peers and act as important change agents in their communities.

Renate Baehr, DSW Executive Director
Hannover, Germany, December 2013

Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
ART	Antiretroviral Therapy
ARV	Antiretroviral
ASRHR	Adolescent Sexual Reproductive Health and Rights
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CSO	Civil Society Organisation
DSW	Deutsche Stiftung Weltbevoelkerung
EOC	Emergency Oral Contraceptives
FP	Family Planning
FGM	Female Genital Mutilation
GBV	Gender-Based Violence
HC	Health Centre
HCT	HIV Counselling and Testing
HIV	Human Immuno-Deficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication materials
IGAs	Income Generating Activities
IUDs	Intra-Uterine Devices
LAM	Lactational Amenorrhea Method
MDG(s)	Millennium Development Goal(s)
MoU	Memorandum of Understanding
NGO	Non-Governmental Organisation
NHP	National Health Policy
NHS	National Health System
NMS	National Medical Stores
PMTCT	Prevention of Mother to Child Transmission
PWD	Persons with Disabilities
PHE	Population, Health, and Environment
RH	Reproductive Health
SGBV	Sexual and Gender Based Violence
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infection

STD	Sexually Transmitted Disease
TBA	Traditional Birth attendant
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
UDHS	Uganda Demographic and Health Survey
UN	United Nations
UNICEF	United Nations Children's Fund
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNODC	United Nations Office on Drugs and Crime
VAW	Violence Against Women and girls.
VCT	Voluntary Counselling and Testing
WHO	World Health Organisation
YEC	Youth Empowerment Centre
Y2Y (Initiative)	Youth-to-Youth Initiative
YFS	Youth Friendly Service
YC	Youth Club

Introduction

Access to information, knowledge and skills is an indispensable condition for young people to live a healthy and self-determined sexual and reproductive health life, to prevent unwanted pregnancies or an infection with HIV & Aids or other STIs.

There are an estimated 1.8 billion young people in the world today (defined as aged 10 to 24 years), accounting for nearly a third of the world's population. Just below 90 per cent live in developing countries, and that proportion will increase during the next 20 years. In 92 countries, young people account for well over 30 per cent of the population. However, almost half of all young people, close to 550 million, survive on less than 2 US-Dollar a day[1].

Young people often face particular barriers in accessing SRH information, learning opportunities and services. The resulting lack of knowledge and access to services as well as stigmatisation of young people's SRH in societies impede the majority of them to live a healthy SRH life.

An estimated 5 million young people between the ages of 15 and 24 are living with HIV. Nearly 80% (4 million) of young people living with HIV live in sub-Saharan Africa. Young females comprise 66% of HIV infections among young people worldwide. [2]2,500 youth become newly infected with HIV every day, resulting in over 900,000, or 40 per cent, of new infections each year. [3]More than half of all sexually transmitted infections (more than 180 million out of a global total of 340 million new infections) other than HIV occur among young people aged 15 to 24[4].

Furthermore, about 14 million teenagers in developing countries get pregnant every year, despite being at a higher risk of dying from pregnancy complications than women in their 20's[5]. Half of these pregnancies are unwanted. In Sub-Saharan Africa, 28% of women aged 20 to 24 got their first child before the age of 18[6]. Millions of people – mostly disadvantaged women and adolescents – still lack access to SRH information and services and contraceptives.

Therefore, addressing the sexual and reproductive health needs and rights of young people is of significant importance. DSW is an international non-governmental organisation that is involved in this endeavour.

This SRH Facilitators' Training Manual constitutes an important learning and facilitation tool in order to improve the sexual and reproductive health situation of young people. It serves as a resourceful guiding document for trainers of trainers and peer educators who facilitate comprehensive Sexual and Reproductive Health (SRH) trainings and learning groups with the aim to empower young people with knowledge, information, as well as skills, and to encourage self-discovered learning and behaviour change.

[1]*UNFPA, 2010, The Case for Investing in Young People*
[2]*UNAIDS, 2010, http://data.unaids.org/pub/outlook/2010/20100713_outlook_youngpeople_en.pdf*
[3]*UNFPA, 2010, The Case for Investing in Young People*
[4]*UNAIDS, 2010, http://data.unaids.org/pub/outlook/2010/20100713_outlook_youngpeople_en.pdf*
[5]*UNFPA, 2010, The Case for Investing in Young People*
[6]*UNICEF, 2012, State of the World's Children*

For whom is this Manual designed?

Acknowledging the strength and effectiveness of peer learning, this SRH Faciliators' Training Manual is designed to ultimately strengthen, improve and effectively facilitate SRH-related knowledge and skills gain of young people.

The Manual is developed in line with DSW's Youth-to-Youth Initiative that includes the training of peer educator trainers and peer educators who pass on skills and essential SRH-information in form of organised trainings or more informal learning groups in respective youth clubs of which they are members.

In order to ensure that the final target group – young people between 10 and 24 years – acquire quality and adequate SRH information, this Manual is designed to be used at three levels by the respective parties:

- **Trainers of trainers (peer educator trainers) trainings**

The manual will be used to train Trainers of trainers (TOTs) also often referred to as Peer Educator Trainers (PETs). The Manual serves as a training tool. The whole training can be structured and conducted in accordance with the sequence, content and structure of this Manual. As such, TOTs/PETs acquire all the necessary knowledge, information and skills that enable them in turn to conduct trainings for peer educators.

- **Peer educator trainings**

In the context of DSW's work, peer educators (as well as PETs) are selected members of the active youth club network. They are trained by PETs/TOTs who facilitate each or selected Modules of this Manual (including Module 1) and ensure that knowledge, information but also skills of effective facilitation are adequately passed on to peer educators.

- **Peer learning group facilitation**

The role of peer educators is to apply the facilitation skills they have acquired during their trainings in order to organise and conduct peer learning groups at the grass root level of youth clubs. Their role is not necessarily to pass on these facilitations skills but to use them in order to create a conducive learning environment for youth and to effectively transfer knowledge and skills to the participants by means of interactive exercises. In this context, the Manual serves both as a resource for SRH information and a reference guide for topics and exercises during peer learning groups.

Approach

This SRH Facilitators' Training Manual includes latest SRH and related information as well as training methodologies that enable effective facilitation, participatory and experiential learning and thus lead to sustainable knowledge and skills gain of and for young people.
"I never teach my pupils; I only attempt to provide the conditions in which they can learn". - Albert Einstein (German-US American physicist, 1879 – 1955).

Conventional learning with a teacher or trainer lecturing in front of a group has proven to be less effective than learning approaches that actively engage participants in the learning process. This Manual is therefore based on a participatory learning approach.

Accordingly, the learning content is not passed on from the trainer to the participants in a one-way communication with trainees only listening. Instead, training participants are encouraged to discover learning contents themselves in an active process. Regardless of the level of formal education, each participant has a valuable contribution to make, if encouraged to be an active partner in the learning process.

Based on this approach, the trainer acts as and is referred to in this Manual as a "facilitator". He/she "facilitates" participatory and experiential learning, i.e. creates the conditions and the environment in which trainees themselves will discover and practice knowledge and skills. By means of exercises, they will explore and share their own experience and knowledge, critically conceptualise and reflect upon solutions from which they will derive learning contents and ways for behavioural change. Appropriate charters and images support the acquisition of knowledge and understanding of SRH information in a youth-friendly way and help to avoid misunderstanding.

Throughout the Modules, participatory methods and creative tools are employed to facilitate learning on SRH topics, other relevant contents and life skills. Moreover, as this Manual addresses TOTs or peer educators who are supposed to facilitate participatory learning themselves after having been trained on this Manual, it provides the trainees with practical skills on how to effectively transfer knowledge and skills to others, e.g. peer educators or young people in learning groups. Consequently, this Manual not only elaborates on the theoretical and conceptual basics of participatory learning and behavioural change, but also on effective communication skills. It provides practical guidance on how to conduct a training and includes methods and techniques that are needed to organise and conduct training sessions based on the principle of participatory learning.

Structure

The Manual is divided into 8 Modules.
Module 1 constitutes the theoretical and conceptual backbone to understand the approach, process and aim of participatory learning, behavioural change and effective facilitation. Moreover, it serves as a practical guideline for facilitators and elaborates on how to prepare and facilitate a SRH training and respective sessions based on the participatory learning approach. As such, it outlines steps that need to be taken ahead of or at the beginning of a training for TOTs/PETs or peer educators - e.g. the recruitment of "trainee facilitators" from the participants. Module 1 provides the groundwork based upon which all other Modules can be facilitated. Modules 2 to 8 deal with different SRH-related topics.

In consideration of the different information and language needs of young adolescents (10-14) and youth between 15 and 24, the information on sexual and reproductive health is dealt with in two Modules (3 and 4) targeting each age group separately in terms of content, wording, and exercises.

The Modules are designed to follow the participatory learning approach and based on a uniform structure. They are divided into different Chapters, which consist of various sub-sections (sessions) that focus on the educational contents and topics related to the overall learning objectives of the Module. .

Each sub-section or Chapter contains a section called basic information on the discussed subject matter. This information is to be read by the facilitator and trainee facilitator in order to prepare for the training (session). It serves as a source for quality and factual knowledge on the subject matter to be dealt with. The basic information can be used as hand-outs for the training participants. Additionally, each sub-section introduces one or several exercises that are designed in line with the participatory and experiential learning approach as outlined in Module 1. Depending on the level of training, exercises can be facilitated by the "trainee facilitators" selected beforehand. The exercises are not designed to result in simple or 'one-and-only'-solutions for specific issues, as DSW strongly believes that young people are capable of developing their own solutions for their individual problems and concerns.

For each exercise the topic, objective, method, tools, as well as the estimated time needed to undertake the exercise are indicated in a clearly arranged text box. The facilitator may prepare the training sessions using the suggested methods, tools and approaches. The participatory methods and tools are not reintroduced in every Module, but the exercises are designed to be conducted based on the practical methods and steps outlined in Module 1.

How to use this Manual

This Manual can be used in various ways.
For the facilitation of TOTs/PETs or peer educator trainings it is recommendable to use this Manual as a compact and holistic training outline and toolkit. It is designed to enable a coherent 7-day training if each Module is worked through as outlined in the Manual.
However, the modular structure also provides for alternative ways to use this Manual:
Following a needs-based analysis of SRH knowledge, facilitators can select particular modules and facilitate a tailor-made training for particular learning needs, e.g. gender or family planning only.

Moreover, against the background of peer learning groups facilitation, the modular structure allows to spread out learning over several weeks or months, so that participants can learn at their convenience and relate the contents to their reality.
Eventually, it is up to the user and facilitator to decide how to use the approach and information presented in this Manual.

MODULE ONE
Effective Facilitation

DSW

Table of Contents

Introduction

This Module 1 introduces the concept and structure of participatory learning. It outlines the principles of effective facilitation and provides practical guidance for organisers and facilitators of participatory learning sessions.

The information presented in this Module 1 constitutes the backbone of a participatory learning process. Each of the following Modules of the SRH Facilitators' Training Manual is based on the concepts and procedures introduced in this Module 1. It is up to the facilitator to decide whether to share the information included in Module 1 in form of participatory learning and exercises as suggested in the relevant Chapters below, or to inform the training participants about the contents and the general concepts of facilitation and participatory learning in form of a general introduction to the training.

Chapters 1, 2 and 3 of Module 1 focus on the practical basics on how to effectively prepare, initiate and close a participatory training and essential steps for creating a conducive environment and ensuring active participation of all trainees.

Chapter 2 is dedicated to the roles and responsibilities participants can take on in a participatory learning process, e.g. as trainee facilitators for particular sessions or as evaluation supervisors for daily activities. Chapter 3 explains the process and importance of evaluation. Every session, every day and the training as a whole will be concluded with an evaluation. Frequent evaluation fosters mutual learning and helps to adapt to changes swiftly. It will also enable, intensify and support the ongoing improvement of the participatory learning process.

Chapter 4 focuses on basic theory and concepts of participatory learning, behavioural change, and effective communication and facilitation skills. It provides a comprehensive overview of special skills, methods and techniques for successful learning as a toolkit for facilitators to organise and conduct training sessions based on the principles of participatory learning.

The facilitation of this module with all its exercises is expected to take about 6 hours

Learning objectives

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

- Understand the concept of participatory learning process
- Describe the main components of the getting started session during training
- Describe how training can be evaluated
- Explain the experiential learning cycle

Chapter 1: How to plan a participatory learning process

1.1 Basics

Participatory learning requires a conducive learning environment. Before starting a participatory learning process on SRH, you need to consider a number of important aspects and engage in various planning and preparatory activities.

The participants
Since interests and capabilities differ, young adolescents (10 to 14 years) and young people (15 to 24) usually work in separate groups. Module 3 and 4 are specifically designed for young adolescents and young people.

The participants are volunteers. If they are not offered a conducive learning environment, they may walk away. In order to create a favourable environment, you should prepare lessons and exercises well ahead of time.

Work with a limited number of participants (20-25 [1]) only to allow for activity, interaction and personal relationship building within the group. You will see that increased participation and group coherence can boost the quality of the participatory learning process.

Seek to form gender balanced groups to ensure that both female and male participants have an equal chance to share and exchange their views on sexual and reproductive health issues.

Encouraging active participation
In a participatory learning process, the facilitator will act as a moderator rather than a lecturer. Participatory learning is based on interaction and exchange between the facilitator and the participants, as well as among the participants themselves.

1.2 Preparatory activities and planning

Depending on the level of training (Training of Trainers, Peer Educator Training or in Peer Learning Groups), there are several planning steps to be considered ahead of the training. The planning process should be initiated well in advance by the facilitator to ensure a successful participatory learning experience.

[1] *The number of participants may differ in different contexts and based on the type of training (e.g. Training of Trainers or Peer Learning Group), but also depend on available resources.*

What needs to be done?	Who is responsible?	By when will it be done?
Choose participants		
Prepare the training schedule		
Prepare learning tools		
Test exercises		
Book and check convenience of the training venue		
Organise refreshments (if necessary)		
Organise transport and accommodation (if necessary)		
Inform local authorities (as appropriate, usually not requested at Peer Learning Group level)		
Organise guest speakers and involve local authorities (as appropriate)		

Budget items	Estimated cost	Budget
Learning Tools		
Transport		
Food and drinks		
Accommodation		
Other		
Total		

Training venue

It is important to ensure that the location for the training is convenient and well-chosen, since the environment may have an impact on the learning process. Therefore, the training venue ideally will:

- Be calm and isolated from distractions
- Be well-aired
- Have enough light
- Have adequate and flexible seating
- Avail learning tools (flip charts, cards,markers, boards) if possible (otherwise you need to bring what you need).

Stakeholder involvement

For trainings at higher levels (usually not at the peer learning level), there might be an official opening ceremony to which representatives of the local authorities should be invited in good time and one or two guest speakers asked to kindly make the opening remarks (10-15 minutes). The opening ceremony is an important occasion to network, advocate and underline the importance of SRH learning and peer education activities in the community. It is valuable to invite not only official representatives but also other stakeholders to the ceremony.

In case the participatory learning process is not initiated with an opening ceremony, it is important to at least inform local authorities/government representatives at the district level about the training and to share the training schedule with them to get their approval, gain their support and further integrate your activities into local structures, thereby strengthening sustainability. This is particularly important when training certificates are to be signed in the name of the organising institution/organisation and certified by the national government (e.g. the Ministry of Health).

Learning Tools

In order to make the learning experience effective and enjoyable, it is crucial to make sure in good time that the necessary materials and supplies for the training are available. You may not find the materials indicated in this Manual readily available at the location of the training and perhaps need to explore alternatives using locally available materials. Make enough copies before you go into areas where there might be no electricity at times, etc.

The following tools will be helpful to conduct participatory learning sessions:

- SRH Facilitators' Training Manual
- Flip chart, flip chart paper or large sheets of paper
- Markers in different colours
- Chalk to write on the floor or a black board
- Note paper
- Glue stick, pins, cello tape
- Scissors
- Cartons to be cut into facilitation cards
- Cards or slips of paper, scrap paper to cut notes
- Optional: a hat (to identify a trainee facilitator)
- A pointer
- Optional: a big coloured scarf (to identify a procedure supervisor)
- A yellow and a red card (to be used by the procedure supervisor)
- A flip chart stand (alternatively, you can put up large sheets on doors and walls)
- A variety of contraceptives for demonstration purposes
- Any other demonstration or supporting tool that may be useful in the context of a specific module or Chapter.
- Handouts as needed

Please note:

Since a flip chart is a paper based teaching aid, it is important to notice the following points.

- It is important to write in a visible handwriting so that those who sit far from the chart can read without problem.
- It is not recommended to write lots of information on a single page.
- Use different colours as possible and necessary.
- Written flip chart sheets will be collated on the wall. They are not taken down before the training is concluded. If the facilitator or participants need to look them again they can use them.
- It is important to number the sheets according to their order and keep them properly. They may be important for later use or report preparation.

Chapter 2: Getting started

A good start will greatly contribute to the success of the training. A training starts with the session "Getting started", that consists of 8 steps. If the facilitator is well prepared and has managed all preparatory activities in good time, "Getting started" should not take longer than two hours.

1. Opening of the training
2. Opening ceremony
3. Introduction of participants
4. Clarifying participants' expectations and concerns
5. Understanding the objectives of the training
6. Agreeing a time table
7. Ensuring a conducive environment and active participation
8. Reaching a consensus on training norms

Note: Step 2 is only relevant for trainings at a higher level or dependent on the context.

2. 1 Opening of the training

A representative of the training organiser (or the facilitator) welcomes all participants and guests to the training.

2.2 Opening ceremony of the training

Exercise 1:	Formal opening ceremony for a training
Objective:	To demonstrate procedures on how to formally open a training session
Method:	Inviting guest(s) of honour to address opening remarks to participants
Tool:	Prepare a podium
Time:	20 minutes

Facilitator's tasks:

1. Ask the organiser or a representative of a relevant institution to welcome the participants to the training and convey a message of encouragement. Invite the guest of honour (if any) to give the official opening speech.
2. After the opening ceremony, ensure that the guest(s) are excused to leave and begin the first session.

Note: The official opening is a valuable opportunity for advocacy and networking to underline the importance of peer educators' activities in the community not only to the participants but also to the various institutions and individuals invited to the opening session.

Basic information

At higher-level trainings and as appropriate, a training will always start with an opening ceremony that needs to be organised beforehand. The opening ceremony helps to raise awareness of the importance and approach of SRH peer learning to society and is an opportunity to increase support among invited guests and guest speakers.

After everyone has been welcomed, the representative of the organiser introduces and invites the guest speaker(s) to the front/ podium. The opening remarks of the guest speaker(s) ideally take between 10-15 minutes each. Following the speeches, the facilitator takes over, starts the participatory learning process and ensures to abide by the time table.

2.3 Introduction of participants

Exercise 2:	Introduction of participants
Objective:	To get to know each other
Method:	Participants group into pairs of two and introduce themselves to each other. After 2-3 minutes they return into the group and introduce their respective partner to the other participants.
Tools:	Large pieces of paper or flip charts, markers
Time:	20 minutes

Facilitator's tasks:

1. Welcome all participants and introduce yourself.
2. Write down on the flipchart the topics for introduction. (See example below)
3. Arrange participants in pairs and ask them to gather in the corners of the room.
4. Allow for 2-3 minutes to work in pairs and interview one another. Suggest that some additional information, such as the meaning of the name and/or something special about the person, a drawing or a particular related story, may be added to the introduction.
5. When the time is over, ask participants to introduce the person they have just interviewed to the whole group.
6. Explain to the participants that starting with a self-introduction will create a good atmosphere among the participants, which will help them to relax and be more spontaneous, thereby building participatory involvement and team spirit.

Example of introduction topics for participants

- Name, meaning of name
- Educational background
- Contributions as a youth club/association member
- Previous engagement in ASRH
- Something special about me

Basic information

Young people have well developed needs and interests. If the training meets their needs and interests, they will learn a lot. During this exercise, participants are asked to express their expectations and concerns in relation to the training. It is time for each participant to become clear about what exactly s/he would be realistically expecting from this training. If their expectation is beyond the scope of the set objectives, it is important for the facilitator to clarify what they actually can expect. Otherwise, a misunderstanding may arise between the facilitator and the participants if they are not following along the same line from the outset.

2.4 Clarifying participants' expectations and concerns

Exercise 3:	Clarifying expectations of participants
Objective:	To identify what participants expect to gain from the training
Method:	Allowing participants to express their expectations and concerns
Tools:	Flip chart and markers
Time:	15 minutes

Facilitator's tasks:

1. Inform participants about the subject of Module 1, "Effective Facilitation".
2. Ask participants to brainstorm on what they expect from the training and to identify one expectation and one concern. Give participants an example. (See below)
3. Note down the ideas from the brainstorming on the flip chart.
4. Group repetitive and similar ideas.
5. Compare the expectations against the training objectives. (See Section 2.5 of this Chapter)
6. Keep the paper/flip chart displayed throughout the whole training and refer to it as appropriate. On the last day of training, participants will be have a chance to compare and discuss whether or not their preliminary expectations have been met during the training.

Examples of expectations and concerns

Expectations:
- Gain knowledge of ASRH issues
- Gain experience and skills in applying participatory learning methods and tools
- Develop skills on how to facilitate peer educator trainings
- Enhance knowledge on contraceptive methods

Concerns
- Time allocated for the training is not sufficient
- Participation is limited

Basic information

Young people have well developed needs and interests. If the training meets their needs and interests, they will learn a lot. During this exercise, participants are asked to express their expectations and concerns in relation to the training. It is time for each participant to become clear about what exactly s/he would be realistically expecting from this training. If their expectation is beyond the scope of the set objectives, it is important for the facilitator to clarify what they actually can expect. Otherwise, a misunderstanding may arise between the facilitator and the participants if they are not following along the same line from the outset.

2. 5 Understanding the overall objectives of the training

Exercise 4:	Understanding the overall objectives of the training
Objective:	Enable participants to understand the objectives of the training
Method:	Participants discuss and compare their expectations against the set objectives of the training
Tools:	Listed training objectives on a flip chart
Time:	10 minutes

Facilitator's tasks:

1. List the objectives of the training (see Basic information below) on the flip chart, put the list up on the wall and read the objectives aloud for the participants.
2. Invite participants to express their own ideas by comparing their expectations against these objectives
3. Explain that reaching a common understanding of objectives and expectations prior to the training will create a favourable working atmosphere and facilitate collaboration and learning.

Overall objectives of the training

i) To equip peer educator trainers, peer educators, and peer learning group facilitators with knowledge and skills on comprehensive sexual reproductive health and rights

ii) Equip SRHR facilitators with effective facilitation approachand methodologies that will enable effective facilitation thus leading to sustainable knowledge and skills gained

Basic information

If the objective of the training is well communicated ahead of the training, there will be few negative comments from the participants' end. A clear understanding of the objectives will foster participation and make the participatory learning process flow smoothly. This activity enables facilitators and participants to clarify their expectations (see Exercise 3 of this Chapter). If participants' expectations go beyond the objectives of the training, the facilitator should clarify this right away, since a lack of clear understanding of objectives can lead to misunderstandings and frustration among (trainee) facilitators and participants alike.

2.6 Agreeing a time table

Exercise 5:	Agreeing a time table
Objective:	To reach a consensus with participants on time table and time management
Method:	Open discussion
Tools:	Detailed time table for the training, Day's Time Table
Time:	10 minutes

Facilitator's tasks:

1. Introduce the training content and present the detailed time table (3-5 minutes) that should be well prepared in advance. Then ask participants to agree upon the Day's Time Table.
2. Inform participants that the detailed time table is flexible, will be reviewed on a daily basis.
3. Point out that the detailed time table will be left visible on the wall until the end of the training.

Proposed by the facilitator		Agreed with participants	
8:30-10:30	Learning time	?	Learning time
10:30-11:00	Break	?	Break
11:00-12:30	Learning time	?	Learning time
12:30-13:30	Lunch break	?	Lunch break
13:30-15:30	Learning time	?	Break
15:30-16:00	Tea break	?	Learning time
16:00-17:30	Learning time, Evaluation & Conclusion	?	Evaluation & Conclusion

2.7 Ensuring a conducive environment and active participation

If the participatory learning process takes place in a conducive setting that allows for active participation, it will bring about very positive results. Active involvement of participants will be ensured by:

1. Choosing a flexible seating arrangement that allows for interactivity. (See "Getting started")
2. Involving participants as trainee facilitators or supervisors.
3. Allowing participants to actively participate in the daily activities.

Exercise 6: Involving participants and assigning roles for active participation

Objective: To ensure participants actively participate in the participatory learning process

Method: Share information on active participation and assign roles to participants

Tools: Participants' Daily Task Table

Time: 45 minutes

Facilitator's tasks:

Each participant is supposed to assume the role of a trainee facilitator at least once in order to gain firsthand experience in the facilitation of participatory learning processes. He/she will be assigned a session or exercise and asked to prepare himself/herself by reading the relevant chapter carefully (exercise instructions, "Facilitator's tasks" and "Basic information") and preparing the materials needed for the session. In order to assign trainee facilitators, the main facilitator will do the following:

a) Assign trainee facilitators to facilitate exercises of the participatory learning process

1. Select and arrange suitable exercises/ activities for different sessions.
2. Note down the exercise number and the number of the page where the respective exercise can be found on a piece of paper and roll it up.
3. Put the paper rolls in the middle of the circle of participants.
4. Ask participants to pick a roll.
5. Ask participants to study and prepare the exercise indicated on their respective notes and offer help and support in case of any questions.
6. Then ask participants to facilitate the learning process attached to the respective exercise. Specify the day and time when they will be expected to facilitate the exercise.
7. Explain that following each facilitated exercise, participants will evaluate and discuss the performance of the trainee facilitator (e. g. using the Effective Communication Check List format - see Chapter 4).

b) Assign volunteers for daily activities

Every day, there will be various other roles to be assumed by participants to help structuring and supporting a smooth participatory learning process in a participatory way. In order to assign such other roles to participants, the main facilitator will do the following:

1. Draft a "Daily Tasks Table" (see example below) on a flip chart/board/ paper that displays daily activities or functions required ensuring a smooth participatory learning process, e.g. "evaluation supervisor" or "energizer".
2. Note down the activities of the day on small pieces of paper corresponding to the number of training days (e.g. for 4 days, write 4 little notes with the role "energizer"), roll them up and put them in the middle of the circle of participants.
3. Ask every participant to pick one or two rolls. The content of the roll and the name of the participant will be noted under the respective activity in the "Daily Task Table" and posted on the wall.

Example of Participants' Daily Task Table

Task	Tuesday	Wednesday	Thursday
Check-in person	Peter	Samuel	George
Reviewer	Charity	Amina	Emmanuel
Energizer	David	Charles	Joyce
Procedure supervisor	Hope	Ibrahim	Daniel
Evaluation supervisor	Miriam	Paul	Samuel

Definition of active roles for participants

Check-in

Every morning, before the first learning session, the person assigned with this task will ask participants how they are doing and how they feel. It is a method that enables the facilitator to know about the conditions of the participants - or about their wellbeing - just before the start of the participatory learning session of the day. The objective of this method is to develop a sense of closure and a relaxed atmosphere, engaging into cooperation between the facilitator and the participants or among peers.

The Check-in person invites the participants to talk about problems or enjoyments they have experienced just before entering the room. Some participants may even present a joke or describe a funny situation, whereas others may wish to talk about their health or not feeling so well. In the latter case, the facilitator tries to respond quickly and find a solution for the problem.

Reviewer

Before starting a new session, the person in charge of this task will ask all participants to stand up and recap what has been dealt with on the previous day or in the previous session. Every participant is asked to briefly say what s/he has retained from the last lesson and how it is related to his/her own prior experience, or how s/he felt about that. The facilitator then creates a bridge and a link between what was learnt the previous day, and what will be learnt today. During the evaluation of the previous lesson, s/he will initiate a brief discussion on what needs to be improved in today's session as compared to the previous one.

Energizer

The participant who is assigned to be the "energizer" is expected to boost participants' attention and motivation when they are in a state of exhaustion or boredom during the participatory learning process. Whenever necessary, in consultation with the facilitator, the energizer will conduct some warming-up activities. These may include physical activities, songs, games, jokes, storytelling, etc. Participants often also come up with a number of own ideas for energizers.

Procedure supervisor

In a participatory learning process, time limits for activities tend to be exceeded. The "procedure supervisor" acts as a referee who watches the time limits and indicates when an activity needs to be wound up or accelerated.

The procedure supervisor's role is also to support the facilitator towards an effective learning process. He/she:

- Ensures that time limits and agreed training norms are respected. If appropriate for the learning and group context, s/he will suggest that participants may identify and agree on possible sanctions for violating training norms. (Example: The one who did not respect the training norms will be made to sing, dance… in front of the audience)

- Uses a bell, clapping or whistle blowing to indicate time limits

- When 5 minutes remain for the time set for a certain activity to elapse, the procedure supervisor will show a yellow card. When the time is up, s/he shows a red card. At this point, the facilitator should interrupt the activity and wind up.

Note: To avoid time shortages at a later stage caused by exceeded time limits, it is important to estimate the duration of all activities and ask trainee facilitators to prepare and test the actual duration of activities beforehand.

Evaluation supervisor:

The facilitator should not monitor feedback sessions. Towards the end of each training day, hand over to the "evaluation supervisor". The evaluation supervisor asks the participants to evaluate the day. (See Chapter 3). The evaluation is subject to further discussion or feedback during the review session of the following day.

Parking Lot:

During discussion sessions in the course of the participatory learning process it is possible that questions will arise, which the facilitator may not be able to answer immediately. To avoid time consuming discussions and misunderstanding, take a note on the flip chart under the heading "Parking Lot" to shorten the debate but identify questions not yet properly dealt with. You may then consult an appropriate source to find an answer to the question and reply to participants at some point before the end of the training.

2. 8 Reaching a consensus on training norms

Exercise 7:	Reaching a consensus on training norms
Objective:	Allowing participants to discuss and reach a consensus on training norms
Method:	Small or large group discussions
Tools:	Flip chart, markers
Time:	20 minutes

Facilitator's tasks:

1. Ask participants to group up in pairs or small groups of 3-6 individuals and to come up with three training norms that they consider important (5-10 minutes).
2. Ask each group to assign a moderator and a rapporteur.
3. Put up a flip chart on which all proposed training norms and procedures will be noted and displayed throughout the entire training.
4. After the small group discussions, the groups are supposed to present their results in plenary.
5. Note down the points raised by the groups on the flip chart and correct or classify redundant points with the help of participants.
6. Summarise the main "training norms" and get the agreement of all participants to adhere to the negotiated norms throughout the entire training.
7. Point out that the procedure supervisor will ensure that the agreed training norms are observed and respected.

Basic information

During the participatory learning process, different participants will assume different, active roles.

Each participant will assume responsibility as an individual and group member, but also as a trainee facilitator, procedure or evaluation supervisor or energizer. To ensure that the different sessions of the participatory learning process run smoothly, it is advisable that participants agree upon and define procedures and training norms. Each participant, no matter which role s/he currently has, must be listened to, understood, respected and appreciated by the others.

Example of Training Norms

1. We are attentive
2. We cooperate with the facilitator
3. We are on time
4. We do not undermine others' opinions
5. We do not refrain from giving our constructive opinions
6. We do not waste time by simply talking
7. We do not interrupt others while they are speaking
8. We listen attentively to what others are saying
9. We do not allow distraction by murmuring private talks with the person sitting next to us
10. We care and will understand if other participants are not feeling well
11. What we discuss in the group is confidential.

Chapter 3: How to conclude a participatory learning process

3.1 Daily evaluation of the participatory learning process

Evaluation is crucial in the context of participatory learning. It is important to follow up and know exactly how participants think about the process at the end of each training day. Their feedback allows for improving and adapting the participatory learning process on an ongoing basis. If participants dislike the process, they might be discouraged, leave or interrupt the participatory learning session. Once this has happened, it will be extremely difficult to encourage and motivate them to resume active participation. Therefore, each training day should be closed by an evaluation session.

Exercise 8:	Practicing how to close participatory learning sessions by evaluation
Objective:	To reflect on sessions and training days and provide feedback to make the process a success.
Method:	Open discussion
Tools:	Evaluation grid, Evaluation questions, Final Evaluation form, pens, markers
Time:	10 minutes

Facilitator's tasks:

1. At the end of the day's last session, ask participants to come together in a circle.
2. Thank participants for their contributions.
3. Distribute any homework or papers (if applicable, this up to the facilitator to decide).
4. Ask those participants who will be next day's trainee facilitators to come prepared.
5. Hand over to the designated evaluation supervisor.
6. The evaluation supervisor will write the following questions on a large paper that the facilitator will put up on the wall.
7. Participants will be asked to evaluate the day's session by answering the evaluation questions (you may also choose a confidential evaluation technique):
   - Which measures were conducive for learning in today's session?
   - Which obstacles did we come across in today's session?
   - What should the facilitator do?
   - And what should organisers do?
8. Note down all the answers on a flip chart and/or use the Evaluation grid (see below). Discuss them with the participants.
9. At the end of the evaluation session, ask participants to answer the following questions for discussion in the revision session for the next morning:
   - What needs to be improved?
   - "Which measures should be taken, by whom, when and how?"
10. Participants are also encouraged to raise their own questions. There are several techniques to organise an evaluation. (See two examples below). Based on the opinions voiced during the evaluation, the facilitator should reflect on ways of improvement for upcoming activities.

Basic information

During evaluation time the facilitator should refrain from any comments. The facilitator should not try to justify his/her point of view based on the participants' criticism or opinion. This will create a sense of trust in the facilitator among participants, who will feel that they are allowed to express their opinion freely. And, as a note to the facilitator: Remember that no one can realistically be expected to know it all in all subject fields with an absolute 100 % knowledge.

Evaluation techniques

Option 1: Confidential evaluation
Every participant writes down his/her comments on a piece of paper and passes it to the evaluation supervisor. The collected written evaluation comments will be posted on the wall for others to have their say on it.

Option 2: Open discussion
Participants are requested to record their evaluation on large grids provided on the wall. The following morning, participants will be expected to give their opinions about the evaluation results and discuss openly.

Evaluation grid to evaluate a training day

The Evaluation grid provides for participants to rate the content and delivery of training and the use of time for each training day.

Evaluation item	Rating					Total
	1	2	3	4	5	
Content of learning						
Process of facilitation						
Time management						

1 = Inadequate 2 = Satisfactory 3 = Good 4 = Very Good 5 = Excellent

The three aspects should be evaluated based on the following questions:

Content of learning:

- Was the content essentially important?
- Was it related to sexual and reproductive health?

Process of facilitation

- Did the facilitator use effective communication skills?
- Was it entertaining?
- Was it encouraging/participatory?
- Has the facilitator used sufficient teaching aids effectively?

Time management

- Was the time use well balanced?
- Was the training too long?
- Was it conducted hastily?
- Was enough time provided?

Rating

Participants will be asked to rate each aspect under the above mentioned criteria on a scale from 1 to 5:

1. Inadequate
2. Satisfactory
3. Good
4. Very Good
5. Excellent

Whenever participants assign 2 or less points, the facilitator will ask very nicely why they gave a poor rating, without blaming or criticising participants. The facilitator will conclude the session of the day after evaluating their daily tasks.

Evaluation questions:

i. Which activities assisted our learning today?
ii. Which activities hindered our learning today?
iii. What should the facilitator do?
iv. What should participants do?
v. What should the organiser do?

3.2 Final evaluation at the end of the training and follow-up

At the beginning of the training, participants have identified their expectations and concerns. On the last day of the training, they will be asked to express their thoughts again and compare it with their initial expectations and concerns as listed on the flip chart and kept on the wall throughout the training. In addition, each participant will be asked to fill in a Final Evaluation form based on a uniform format (please prepare enough copies in good time).

Facilitator's tasks:

Encourage discussion and ask participants to answer the following questions:

1. What did we expect from the training?
2. Have our expectations been met?
3. Which expectations have not been met?
4. Were initial concerns tackled on the way?

Ask the participants to complete the Final Evaluation form

No	Evaluation item	Points				
		1	2	3	4	5
1	The training was fun.					
2	The training has enabled me to better understand the process of behavioral change					
3	I have acquired new knowledge and information on SRHR					
4	I will try to put into practice what I have learnt?					
5	The facilitator has contributed to the success of the training.					
6	The training increased my knowledge of sexual and reproductive health.					
7	The training was well prepared.					
8	After the training, I feel able to facilitate a participatory learning process myself (with a copy of the Facilitators' SRH Manual).					
9	There was enough time.					
10	Participants participated greatly in the learning sessions.					
11	The training tools were useful.					
12	The training achieved its goals.					

Rating

Participants are requested to rate each of the above mentioned items on a scale from 1 to 5:

1 = I don't agree
2 = I don't know
3 = I partly agree
4 = I agree
5 = Absolutely

3.3 Closing ceremony and participant certificates

At the end of the training, organise a short closing ceremony. Prepare for a brief speech by the facilitator or a representative of the organiser. Tell participants how they can apply what they have learned (as a Trainer of Trainers, Peer Education Trainer, or with young peer learners). The participants will expect to receive a participant certificate at the end. A certificate is a reward and an incentive to participate in further trainings or peer learning sessions. The award of the certificates marks the successful completion and end of the training for the participants.

Facilitator's tasks:

1. Prepare Training Certificate in advance and have printed copies with names and stamps prepared for the closing ceremony.

3.4 Follow-up for Peer Educators

Peer Educators who have been trained on how to facilitate Peer Learning Groups should always record the details of any peer trainings or learning sessions they provide in order to document their contribution to youth SRH programs, quantify their successes and report back to their home organisation, local authorities and/or donors as appropriate.

The form provided on the next page may serve as a template for reporting on participatory learning activities/ Peer Learning Groups.

Peer Learning Report Form

1. Peer Learning Team (participants): _____

2. Place of training: _____

3. Number of Participants: Male _____ Female _____

   Age a) 10-14____ b) 15-19____ c) 20-24_____ d) 25+_____

4. Duration: Time___ Days____ Weeks____ Months___

5. Trained on Module(s) _____

6. Participants' comments (positions, decisions, or pledges made as a result of having participated in the training (use reverse side as necessary)

_____

_____

_____

_____

_____

7. Problems / challenges encountered

_____

_____

_____

8. Have you observed any signs of behavioural change after the training? (use reverse side as necessary)

_____

_____

_____

9. Facilitator's comments:

_____

_____

_____

10. Facilitator's full name _____

    Signature _____ Date_____

    Name of organisation/project _____

Chapter 4: Participatory learning and effective communication skills

4.1 Conventional education

Generally speaking, there are two types of education and training provision or delivery. The first one is formal or conventional/traditional education or training, whereas the second one is the participatory learning process. The two procedures differ widely.

Formal or conventional education

In conventional or formal education settings, there will be a teacher lecturing students or trainees. The trainer usually submits information to the trainees in a one-way-communication, while trainees are supposed to sit and listen. The following are characteristics of conventional teaching:

- The teacher knows, the student doesn't.
- Knowledge is transferred from the teacher (sender) to the student (recipient).
- The teacher decides what is being taught, and how it is being taught.
- Education occurs through teaching in the form of a lecture.
- The role of the student is limited to listening and accepting as the teacher is talking.

4.2 Participatory learning

When applying/implementing participatory methods/approaches/tools, it is not enough to apply a certain participation technique. You must have understood the underlying key principles and the mind-set that is requested for successful participatory learning.

Moreover, in a participatory learning process:

- The trainer manages the learning process as a "facilitator of learning".
- Knowledge is discovered through joint investigation of problems and issues.
- The facilitator guides the learning process in cooperation with the trainees and even takes on the role of a participant occasionally.
- Trainees learn from each other.
- Learning is a gradual process.
- Knowledge is discovered through experience sharing, analysis and identification of possible solutions.
- The trainer works in partnership with the trainees.
- The trainees assume responsibility in the learning process and actively participate.
- Participatory learning methods and tools are used.

A participatory learning approach seeks to enable participants to control their own learning, to actively involve and make them aware of existing alternatives for decisions they take, thereby enabling and empowering them to make responsible choices for themselves. Participants are introduced to participatory methods and tools also with the intention that they will use these methods and tools to facilitate participatory learning sessions themselves, e.g. peer educator trainers and peer educators who can use the participatory approach in their own learning groups.

4.2.1 Learning with all senses

A Chinese proverb says: "What I HEAR, I forget, what I SEE I remember, what I DO I know". This basically means that a person learns best by using all of his/her senses and engaging the whole of his/her body. Learning includes mind, hands and emotions.

Exercise 9: The principles of learning - What I HEAR, I forget, what I SEE I remember, what I DO I know. (Confucius)

Objective: To introduce the principles of learning by engaging participants' senses in several activities

Method: Role plays

Time: 20 minutes

Facilitator's tasks:

Listening only

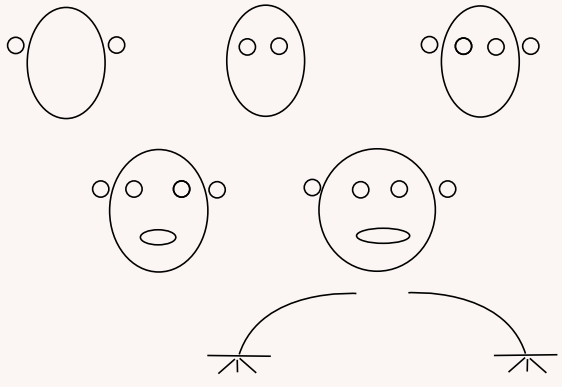
1. Ask participants to sit relaxed.
2. Ask them to be silent (close their mouth), shut their eyes and not move their hands.
3. Briefly describe a picture on the wall or what you see through the window.
4. Ask participants to think about how much they know about what they have being told them.
5. After thinking about that for a while, ask participants to open their eyes and ask them how much they can remember.
6. Point out that it is assumed that people learn about 20% through mere listening.

Seeing only

7. Ask participants to close their mouth, shut their ears and not touch anything with their hands.
8. Point at a picture/image/out of the window. Ask them how much they have learned about what they are seeing by simply looking at it.
9. Inform them that it is assumed that by seeing only, people learn about 30% of the presented content.

Listening and seeing only
When listening (oral explanation) and seeing (visual presentation) are combined, a person can learn up to 50% of the presented content.

Listening, seeing and talking
When listening is supported by a visual presentation and the content is talked about (questions asked and answered), the learning effect is about 70%.



Learning with all senses

10. Explain that where listening, seeing, talking and practical activity are involved in a learning process, a person can learn up to 90% of the presentedcontent. In a participatory learning process, oral and visual presentation is accompanied by practical activity (drawing images, for example) and active involvement of the learner, which increases the learning effect in most people. There are various communication skills, teaching aids, materials and techniques to actively involve participants.
11. As a conclusion, point out that the concept of participatory learning actually integrates all senses through experiential education, as participants are actively involved in the learning process, which is mostly not the case in conventional learning settings.

4.3 Achieving behavioural change through experiential learning

4.3.1 How behavioural change occurs the Experiential Learning Cycle

Source *(http://learningfromexperience.com)*

The main objective of this Manual is to provide information on how to kick-off and guide a successful participatory learning process using experiential learning with the ultimate goal to bring about behavioural change. But how does behavioural change occur?

The Experiential Learning Cycle

A useful basis to understanding behavioural change is the theory of experiential learning by David Kolb in 1986. He developed an Experiential Learning Cycle that comprises four different stages of learning from experience resulting in behavioural change.

The Experiential Learning Cycle suggests that it is not sufficient to merely make an experience in order to learn. It is necessary to reflect on the experience, to make generalisations and formulate concepts which must then be applied to and tested in new situations in order to eventually result in behaviour change.

> *"Learning is the process whereby knowledge is created through the transformation of experience"*
> (David A. Kolb, 1984)

Through facilitation of the Experiential Learning Cycle, young people evolve from having a low level of awareness e.g. on their own risky sexual behaviour, to a higher level of awareness which can then be 'fed back' into the Experiential Learning Cycle. Participatory methods and tools are applied and exercised in the course of the learning cycle. The Experiential Learning Cycle helps to achieve sustainable behaviour change among participants/youth. It enables them to increase their level of awareness, to learn from their own experience, to transform information into useful knowledge, to come up with solutions themselves, thereby increasing ownership, motivation and ability to actually change their behaviour.

Kolb's Experiential Learning Cycle consists of 4 elements:

1. Concrete Experience (doing / having an experience)

The cycle starts with a concrete experience. In other words it begins with implementing or assigning a task (discussion, activity, game or similar). Experience involves being engaged in an activity and/or simply identifying, expressing and collecting one's own experiences related to a certain topic/issue.

2. Reflective Observation (reviewing / reflecting on the experience)

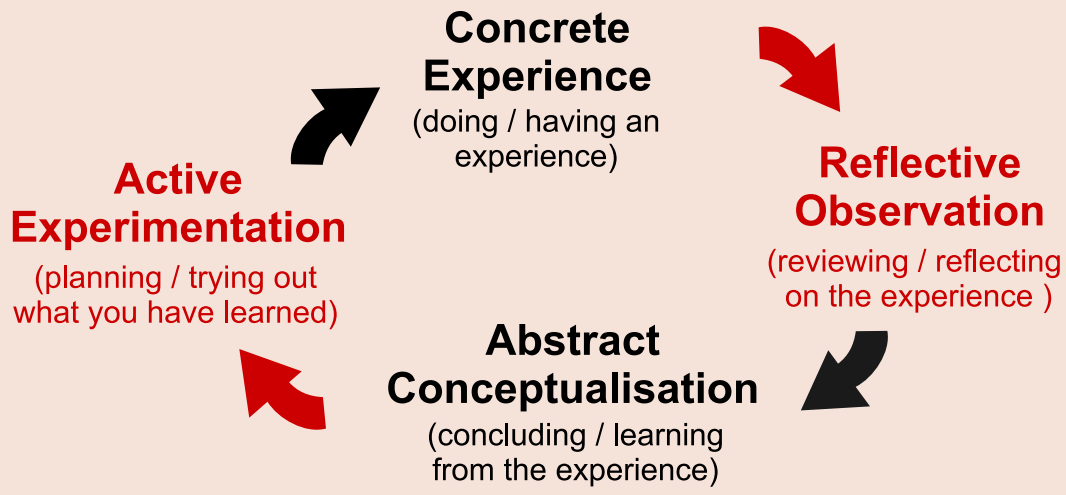
In this stage participants review and reflect upon the task/ activity or share observations from the "Concrete Experience" stage. Causes and effects are analyzed, scientific knowledge may be added or shared by the (trainee) facilitator (e.g. extracted from the section "basic information") and positive and negative aspects identified.

3. Abstract Conceptualisation (concluding / learning from the experience)

During this stage, participants extract a meaning from the observations and reflection they made before. They will understand their experiences conceptually and critically by identifying the advantages and the disadvantages, the consequences, the causes of the problems and their impacts. They compare and contrast the experiences and knowledge. The (trainee) facilitator can here also add information as appropriate (e.g. extracted from the section "basic information"). General principles and patterns are identified and participants, step by step, will take a stand. During this phase, participants will proceed to another level. In the process to behavioural change, this is one big step.

4. Active Experimentation (planning / trying out what you have learned)

The conclusions that have been formed in the 'Abstract Conceptualisation' stage form the basis by which participants identify solutions to problems and their causes. The (trainee) facilitator asks the group to determine what should be done to reinforce the positive sides and minimise the negative aspects of the discussed topic. Participants are encouraged to develop strategies and a plan of action based on the insights they have gained from previous steps. The facilitator should structure this planning process asking why, who, what, when, how, where-questions.



Exercise 10:	Understanding the Experiential Learning Cycle
Objective:	To introduce participants to the stages of behavioural change through experiential learning
Method:	Presentation of the Experiential Learning Cycle by participants in groups
Tool:	Image of the Experiential Learning Cycle, list of the 4 elements, paper, flip chart or large papers, marker
Time:	30 minutes

Facilitator's tasks:

1. Write each of the four elements of the Experiential Learning Cycle on a piece of paper and role it up.
2. Throw the rolls towards the partici pants.
3. Ask the participant who catches a roll to try to explain the element s/he sees written on the paper.
4. Complete the explanations given by the participants as necessary.
5. Ask a volunteer to draw the complete Experiential Learning Cycle on a flip chart / large paper.
6. Summarize the information on the Ex periential Learning Cycle.

Exercise 11: Experiment: Behavioural change through experiential learning

Objective:	To help participants understand how behavioural change through experiential learning works
Method:	Putting the Experiential Learning Cycle into practice
Tool:	Image of the Experiential Learning Cycle
Time:	40 minutes

Facilitator's tasks:

1. Group the participants into small groups of 4 to 6 members and allocate to each group 10 to 15 minutes for discussion.
2. Ask them to experiment behavioural change by applying the elements of the Experiential Learning Cycle to a certain topic. Here are two examples:

Group 1: Drinking alcohol

- Ask participants to discuss the issue of drinking alcohol along the four elements of the Experiential Learning Cycle.
- Ask group 1 to exchange their experiences related to drinking habits or problems
- They are expected to analyse the pros and cons of drinking alcohol and exchange their experiences. During the presentation, participants will reflect themselves against the statements made and take a stand.
- After taking their stand, the participants will be led to taking a new position. For instance, the discussion will continue to find solutions against harmful drinking habits.
- The group is then supposed to define a solution to the problem of drinking alcohol and formulate it in a positive way.
- The group is then supposed to develop a plan to put this solution into practice.
- As a conclusion, those participants who are willing to put this plan into practice will make a corresponding commitment.

Group 2: Drug abuse

- Ask the group members to discuss the issue of drug abuse (e.g. chewing khat) in line with the four elements of the Experiential Learning Cycle.
- Ask group 2 to exchange their experiences related to drug abuse
- They are expected to analyse the pros and cons and deliberate about that. During the presentation, participants will reflect themselves against the statements made and take a stand.
- After taking their stand, the participants will be led to taking a new position. For instance, the discussion will continue to find solutions against harmful drug consumption habits.
- The group is then supposed to define a solution to the problem of drinking alcohol and formulate it in a positive way.

- The group is then supposed to develop a plan to put this solution into practice.
- As a conclusion, those participants who are willing to put this plan into practice will make a corresponding commitment.

3. When the time has elapsed, ask each group to briefly present on their experience (5 - 10 minutes per group).
4. Following the presentations, explain the behavioural change process the groups have undergone by matching each phase of the group work as presented to the respective element of the Experiential Learning Cycle as described in more detail above.
(Refer to page 27 f.)

4.4 Effective communication skills for facilitators

Exercise 12:	Identifying the qualities of a good facilitator
Objective:	To introduce the most important communication skills for a facilitator.
Method:	Brainstorming, group discussion
Tools:	List of facilitator's qualities, flip chart/large paper, marker
Time:	10 minutes

Facilitator's tasks:

1. Ask participants what they think to be the most important communication skills of a good facilitator.
2. Ask one volunteer to note down the answers on the flip chart/large paper.
3. Add information as necessary.

Basic information

List of qualities: An effective facilitator has to…

- Be alert
- Be creative
- Be a good listener
- Accept criticism
- Accommodate everybody
- Be knowledgeable of the issues
- Be able to communicate
- Be able to make connections
- Have knowledge of all tools
- Allow participation, not dictate

The Fish Bowl

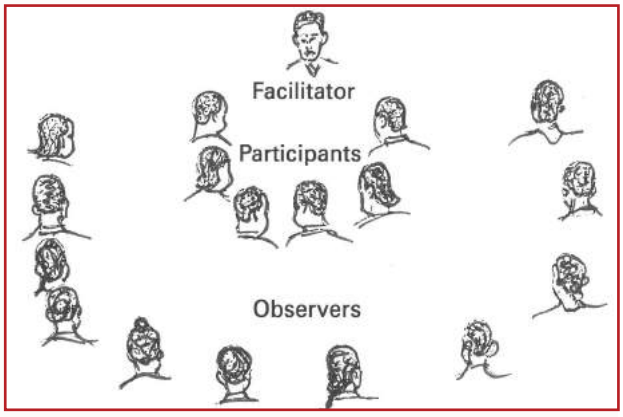
Each of the participants should have the chance to practice facilitation at least once during the training. It is important to ask trainee facilitators to prepare in advance for this exercise. Remember to remind future trainee facilitators to prepare for their session thoroughly and in good time. For this exercise, all participants will come together and form a "fish bowl".

Exercise 13: Practicing effective communication skills

Objective: To enable participants to practice facilitation
Method: Facilitation activity, feedback
Tools: Fish bowl scenario, Effective Communication Check List
Time: 40 minutes

Facilitator's tasks:

1. Identify one (or two if time allows) volunteer(s) to be the trainee facilitator.
2. Assign 5 participants to be the trainees.
3. Ask the others t o act as observers and distribute the Effective Communication Check List to help them evaluate the trainee facilitator and record their impressions and observations.
4. Ask the trainee facilitator to identify the type of trainees s/he is dealing with and the tools s/he would like to use. S/he can put on a "hat" or anything you choose to use as identification for the trainee facilitator
5. Let the trainee facilitator facilitate on the topic of their choice.
6. At the end of the facilitation exercise, ask the trainee facilitator to evaluate his/her own performance: Do you think you have done well? How do you assess your own communication skills, such as body language, visualization, effective use of tools, listening, time consciousness, etc.?
7. Ask the trainees what they feel about the facilitation and what they liked and disliked.



8. Eventually ask the observers for their evaluation of the performance according to the Effective Communication Check List.
9. Write down the outcomes of the activity on a flip chart.
10. If time allows, do another round with a different trainee facilitator
11. Conclude and relate this activity with the qualities or characteristics of a good facilitator and the basic information on Communication as provided herein above.

Basic information

What is communication?

In the learning process, we see that the following three points are interlinked:

a. The learning content
b. The facilitator
c. The participants who receive the message

The three points above are linked by what is known as a process of communication.

Communication is the exchange of information (the learning content) between a sender (the facilitator) and the receivers (participants).

In its most simple form, communication comprises 6 stages: - (www.cedpa.org- CEDPA, Training Trainers for Development)

1. **Idea:** The sender has one piece of information (idea, thought, feeling, opinion, etc.) which he wishes to impart.

2. **Encoding:** The sender has to encode the information. He has to translate his thoughts or feelings into sound, words or characters (verbal communication) or into gestures, facial expression, stance etc. (non-verbal communication), which can be understood by the receiver.

3. **Sending:** The sender now has to send the message so that it can be received by the communication partner.

4. **Picking up:** The receiver picks up the message via one or more perception channels: If this occurs perfectly, without any falsifications, he now has an exact duplicate (a perfect copy) of the message sent.

5. **Decoding:** The receiver has to decode and interpret the message, making it his own, in order to understand it properly.

6. **Confirming:** The receiver must confirm that he has received the message, i.e. he has to send a message back to the sender to say that he has received, duplicated and understood the message.

This is not a simple process. In reality it does not run as smoothly as depicted here. Communication which leads to an exact duplicate of the message which has been sent hardly ever occurs. Interruptions, which can lead to misunderstandings or non-understanding, can occur at every stage. To keep misunderstandings to a minimum, it is important to observe the rules of good communication.

The components of a message

The object of communication is imparting a message from the **sender** to the **receiver.** Each message has four sides, which have to be properly recognised and taken into consideration during communication. Both, in the role of the sender ularly applies to trainers and presenters, whose tool is communication.

A message has four components:

1. Factual content

Each message contains a piece of factual information, i.e. a depiction of facts from the viewpoint of the sender. The factual information should be easily comprehensible and clear.

2. Identity (the sender)

A message does not just contain information concerning the facts but also information about the sender's identity. From the message, you can tell how the sender sees himself and how he would like to be seen by others. However, you can also find traits in the message which the sender himself is unaware of. Therefore, opening up can include both deliberate depiction as well as involuntary revelation of one's identity.

3 Relationship (between the sender and the receiver)

A message also shows the position of the sender in relation to the receiver, what he thinks of him. Therefore, the message also includes information concerning the relationship between the sender and the receiver.

This side of a message is often demonstrated by intonation, gestures and other non-verbal accompanying signals as well as the chosen formulation.

4 Appeal/objective (the desire to influence)

A sender does not normally send a message, "just so". A message is nearly always linked with the attempt to have an influence on another person. The sender does not only want his message to be understood, he also wants it to have an effect.

What are communication skills?

Effective communication between the facilitator and the participants is the foundation of all participatory learning.

Effective communication is determined by three aspects:

- The message
- The communication tools
- The skills of the sender

A facilitator needs to be clear and knowledgeable about the message to be submitted. Moreover, s/he needs to identify which communication tools are suitable to submit this message, e.g. asking analysis questions, brainstorming or employing role-plays. Most of the participatory tools presented below are, if used effectively, good means of communication.

The facilitator needs certain personal skills in using these participatory tools to really "get the message across". "Communication skill" means the ability of a sender (here: the facilitator) to introduce, explain, tell, recap, summarize, inform, persuade, listen, demonstrate and submit a message or piece of information to the receiver (here: the participant). How well a facilitator can communicate is determined by the way s/he imparts a message to participants e.g. by using appropriate wording, methods and techniques.

Participants receive the message gratefully when the facilitator comes up with good knowledge and shares it in a close and friendly spirit using a participatory method. If they do not like the way s/he expresses him/her self, they will avoid him/her. When we engage in talking, be it in private or in group contexts, the way we speak reflects our personality. Each person has his/her own way of speaking and unique personality traits. This is related to our upbringing. Some people seem to be quick-tempered by the way they express themselves. Others give the impression of being happy, sociable or authoritative. Others might seem careless.

Effective communication skills of a facilitator imply that the facilitator conveys messages in an appropriate way, using proper methods, techniques of speech, gaining participants' acceptance. Participants' individual difference should be taken into consideration because the fact that they are male or female, young or older plays out in their needs and expectations. Therefore, it is important to give attention to individuals. Facilitators should not present themselves as careless, indecisive, controlling or authoritative. They should rather work on projecting themselves as friendly, helpful, patient, tactful and good mannered. Such skills can be acquired through continuous practicing in the course of this training.

Effective Communication Skills Check List

Name of trainee facilitator_____

Date:_____ _____

Topic:_____ _____

How clear was the message/content brought across?_____

Was the facilitator well prepared?_____

Was the facilitator knowledgeable and well informed about the subject matter?_____

Behaviour

Greeted participants	Yes ☐ No ☐	Blamed participants	Yes ☐ No ☐
Addresses participants by name	Yes ☐ No ☐	Shy	Yes ☐ No ☐
Friendly	Yes ☐ No ☐	Confident	Yes ☐ No ☐
Bossy/rude	Yes ☐ No ☐	Indifferent	Yes ☐ No ☐

Language

Verbal language

Loud enough	Yes ☐ No ☐	Listens well	Yes ☐ No ☐
Clear language	Yes ☐ No ☐	Talks, lectures too much	Yes ☐ No ☐
Understandable words	Yes ☐ No ☐		

Body language

Eye contact	Yes ☐ No ☐	Facial expression	
Movement, gestures	Yes ☐ No ☐		

Time management

Balanced	Yes ☐ No ☐	Too slow	Yes ☐ No ☐
Time-conscious	Yes ☐ No ☐	Hurried	Yes ☐ No ☐

Techniques

Did the facilitator use teaching aids to support communication of the message?

Has s/he employed participatory tools/methods? Which ones?

Effectiveness

How successful was the facilitator in performing the facilitation?

What were the reasons for his/her success?

In what ways did the participatory learning process help participants to learn?

4.5 Facilitating a participatory learning process

4.5.1 Exercise - The facilitation of a participatory learning process

Practicing the facilitation of a participatory learning process allows trainee facilitators to learn how to facilitate the process directly and how to apply the acquired communication skills, methods and techniques to support behavioural change in young people.

The participatory learning process includes practical exercises on various topics. These exercises are meant to support experiential learning.

4.5.2 How to facilitate practical exercises in a participatory learning process

Exercise 14:	Facilitation of practical exercises
Objective:	To familiarise participants with the facilitation of practical exercises
Method:	Discussing the structure and procedure of an exercise
Tool:	Cards or sheets of paper.
Time:	40 minutes

Facilitator's task

1. Write the headings for practical exercises on cards or short pieces of paper and randomly give them to participants.
2. Ask participants to arrange the headings in the right order
3. Clarify the order with participants

Headings to be written on cards:

A Topic

B Objective

C Method

D Tools

E Time

F Facilitator does the following with participants

G Revise in short the last exercise

H Energizer

I Training norms

J Energizer

K Analytical questions & discussion on the topic

L Conclusion

M Implement

N Evaluation

O Communication skills check list

The instructions for practical exercises in this Manual provide the following information:

Exercise No.: (Brief description of the activity/exercise)
Objective: (What do we want to achieve?)
Method: (Which method is used to achieve the objective?)
Tool: (Which tools are employed to achieve the

Practical Exercise - Structure

- Revision of the previous exercise
- Briefing - What's coming up?
- Warming up as necessary
- Exercise (discussion,...)
- Conclusion
- Accomplishment

Facilitator's tasks:

Description of the tasks the (trainee) facilitator for the particular activity is expected to fulfil in cooperation with the participants in the participatory learning process.

The following structure may be helpful in conducting a practical activity:

1. Revision
A brief revision of the previous exercise may be carried out before starting a new activity. (See Chapter 2)

2. Briefing
The (trainee) facilitator

3. Warming up
Warming up activities are useful to keep up participants' interest and attention. The "energizer" conducts warming up activities using different methods as necessary. (See Chapter 2)

4. Exercise (here: Discussion)
Example: After sharing experiences, analytic questions may be raised for discussion on the topic. (Trainee) facilitator and participants will discuss in pairs and/or in plenary using different methods and techniques. In the process of analyzing and sharing experiences, participants will learn step by step to take a stand. This happens as they ask themselves: Is it right or wrong? Is it good or bad? Shall we accept or reject? The facilitator then encourages them to take a position. Open questions may be asked during the process.

5. Conclusion
The (trainee) facilitator asks participants if they feel that they have explored the issue from all angles. Then s/he will conclude the activity by giving additional information as provided for under the instructions for practical exercises (if any).

6. Accomplishment
As part of the participatory learning process, participants will be asked to put into practice the knowledge they have acquired individually or in group.

Ask participants
- If they have enjoyed the exercise
- What they have learned from the exercise
- If they consider useful what they have learnt
- If they can give examples for situations in which they can put what they have learnt into practise

7. Evaluation
If there is a trainee facilitator, participants may evaluate him/her according to the Effective Communication Check List provided in this Manual. Additionally, before participants depart, the end-of--the-day evaluation will be conducted under supervision of the "evaluation supervisor". (Remember: The facilitator should not get involved in the evaluation)

Training norms
As we have established to the requisite standard, participants are supposed to actively participate in all phases of a session or training, also in the establishment of the training norms that are applicable to all participants and facilitators in whichever role. If the agreed training norms as set by the group are not obeyed, participants will be asked to respect the norms agreed upon by the day's "procedure supervisor" (who may optionally wear a coloured scarf). If responding to participants' questions and issues raised during an activity takes longer than expected, remember to write down 'unsolved questions' on the "Parking Lot" to deal with it later and continue the session. The "procedure supervisor" will show a yellow card 5 minutes before the time given for the activity and shows a red card when the time is up. The facilitator should then wind up the activity. (Refer to Chapter 2)

4.6 Participatory methods, techniques and tools

The use of participatory methods, techniques and tools is very important for participants to gain a clear understanding of the learning content. We have mentioned previously that according to the basic principles of learning, a person learns best using all senses and the whole body. There are a number of techniques, tools and teaching aids available to support experiential learning, including group or face-to-face discussions, role-plays, performances, drawing pictures and learning with cards (always supported by effective communication skills).

The list below indicates some of participatory methods, techniques and tools; however, it is not exhaustive. The facilitator may know additional methods, techniques and tools to employ in the participatory learning process from his/her own previous experience that may of course be used as well.

1. Group discussion
Facilitated group discussions are particularly interesting for young people as they allow for extensive active participation. Group discussion is useful to exchange and information and provides "living examples" for life skills. It can increase self-confidence and bring about behavioural change as young people tend to follow their role models.

1. Divide a large group into smaller groups

To form three groups, every participant will be asked to call name of a fruit such as banana, orange and mango. Those who called the same fruit name will form a group. By using this technique three groups will be formed randomly.
In strict rotation, participants will be asked to count 1,2,3,..(depending on the intended number of groups). Each participant will have a group number: Those who counted "1" will form a separate group, those who counted "2" will form a separate group, and so on.

Inform the groups clearly about the task to carry out. Each group shall assign a group leader and a rapporteur. Before starting the respective activity, the group leader must make sure that all group members have understood the task to be done. The groups are supposed to accomplish their task within the time given. Even if they have not finished, call them back into the plenary nicely and let them report on what they could accomplish within the given time frame.

2. Buzzing

Participants in plenary are asked to exchange ideas or have a short discussion on a single topic by forming a pair or three-some with their direct neighbours without leaving their seat. This technique is useful to have a quick discussion. Buzzing is a good opportunity to participate for shy participants who are hesitant to speak to a large audience.

3. Analytical questions

The facilitator raises key questions regarding a topic to all participants. Offering a short question-answer is useful to analyse ideas, whereby it is not intended to test participants' knowledge, but rather to bring about a discussion and analysis. Participants can discuss individually or in groups to answer the questions raised.

4. Warming up/ energizer

"Warming up's" or "energizers" are good techniques to entertain participants and keep up their attention. Every training day should begin with a warming up activity. It is also recommended to use warming up activities when participants feel exhausted and bored. A warming up is a group relaxation or activation activity that can take 2 to 3 minutes. This helps to stimulate their working and learning spirit before participants engage in more serious undertakings. It helps to avoid exhaustion in prolonged sessions.

It is great when warming up activities or energizers are somehow related to the content of the training, but this is not a requirement. It may be a simple joke or a physical activity, a songs, a role-play, or a funny story. Participants should understand the importance and objective of warming up activities, and all participants should actively participate. It should be clear to everyone before the activity starts. When it is over, all participants should have knowledge of why and how warming up activity can be useful. They should also able to lead warming up activities themselves. The facilitator (or the participants) assign(s) one member of the group (the "energizer") who takes on the responsibility to occasionally warm-up/energize participants during the training.

Warming up's and energizers...

- Can create a positive atmosphere among participants and build team spirit
- Can be a good opportunity for shy participants to "come out" and express themselves in the group but...
- Should not create unnecessary competition and excitement.
- Should be well tested - it is recommended to turn down a very difficult or complex warm up activity rather than trying it.

A sure sign that a Warming up or energizer has achieved its target is when participants dissolve into laughter.

5. Brainstorming

Brainstorming means gathering of ideas and opinions from a group within a short period of time. It often takes place at the beginning of a new activity.
Participants will be encouraged to give their opinions as much as possible. Brainstorming has its own dynamics. In the process of brainstorming, the facilitator must accomplish the following:

- Write down the topic of the discussion.
- Invite all participants to give their opinions.
- Note down on the blackboard or cards the ideas or opinions.
- Refuse any explanations and questions for the time being.
- Revise the points mentioned after participants finish the brainstorming.
- Group repetitive and similar ideas for the following discussion.
- Encourage participants to further develop their ideas through discussion.

6. Role-play

Role-play is an act that shows real life conditions in form of theatre or drama. Participants express characters, views or prior experiences in the form of drama.
"Role-playing is a teaching strategy that fits within the social family of models (Joyce and Weil, 2000). These strategies emphasize the social nature of learning, and see cooperative behaviour as stimulating students both socially and intellectually.
Role-playing as a teaching strategy offers several advantages for both teacher and student. First, student interest in the topic is raised. Research has shown that "integrating experiential learning activities in the classroom increases interest in the subject matter and understanding of course content" (Poorman, 2002, pg. 32)."

It is important to allow participants to prepare for the play then after the performance, participants can discuss about the role play.

Role of the facilitator

- Decides which characters and which skills to be learnt by participants from the play.
- Chooses and tells 2, 3 or 4 actors to perform easy characters and conditions.
- Tells them what they should do. If possible, s/he gives them enough time.
- After the performance, s/he separates main characters and uses analytical questions to lead a discussion.

7. Sculpture

Sculpture is a body language that helps to transmit a message by standing without making a movement like a monument. The type of message to be transmitted should be short and easy. The performance is carried out by a single person or a small number of people without making movement and speech.

8. Mime

This performance uses body language and movement, but no voice, to convey a message.

Annex - Tools and master copies for Module 1

List of learning tools

- SRH facilitators' training manual
- Flip chart, flip chart paper or large sheets of paper
- Markers in different colours
- Chalk to write on the floor or a black board
- Note paper
- Glue stick, pins, cello tape
- Scissors
- Cartons to be cut into facilitation cards
- Cards or slips of paper, scrap paper to cut notes
- Optional: a hat (to identify a trainee facilitator)
- A pointer
- Optional: a big coloured scarf (to identify the learning process supervisor)
- A yellow and a red card (to be used by the supervisor)
- A flip chart stand
- A variety of contraceptives for demonstration purposes
- Any other demonstration or supporting tool that may be useful in the context of a specific module or chapter.

Master copies

How to plan a training - Check list

What needs to be done?	Who is responsible?	By when will it be done?

Budget planning

Budget item	Estimated cost	Budget

Day's Time Table (page 13)

Proposed by the facilitator		**Agreed with participants**	
8:30 - 10:30			
10:30 - 11:00			
11:00 - 12:30			
12:30 - 13:30			
13:30 - 15:30			
15:30 - 16:00			
16:00 - 17:30			

Participants' Daily Task Table

Task	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Check-in person						
Reviewer						
Energizer						
Procedure Supervisor						
Evaluation Supervisor						

EVALUATION GRID

Date: _____

Name of facilitator: _____

Evaluation item	**Rating**					**Total**
	1	2	3	4	5	
Content of learning						
Process of facilitation						
Time management						

1 = Inadequate 2 = Satisfactory 3 = Good 4 = Very Good 5 = Excellent

Final Evaluation form

Date: _____

Name of facilitator: _____

Training: _____

From _____ to _____

No	Evaluation item	Points				
		1	2	3	4	5
1	The training was fun.					
2	The training has enabled me to better understand the process of behavioral change					
3	I have acquired new knowledge and information on SRHR					
4	I will try to put into practice what I have learnt?					
5	The facilitator has contributed to the success of the training.					
6	The training increased my knowledge of sexual and reproductive health.					
7	The training was well prepared.					
8	After the training, I feel able to facilitate a participatory learning process myself (with a copy of the Facilitators' SRH Manual).					
9	There was enough time.					
10	Participants participated greatly in the learning sessions.					
11	The training tools were useful.					
12	The training achieved its goals.					

Rating

Participants are requested to rate each of the above mentioned items on a scale from 1 to 5:

1 = I don't agree

2 = I don't know

3 = I partly agree

4 = I agree

5 = Absolutely

Peer Learning Report Form (page 23)

Peer Learning Report Form

1. Peer Learning Team (participants): _____

2. Place of training: _____

3. Number of Participants: Male _____ Female _____

Age (a) 10-14 b) 15-19 c) 20-24_____ d) 25+_____

4. Duration: Time___ days__ weeks____ months___

5. Trained on Module(s) _____

6. Participants' comments (positions, decisions, or pledges made as a result of having participated in the training (use reverse side as necessary)

_____
_____
_____

7. Problems / challenges encountered

_____
_____
_____

8. Have you observed any signs of knowledge acquisition? (Knowledge check/pre-test result)

_____
_____
_____

9. Facilitator's comments:

_____
_____

10. Facilitator's full name

_____

Signature _____ Date:_____

Name of organisation/project

_____

Effective Communication Skills Check List

Name of trainee facilitator_____

Date:_____ _____

Topic:_____ _____

How clear was the message/content brought across?_____

Was the facilitator well prepared?_____

Was the facilitator knowledgeable and well informed about the subject matter?_____

Behaviour

Greeted participants	Yes ☐ No ☐	Blamed participants	Yes ☐ No ☐
Addresses participants by name	Yes ☐ No ☐	Shy	Yes ☐ No ☐
Friendly	Yes ☐ No ☐	Confident	Yes ☐ No ☐
Bossy/rude	Yes ☐ No ☐	Indifferent	Yes ☐ No ☐

Language

Verbal language

Loud enough	Yes ☐ No ☐	Listens well	Yes ☐ No ☐
Clear language	Yes ☐ No ☐	Talks, lectures too much	Yes ☐ No ☐
Understandable words	Yes ☐ No ☐		

Body language

Eye contact	Yes ☐ No ☐	Facial expression	
Movement, gestures	Yes ☐ No ☐		

Time management

Balanced	Yes ☐ No ☐	Too slow	Yes ☐ No ☐
Time-conscious	Yes ☐ No ☐	Hurried	Yes ☐ No ☐

Techniques

Did the facilitator use teaching aids to support communication of the message?

Has s/he employed participatory tools/methods? Which ones?

Effectiveness

How successful was the facilitator in performing the facilitation?

What were the reasons for his/her success?

In what ways did the participatory learning process help participants to learn?

MODULE 2
Life Skills

DSW

Table of Contents

Introduction

This Module 2 of the SRH Facilitators' Training Manual on Life Skills follows a comprehensive behaviour change approach that concentrates on the development of the 'skills needed for life'. It addresses important issues of empowering and guiding girls and boys towards new values. All modules of this SRH Facilitators' Training Manual are based on a set of life skills which we look at in more detail in this Module 2.

This Module 2 addresses the personal development of the individual and aims at providing the skills required to actually use and apply information provided on e.g. HIV & AIDS, STIs, reproductive health, contraceptives and family planning, but also to successfully deal with any situation that may require communication and decision making skills beyond this Manual and/or the respective training.

The Module 2 defines and categorises important life skills in the context of sexual and reproductive health according to a 'Bridge Model' that shows how life skills can support behavioural change.

The facilitation of this module with all its exercises is expected to take about 2 hours

Learning objectives

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

- Discuss life skills and how they relate to their real life situations,
- Understand the importance of applying life skills for taking actions (behaviour)

Chapter 1: Introduction to Life skills

1.0. What are Life Skills?

Basic Information/Handout

The World Health Organization defines life skills as "the abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life".

UNICEF defines life skills as "a behaviour change or behaviour development approach designed to address a balance of three areas: knowledge, attitude and skills". The UNICEF definition is based on research evidence that suggests that shifts in risk behaviour are unlikely if knowledge, attitudinal and skills based competency are not addressed.

> *Life skills are capabilities that empower young people to take positive action, to protect themselves and have positive social relationships, thereby promoting both their mental well-being and personal development as they are facing the realities of life.*

Responsible decision making in questions related to health and social interaction with others requires life skills, which is why they are included in most health related and social programs, e.g. in the contexts of drug prevention and mental health, consumer education, environmental education, peace education or education for development, livelihood and income generation, among others.

Life skills have been defined in various ways but this manual chooses to adopt the WHO definition:

- WHO defines life skills as "Abilities for adaptive and positive behaviour that enable indi viduals to deal effectively with the demands and challenges of everyday life" (WHO 1997). They provide a link between motivating factors and behaviour by translating knowledge of 'what to do' and the attitudes and values of what 'one should do', into abilities for 'how to do'. For the purpose of this guide the following working definition will be used:

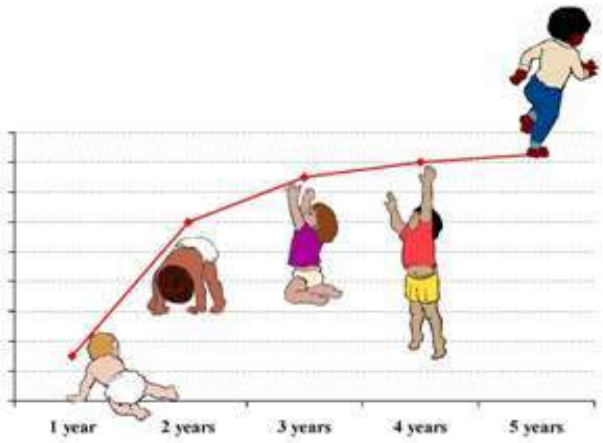
At the United Nations Inter-Agency Meeting held at WHO, Geneva (WHO, 1999:p.4) life skills education was considered as crucial for:

- The promotion of healthy child and adolescent development;
- Primary prevention of some key causes of child and adolescent death, disease and
- disability;
- Socialization;
- Preparing young people for changing social circumstances.

Life skills are the strategies, abilities, expertise or competences that enable adolescents to develop positive attitudes and responsible sexual behaviours, leading towards a healthy lifestyle. As such a life skill refers to a person's ability or competence.

Throughout our life, from childhood into adulthood, these skills are developed and improved.

Initially these skills are related to one's own well-being but gradually evolve to reflect our environment and personal relationships. Practicing life skills leads to self-esteem, sociability and tolerance; to the ability to take action and make a change; and eventually to the freedom to decide what to do and who to be. These qualities are essential tools for understanding our strengths and weaknesses, which will consequently enable us to recognise opportunities and face possible threats, as well as to identify problems that arise within both the family and society.

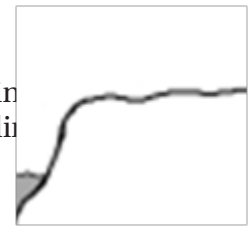


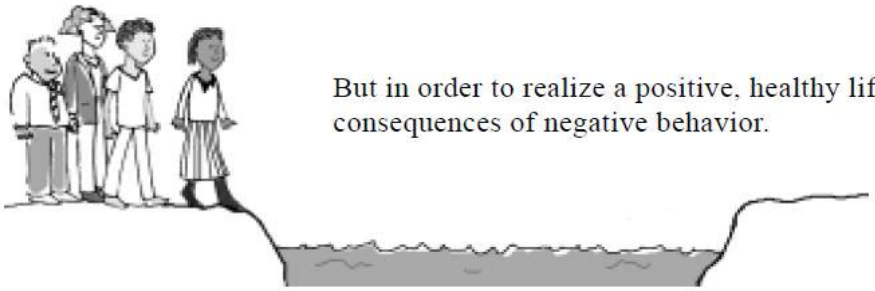
With life skills, one is able to explore alternatives, consider pros and cons, and make rational decisions in solving problems or issues that arises. Life skills will also bring about productive interpersonal relationships with others, since effective communication in terms of being able to differentiate between hearing and listening, and the assurance that messages are transmitted accurately to avoid miscommunication and misinterpretations, the ability to negotiate, to say "no", to be assertive but not aggressive and to make compromises that will bring about positive solutions.

Life skills training works on developing people's individual skills throughout their life to help them make healthier decisions, thus enabling them to choose more positive behaviours/actions.

1.1. How to build a bridge - from information to a positive healthy lifestyle (Peace Corps 2001 p.28)

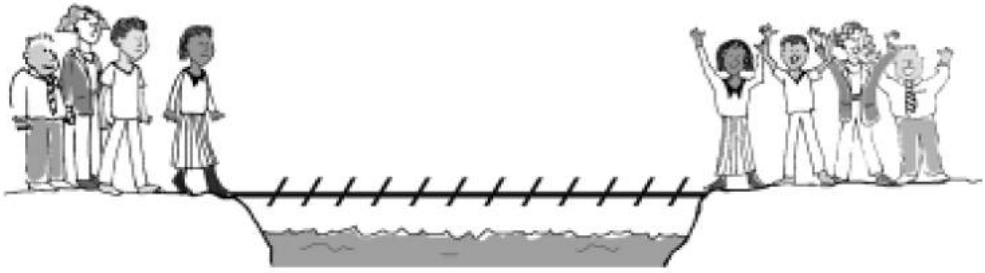
Life skills provide a solid foundation for life, allowing in
viduals/communities to live healthy, happy, and fulfilli
lives.



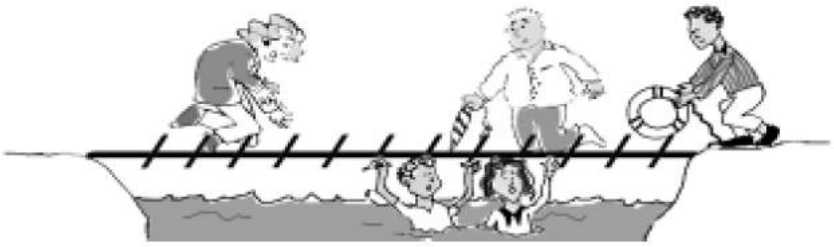


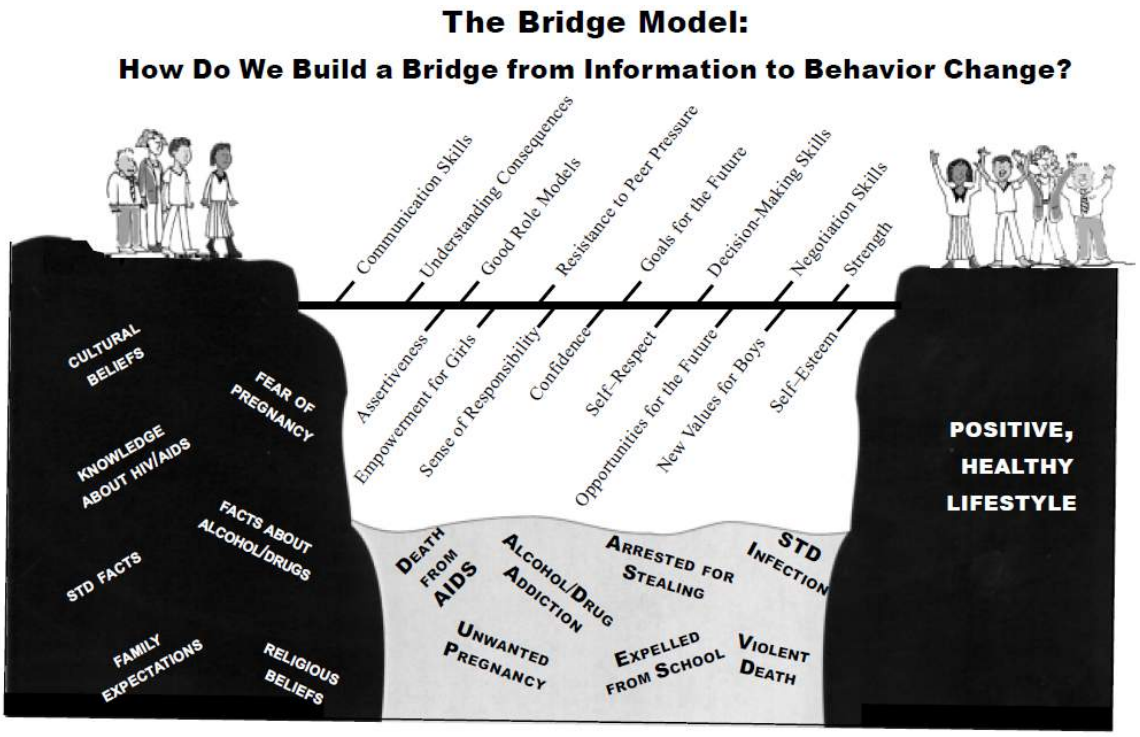
But in order to realize a positive, healthy life, we need to avoid the consequences of negative behavior.

A Life Skills Program focuses on building the "planks" in the bridge—working on the individual skills that help people to make healthier decisions about their lives.



Relapse is expected in any behavior change, so we must build in "life-preservers" or ways to bring people back onto the "bridge" should they suffer the consequences of a negative behavior.





Life skills empower young people to take positive action to protect themselves, to promote health and positive social relationships.

1.2. Aims of Sexual and reproductive health life skills

The main aim of the life skill exercises in this Module 2 is to promote people's capabilities to:

1. Make positive sexual choices;
2. Take informed decisions in sexual matters;
3. Practice healthy sexual behaviours;
4. Recognise and avoid risky sexual situations and behaviours.

Exercise 1:	Types and categories of life skills
Objective:	To help participants be aware of categories and types of life skills.
Method:	Commercial advertising method
Tools:	Cards or papers, flip chart, Cello tape
Time:	30 minutes

Facilitator's tasks

1. Introduces this exercise. Prepare as follows with the help of the participants:
2. Write down the different life skills on a flip chart to be put up on the wall for reference.
3. Write down the types of life skills on 3 cards.
4. Post the 3 cards in different places (the wall, door, window etc.)
5. Write down all life skills as introduced below on cards to be attached to participants' shirts.
6. Using the following information, discuss the life skill types and sort participants accordingly.

Chapter 2: Categories and Types of life skills

Life skills are numerous and it is difficult to limit their type and number. Here you find 12 of the most important life skills. They are categorised into three main areas:

A: Skills of knowing and living with oneself
B: Skills of knowing and living with others
C: Skills of making effective and good decisions

2.0. Skills of knowing and living with oneself

A: Self-awareness

Self-awareness is an individual's ability to appreciate the strengths and weaknesses of one's own character. Realising this will enable one to take actions, make choices and take decisions that are consistent with one's own abilities.

Examples of self-awareness skills include the ability to:

- Recognise the weak and strong sides of one's own behaviour.
- Recognise the weak and strong sides of one's own abilities.
- Differentiate what one can do or cannot do by her/himself.
- Recognise things which cannot be changed, and accept them (example: height, size of breasts, etc.).
- Appreciate oneself - people are not alike, and diversity is a good thing.
- Recognise one's own unique talents.

Self-esteem

Self-esteem is the way an individual feels about her/himself and believes others to feel. It has been described as the 'awareness of one's own value as a unique and special person endowed with various attributes and great potential'. A person's self-esteem can be damaged or enhanced through relationships with others. High self-esteem tends to encourage and reinforce healthy behaviour. Low self-esteem tends to encourage unhealthy behaviour.

Examples of self-esteem include the ability to:

- Develop a positive self-image.
- Respect oneself and one's choices.
- Not be unnecessarily influenced by what others think.

Coping with emotions

The ability to manage or deal effectively with an emotional situation or problem. Emotions such as fear, passion, anger, jealousy etc. are subjective responses to a situation. They can result in behaviour which one might later regret. Coping with emotions means to be able to recognise them as such and deal with them to make a positive decision nonetheless.

Coping with stress

Stress is a condition of increased activity in the body, which can overwhelm the individual beyond his/her capacity. Stress can be caused by physical, emotional or psychological factors. Family problems, broken relationships, examination pressure, the death of a friend or a relative are examples for situations that can cause stress. As stress is an inevitable part of life, it is important that to recognise stress, its causes and effects and know how to deal with it.

2.1. Skills of knowing and living with others

B: Skills of knowing and living with others

Interpersonal relationships

Interpersonal relationships are supported by the ability to:

- Co-exist amicably with other people and establish meaningful and healthy associations with them.
- Understand, form and develop mutually beneficial friendships.
- Understand that human beings tend to build profound one-to-one relationships with those they love and are committed to. Between sexual partners, it is only in the context of such loving and respectful relationships that sexuality can be lived in a healthy and fulfilling way for both partners.

Examples of interpersonal skills are:

- The skill to establish a lasting partnership.
- The ability to enter into an intimate relationship.
- The ability to end a temporary or undesirable sexual partnership.
- The ability to be faithful to a partner.
- The ability to make contacts.
- The willingness to be committed to friendship.
- The skill to develop respect and trust in a partner.
- The skill to develop positive relationships through effective communication.
- The desire to help, care, and sympathise with others.
- The ability to overcome a disappointing relationship.

Negotiation Skills

Negotiation is something that we do all the time, not only for business purposes. For example,

we use negotiation skills in our social lives, perhaps for deciding on a time to meet, or where to go on a rainy day. Sometimes though it does involve being able to cope with potentially threatening or risky situations.
Negotiation is an important skill in interpersonal relationships and is usually considered as a compromise to settle an argument or issue that will best benefit everyone's needs. It involves an ability to listen to and respect other people's views, while at the same time trying to convince them instead to follow yours (this happens through meaningful bargaining). Ultimately, the outcome of the discussion will be one of the following:

Win-Win: both parties achieve their goals and are satisfied with the outcome.

Win-Lose: one party achieves the goal at the expense of the other party.

Lose-Lose: both parties are dissatisfied with the terms of the negotiated contract.

The keys to successful, non-threatening negotiation are:

- Be prepared
- Have a positive attitude
- Listen carefully
- Show respect for other points of view
- Be firm yet friendly
- Build trust
- Persuade and don't coerce
- Warn but never threaten
- Acknowledge your negotiation partner's authority and competence
- Ask for advice; what would make it a fair deal?
- Look for mutual agreement, not for victory

Negotiation as a skill can never stand alone, but will always be in the company of self esteem, interpersonal relationships, assertiveness, non-violent conflict resolution, and problem solving. It can also play a role in context-driven situations, e.g. peer pressure.

Empathy skills

Empathy is the ability to understand, consider and appreciate other peoples' circumstances, problems and feelings (step in ones shoes). Empathy also enables a person to give support to another in order to enable him/her to still make a good decision despite of the circumstances.

Peer resistance

Peer resistance is the ability to consciously resist the desire "to go along with the crowd". It means not taking part in undesirable/unsafe activities without feeling obliged to make explanations to peers who may have conflicting ideas and threaten you with exclusion from the group for not

participating. If the group is engaging in negative influences and habits, peer resistance is a very important skill for young people. It makes a person stand up for his/her values and beliefs in the face of conflicting ideas or practices from peers.

Examples of abilities in resisting peer pressure:

- Maintain your own beliefs about when to become sexually active.
- Refuse alcohol or drugs, even if others do not.
- Decide to remain faithful to one partner, no matter what others say.

Assertiveness

Assertiveness refers to the ability or competence to express one's feelings, needs or desires openly and directly but in a respectful manner or without hurting ones feelings.

Effective communication

Effective Communication is the ability of expressing oneself clearly and effectively during interactions with other people in any given circumstances.

Verbal or nonverbal communication forms the essence of human relationships. It is one of the most important life skills. Simply exchanging words or ideas does not ensure good communication. Effective communication is a skill that can be learned and developed through constant practice. It involves, among others; active listening, effective use of verbal and body language, observation, and respect for others' feelings. Although good communication does not guarantee an end to problems, it can go a long way in improving relationships and minimising possibilities of conflict.

The following are examples of abilities in effective communication:

- The ability to communicate ideas skilfully and be able to persuade but not bully a partner.
- The ability to use the appropriate tone of voice in expressing anger, sadness, happiness, nervousness, respect, shame and understanding.
- The ability to use the appropriate verbal and non-verbal language in asking for and presenting information, influencing and persuading.
- The ability to use non-verbal methods during negotiations by sustaining eye contact and using appropriate facial expressions.
- The ability to use verbal hints to communicate i.e. "Yes", "I see" etc.
- The ability to demonstrate active listening and to communicate empathy, understanding and interest.

For further information on effective communication please refer to module 1 of this manual

2.2. Skills of making effective and good decisions

C: Skills of making effective and good decisions

Critical thinking

Critical thinking is the ability to think through a situation properly, assessing the advantages and disadvantages so as to be able to make appropriate decisions concerning one's course of action. Young people are confronted by multiple and contradictory issues, messages, expectations and demands. They need to be able to critically analyze sexual situations and challenges and confront them.

Examples for critical thinking are abilities to:

- Identify the positive and negative aspects of a partner's behaviour (sexual or otherwise).
- Assess a potential partner.
- Assess promises that a partner/potential partner might make.
- Assess and judge a risky sexual situation.
- Differentiate between myths and facts.
- Recognise risky behaviours.

Decision-making

Decision-making is the ability to utilise all available information to assess a situation, analyze the advantages and disadvantages, and make an informed and personal choice. As a person grows up he/she is frequently confronted with serious choices that require his/her attention. These situations may present conflicting demands that cannot possibly be met at that same time. ("I want to have sex but I am afraid of STIs and I don't know my partner's status"). One must prioritise and make choices, but at the same time be fully aware of the possible consequences of those choices. One must learn to understand the consequences before making a decision.

Examples of abilities in decision-making:

- "No, I don't want to have sex" or "Yes, I do want to have sex", and understand the consequences of both decisions.
- To decide on the appropriate contraceptive (condom, the pill) to use if you do have sex.
- To decide to remain faithful to one partner.
- To decide to avoid high risk activities, such as drug and alcohol use.
- To decide to visit a health clinic to be tested for STIs and HIV.

Problem solving

Problem solving is the ability to identify, cope with and find solutions to difficult or challenging situations. Problem solving is related to decision-making and the two may often overlap. It is only through practice in making decisions and solving problems that young people can develop the skills necessary to make healthy choices for themselves.

Chapter 3: Benefits of life skills

Exercise 2:	Understand why life skills are critical for a healthy and productive life.
Objective:	To learn about the importance of life skills in our lives
Method:	Discussions and writing
Tools:	Flip charts, markers.
Time:	30 minutes

Facilitators' tasks:

1. Ask the participants to divide in groups of three.
2. Distribute flipcharts and markers.
3. Ask the groups to write down the benefits of having life skills and problems one would face without them.
4. Invite the groups to display their work and make presentations.
5. Encourage discussion and cross questioning in the groups.
6. Discuss and list the benefits that have been noted by each group.
7. Discuss and list the problems one would face without them.
8. Summarise and close the exercise by emphasising the importance of life skills.

3.0. The Importance of life skills - Suggestions:

- Life skills promote healthy behaviours that may reduce early sexual involvement, early pregnancy and the risk of STIs including HIV transmission.
- They are designed to empower young people to act positively and effectively when confronted with difficult situations. Furthermore, life skills enable young people to protect their own sexual health as well as that of others.
- Life skills also help young people make informed SRH decisions

3.1. Application of life skills

Exercise 3:	Application of different life skills
Objective:	Participants to distinguish the application of different life skills
Method:	Story reading and discussions
Tools:	Story, list of life skills from previous exercises
Time:	20 minutes

Facilitators' tasks:

1. Introduce this exercise
2. Use the life skills list put up on the wall
3. Ask participants to sit relaxed and listen attentively
4. Choose a good reader to read out the story of Julie and Eric
5. Ask the following questions by reading the life skills posted on the wall
   - What life skills did Julie employ?
   - Which are the life skills she did not use? And how could she use them?
   - Which life skill did she use when he tried to force her? How successful was she?
   - What were the rights and obligations of Eric and Julie? Which ones were respected, which ones were violated?
   - What could peers learn from Julie's life skills methods?
4. Summarise the life skills learnt during this exercise. *(See below for example)*

The story of Julie and Eric

Eric is a married college graduate. He maintains a close family relationship with a girl named Julie. His wife went abroad for further studies. Julie is a very beautiful girl from a low social class. Whenever they met at family gatherings, Julie used to tell Eric her jokes and at times, he dared laying his hands on her shoulders. Julie by then was aware that he was attracted to her.

One day, in the afternoon, Eric happened to see Julie on the streets walking towards home. He proposed to give her a ride but he instead took her to the city. He then offered to buy her a drink with alcohol. However, she chose a soft drink. After giving her a city tour, he drove her to a hotel in the outskirts of the city.

He then asked her to come in for lunch, but Julie was so afraid of getting out of the car. He even tried to force her out of the car. As people were around and watching, Julie preferred not to make a scene. So she followed him quietly in.

Once in the hotel room, Eric tried to make her feel comfortable. He even ordered something for her to eat and drink. After a while, Eric started pulling Julie towards the bed. She started crying and begged him to leave her alone. But she thought her crying and begging would draw other people's attention, so she did not scream for help. After one hour struggle, she said to him: "If you touch me I will tell your wife and my family! And you could be jailed for this"! At this point, Eric got really anxious and threw Julie out of the bed room.

What did we learn from the story? (Summary note for the facilitator)

1. Julie decided not to have sexual intercourse
   - Decision making skill
2. She did not realise the danger of going out with Eric
   - Limitation of critical thinking
3. She did not scream to protect her self
   - Self esteem skill
4. She chose to take a risk by going into the hotel room because of fear
   - Limitation of self confidence and self awareness
5. Julie threatened Eric seriously
   - Effective communication skill
6. Eric forgot his obligation towards his wife
   - Limitation of critical thinking, inter-personal skills, empathy

3.2. Matching life skills with behaviour

Exercise 4:	Matching life skills with behaviour
Objective:	Participants to different life skills to behaviour
Method:	Writing different life skills and behaviours on cards
Tools:	Different life skills on cards, markers, masking tapes
Time:	20 minutes

Facilitators' tasks:

1. Introduce this exercise
2. Pins up or asks a volunteer to put up the list of behaviours
3. Invites 6 volunteers and gives each volunteer a card with a life skill written on it
4. Each volunteer (one at a time) reads out loud the life skill on their card and participants link it to behaviour from the list of behaviours pinned up.
5. Facilitator clarifies where need be
6. Facilitator summarises the exercise by highlighting the importance of life skills in shaping behaviour

List of life skills and behaviour

Life skills	Behaviour
If I am in a healthy and intimate relationship with someone I know and trust **(Decision Making Skill)**	I am less likely to engage in risky sexual practices **(Behaviour)**
If I am not able to assess the hidden motives behind the promises or gifts of an unknown person **(Critical Thinking)**	I am more likely to end up having unsafe sex **(Behaviour)**
If I am not able to control my sexual feelings **(Decision Making Skill)**	I am more likely to have multiple sexual partners **(Behaviour)**
If I do not have the courage to assert my decision not to have sex **(Assertiveness Skill)**	I may end up being used as a sexual object **(Behaviour)**
If I do not resist my friends' suggestions to go along and enjoy alcohol **(Pressure Resistance Skill)**	I may end up getting drunk and having unsafe sex **(Behaviour)**
If I am not able to express myself clearly about the importance of using condoms **(Communication Skill)**	I am more likely to have unprotected sex **(Behaviour)**

MODULE 3

Young Adolescents' Sexual and Reproductive Health

DSW

Table of Contents

Introduction

This Module 3 of the SRH Facilitators' Training Manual focuses on young adolescents' sexual and reproductive health. The term "young adolescents" as used herein refers to the age group of young people between 10 and 14 years of age. Young adolescents are in an age during which they experience many physiological, social and emotional changes. Most of these changes are known as puberty. During that phase young adolescents begin to develop the ability to think more abstractly. They become less dependent on parents and more dependent on friends. At this stage, young people begin to experience sexual arousal, although boys are more focused on genitals and girls more focused on romance. While pre-adolescents begin to develop a set of best friends and start to feel peer pressures to conform, early adolescence is the peak time when peer pressure rules, and girls and boys spend more time with friends.

For boys, overall maturation and initiation of puberty is about one to two years later than for girls, and therefore they are always catching up to girls biologically, cognitively and emotionally. Regardless, both groups may be unprepared for the changes they experience during puberty. While girls have the "experience" of getting their first periods and discussing this event with others, boys do not necessarily have social spaces to share similar experiences.

A ten-year old looks and acts like a child. However, by the time s/he turns 13 or 14 a huge shift has taken place. In some societies, 14-year old girls are considered to be old enough for marriage, sex and childbearing while 14-year old boys may be asked to help support their families economically, may experience peer pressure to have first sexual experiences or may start imitating men who they know or admire and take more risks.

Against the background of the amount of challenges that these young people face, early adolescence presents an opportune time to address topics related to sexual and reproductive health, share important knowledge and thus to positively influence young adolescents' future choices and decisions. This Module contains basic but fundamental information on reproductive health, sexuality and healthy lifestyles.

It is important that the facilitator prepares well and is aware of the feelings and mind sets of this young target group that this Module addresses. Every topic and issue of this Module are highly sensitive and can easily make young adolescents feeling shy, embarrassed or ashamed. It is therefore indispensable that the facilitator employs very sensitive and youth-friendly language and method especially during the facilitation of exercises. Participants may not feel comfortable in speaking openly about SRH or experiences or interacting in

exercises with other peers, especially if they of the other sex. The facilitator shall therefore create a confident and trustworthy learning environment, be flexible and listens well to the needs and feelings of participants provide a safe space to discuss SRH and related risks and opportunities, and treat sexuality as a positive part of social development.

Module 3 is divided into three chapters:

Chapter 1 provides detailed information on male and female anatomy, the developments young people undergo during puberty and human sexuality.

In Chapter 2 we look at the differences between healthy and unhealthy behaviour including harmful practices and sexual violence that young adolescents may encounter while growing up.

Chapter 3 provides basic information on sexually transmitted infections (STIs) including HIV & AIDS .
The facilitation of this module with all its exercises is expected to take about 5 hours

DSW

Learning objectives

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

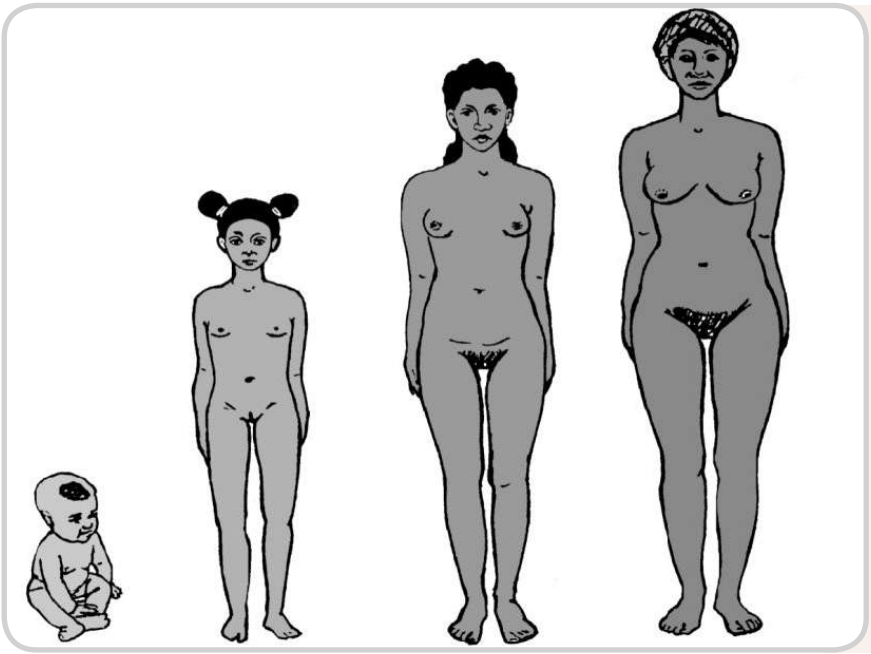
- Describe female and male reproductive organs and functions
- Discuss the body changes during puberty
- Understand menstruation and the situation girls are facing
- Understand the concept of unhealthy relationships
- Identify and understand harmful practices and know how to deal with sexual violence
- Discuss their sexuality and memorize the circles of sexuality

Chapter 1: Reproductive organs, puberty and body changes

1.0 General introduction and/or icebreaker

Before starting the facilitation of this Module, the facilitator may opt for an extensive general introduction where s/he explains what will be discussed and gains general trust of the participants. If the group of participants do not know each other well or seem to be very shy, the facilitator could opt for an icebreaker or energiser (see Appendix) to loosen up the atmosphere and help participants getting to know each other and feel comfortable

1.1 Female and male reproductive organs



1.1.1 Female reproductive organs

Exercise 1:	Learning more about female reproductive organs
Objective:	Participants to acquire in-depth knowledge of female reproductive organs
Method:	Large group discussions
Tools:	Cards, labelled charts of female reproductive organs
Time:	20 minutes

Facilitator's tasks:

1. Ask participants to form a circle.
2. Distribute cards or slips of paper with the correct designations of the female reproductive organs and other cards with the corresponding functions of descriptions. (See table below).
3. Ask each participant to read the card/paper he/she has been given.
4. Ask for the corresponding card/paper owned by one of the other participants to be read out loud.
5. Ask participants to name the organ correctly and explain its functions. Encourage other participants to ask questions.
6. Summarize the main points learnt on female reproductive organs and
7. Ask for feedback. How did the cards activity help to explain the female reproductive organs?

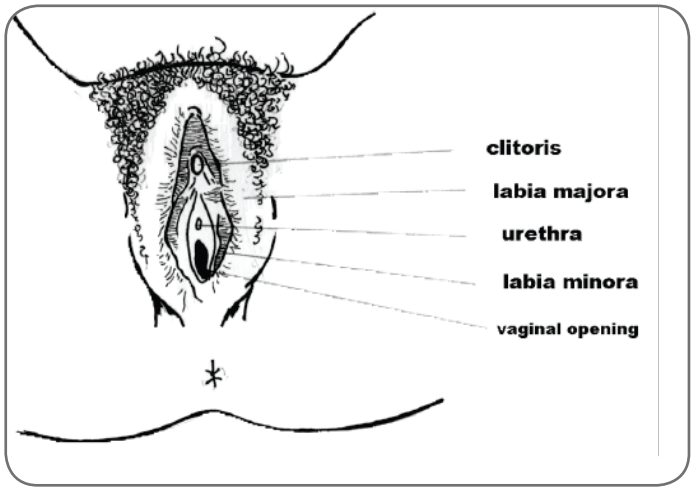
Card game

Female reproductive organs	Corresponding description/function
Uterus	Implantation takes place and holds a growing baby. The inner lining of it sheds blood once every month during menstruation and comes out as blood.
Fallopian tubes	Are two hollow like structures that connect the ovaries to the uterus on either side.
Cervix	The neck or opening of the uterus. The lower end of the womb connecting with the upper part of the vagina.
Vagina	Is the passage from the outside of the body to the mouth of the uterus. The penis is placed in it during sexual intercourse and the baby passes through it during delivery.
Vulva	The external parts of the female genital organ.
Clitoris	It is a small, sensitive organ above the vagina that responds to stimulation during sexual intercourse.
Vaginal fluid	Fluid produced by a pair of glands in the vagina to moisten the vagina.
Labia majora	The outer lips of vulva covered with hair that protects labia minora and internal structures.
Labia minora	The two inner lips covering and protecting the vaginal opening.
Pelvis	The bones containing and protecting the internal genital organs.
Ovaries	Produce eggs and two major hormones, estrogen and progesterone .
Urethra	Narrow tube for passage of urine to the outside.
Hymen	Thin membrane covering the opening of the vagina.

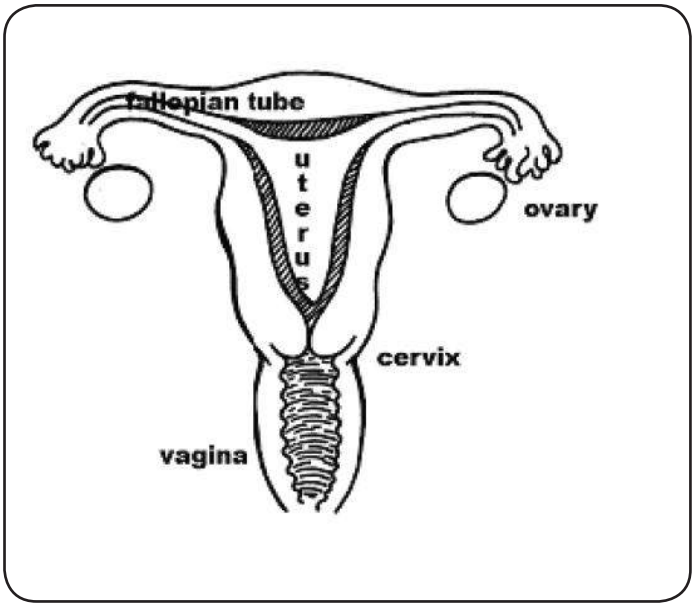
Basic information

(This information could also be used as a hand-out) External female reproductive organs

The vulva is the area surrounding the opening of the vagina, which can be seen from the outside. They consist of the clitoris, the vagina opening, the labia majora and the labia minora. The hymen is a membrane that surrounds or partially covers the external vaginal opening. It forms part of the vulva, or external genitalia. The size of the hymenal opening increases with age. The hymen can break from physical activity, tampons, or from sexual intercourse



Internal female reproductive organs



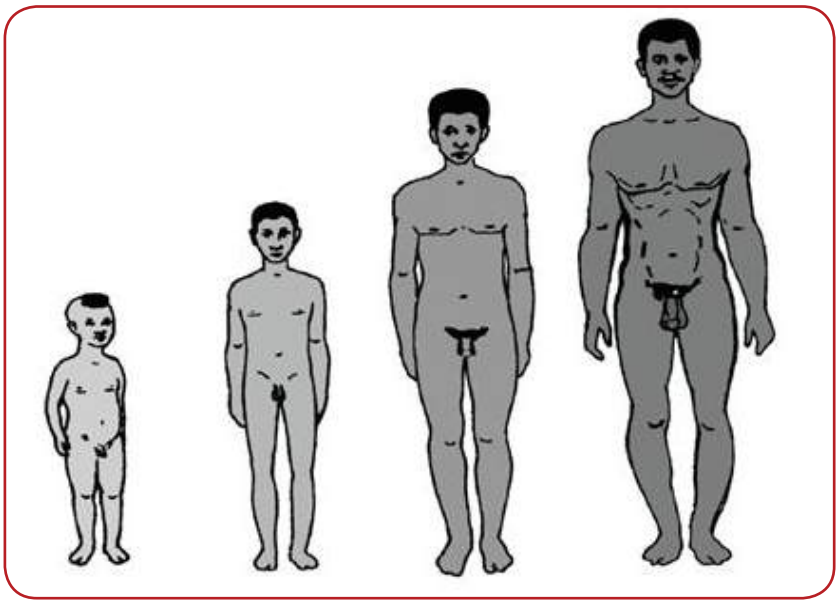
These are organs of the female body that are located inside the lower part of the abdomen, called the pelvis, and are protected by bones and muscles (see figure below). They consist of the vagina, the uterus (womb), two ovaries, and two fallopian tubes. The walls of the vagina produce a fluid or discharge that serves to keep the region clean. The amount of discharge may differ over the month and increases particularly at times of sexual excitement. Please note that this is completely normal. However, whenever its colour changes, it causes itching or takes on a bad smell, this may indicate an infection. So it is important to pay attention to the discharge and how it changes during the menstrual cycle.

The uterus (womb) is a muscular organ inside a woman's body where a baby grows during pregnancy. The cervix is sometimes also called opening/neck/mouth of the womb. It connects the uterus to the vagina and normally has a very small opening to protect the uterus from infections. During childbirth, the cervix opens as the baby has to leave the womb and enter the world through the vagina. This is why the vagina is sometimes called "birth canal" as well. The walls of the vagina are elastic and can stretch to allow the passage of the baby's head and body.

http://en.wikipedia.org/wiki/Hymen

1.1.2 Male reproductive organs

Male reproductive organs are those parts of the male body that are directly involved in reproduction. They consist of the external and internal parts.



Exercise 2:	Learning more about male reproductive organs
Objective:	Participants to acquire in-depth knowledge of male reproductive organs
Method:	Large group discussions
Tools:	Cards, labelled charts of male reproductive organs
Time:	20 minutes

Facilitators tasks:

1. Ask participants to form a circle
2. Distribute cards or slips of paper with the correct designations of the male reproductive organs and other cards with the corresponding functions of descriptions. (See table below)
3. Ask each participant to read the card/ paper he/she has been given.
4. Ask for the corresponding card/paper owned by one of the participants to be read out loud. Ask participants to name the organ correctly and explain its functions. Encourage other participants to ask questions.
5. Summarize the main points learnt on male reproductive organs and
6. Ask for feedback. How did the cards activity help to explain the male reproductive organs?

Card game

Male reproductive organs	Corresponding description/function
Penis	Male organ for sex used for placing sperms into the vagina and also for passing urine.
Prepuce	Foreskin that protects the head of the penis.
Urethra	Long narrow tube inside the penis through which both sperms and urine pass.
Testes	Two sex glands that produce sperm and male hormones. They are responsible for the development of secondary sexual characteristics in a man.
Seminal vesicles	Are like pockets or glands where the white fluid (semen) is produced and the sperms stored.
Prostate	Produces fluid, which helps create a good environment for the sperms in the vagina.
Vas deferens	Are tubes through which the man's sperms pass from the testicles to the penis.
Scrotum	It is a sac, which holds the testes, and protects them against extreme temperature.
Epididymis	Coiled tubes leading from the testes to the vas deferens where sperm mature.
Cowpers gland	Produces fluid, which helps create a good environment for the sperm in the penile urethra

Discussion: *Taking care of your body and reproductive organs*

Adolescence is a stage where growth happens very fast. With this time, especially with the start of puberty the body is very active, involving hormones and glands that produce sweat and other body fluids that can emit smell. To have a different smell than before due to hormonal change is not unnatural, it just requires us to clean ourselves regularly. Personal hygiene and cleanliness of clothes and environment is also important to keep off diseases and infections, which are dangerous for our health.

Therefore, it is advisable that the facilitator discusses with the participants ways to take good care of their body and Reproductive Health organs.

Facilitator's task:

1. Discuss with participants ways of how to take care of their reproductive health Organs in order to keep them healthy For young adolescents and youth to maintain a high degree of hygiene:

    - The body should be washed at least once every day with clean water and soap.
    - Clothes, especially underwear, should be washed regularly and dried in the sun or at dry and clean places.
    - Males need to know that the penis has a foreskin (prepuce) that protects the head of the penis. Usually the penis produces a whitish creamy substance called smegma, which helps the foreskin to slide back smoothly. When smegma accumulates under the foreskin, it causes a bad smell or even infection.
    - Therefore, boys who are not circumcised (have not had the foreskin removed) need to pull back the foreskin and gently wash underneath it with clean water every day.

Basic information

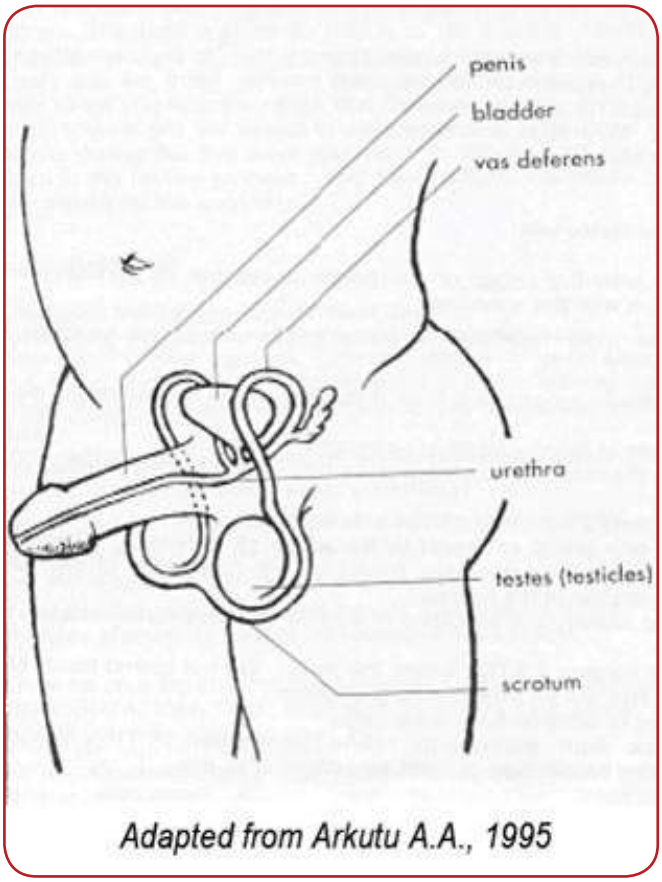
External male reproductive organs

External male reproductive organs are those male organs that are on the outside and can be seen. They comprise the penis, the scrotum, and the testes.

The penis

The penis is the organ that carries the semen with the sperm into the vagina. During sexual arousal, blood is pumped into the muscles of the penis. This makes the penis stiffen/erect so it can easily enter the vagina.

The penis additionally serves as the urinal duct. Although both semen and urine pass through the tube called the urethra in the penis, at the time of ejaculation the opening from the bladder is closed so that only semen comes out of the penis. After ejaculation, the blood quickly drains away into the body and the penis returns to its normal state.



Adapted from Arkutu A.A., 1995

The scrotum
The scrotum is a sac of skin containing two egg-shaped organs called the testes, found in front of and between the thighs. The scrotum protects the testes from physical damage and helps to regulate the temperature of the sperm.

The testes (testicles)
They are two sex glands that produce sperm and the male hormones, which are also responsible for the development of secondary sexual characteristics in men. At the onset of young adolescence stage, in boys the testes begin to produce sperm. This usually happens between the ages of 12 and 15, although it can also happen earlier or later.

Internal male reproductive organs

The internal male reproductive organs are situated within the lower part of the abdomen called the pelvis that is protected by bones and muscles (see figure below). They consist of the epididymis, the vas deferens, the seminal vesicles, the prostate, and the Cowper's gland.

Epididymis
A cord-like structure coiled on top of the testes, it stores sperm. When sperm matures, it is allowed to pass into the vasa deferentia before being released during ejaculation.

Vas deferens
The vasa deferentia are tubes through which the man's sperm passes from the testicles to the penis. When a man has a "vasectomy", these tubes are cut and sperm can no longer pass from the testicles to the penis. This is one of only two methods of contraception (family planning) available to men. The other is use of condoms. Having a vasectomy does not prevent a man from having an erection, or from ejaculating.

Seminal vesicles
The seminal vesicles are like pockets or glands where the white fluid, semen, is produced. Semen is a fluid that is released through the penis when a man has an ejaculation. It provides nourishment for the sperms and helps their movement.

Prostate
The prostate is situated below the bladder. The prostate procedures fluid that makes up part of the semen; it helps create a good environment for the sperm in the penile urethra and vagina, enables movement of the sperm and provides nutrients for the sperm.

Cowper's gland
The Cowper's gland comprises two small glands situated below the prostate with ducts opening into the urethra. Its function is to produce some fluid, which helps create a good environment for the sperms in the penile

urethra.
Note: Semen is produced at three different levels, by three different organs i.e. the Cowper's gland, the prostate and the seminal vesicles.

Hormones and their functions
Testosterone is the major male hormone produced mainly by the testes but also the adrenal glands. In case a man has lost his testes, these glands would continue to produce testosterone to support the male physical appearance. Testosterone is responsible for the growth and development of a boy during adolescence and for the development of sperm and secondary sexual characteristics.

1.2 Puberty and body changes

Between the ages of 10 and 14 most boys and girls begin to notice changes taking place in their bodies. These changes occur over a number of years and are generally referred to as "puberty". Puberty is the process of physical, social, mental, emotional and behavioural changes and development that happen to young people as they move from being children to being adults who are capable of sexual reproduction and fertilisation. It is characterised by the fast growth of the body and reproductive health organs. The changes are gradual and occur at different ages and speed in different people. Puberty happens to most young people between the ages of around 9 to 18 years. Some young adolescents' will reach this stage earlier than others. However, girls tend to reach this stage a little earlier than boys.

Experiencing sudden growth and change of certain body parts during the early stages of puberty can be shocking and stressful for young adolescents. It is therefore helpful for them to be know about the changes and the causes of the changes that will occur in their bodies so as to overcome the shock and stress.

Exercise 3: Body mapping

Objective: Participants understand the body changes during puberty

Method: Large group discussions

Tools: Large paper and pens, labelled charts of male and female reproductive organs

Facilitator's tasks:

1. Divide participants into groups
2. Ask each group to draw the outline of a female and male body on a big paper and put it on the ground.
3. Ask participants to mark on the body all the physical changes that happen to an adolescent person (male or female) during puberty.
4. Ask them to discuss the following questions:
   - What are the good things about growing up and body changes?
   - What are the bad things about growing up and body changes?
   - Why do body changes happen?
   - How do people feel about these changes?
   - What problems do we have with the changes?
   - What questions do we have about growing up?
5. Ask participants to write down any other questions they may have, which you will answer later in plenary.
6. Bring all participants together and invite them to share their body maps, if they are happy to do so. Share ideas about the good and bad things about growing up, the changes and why they happen.
7. Add any additional and missing background information, using charts or pictures if available.
8. Discuss all questions that were posed and share ideas on possible answers in the group. Correct or add information as needed. If you do not know an answer to a question, say you will find out. Then find out, and answer the question at the beginning of another session.

Body changes and the development of the reproductive organs

Puberty is initiated by hormonal signals from the brain to the gonads: the ovaries in a girl, the testes in a boy. In response to these signals, the gonads produce hormones that stimulate libido and the growth, function, and transformation of the brain, bones, muscle, blood, skin, hair, breasts, and sexual organs. Physical growth - height and weight - accelerates in the first half of puberty and is completed when the child has developed an adult body.

The major landmark of puberty for males is the first ejaculation, which occurs on average at age 13. For females, it is menarche, the onset of menstruation, which occurs on average between ages 12 and 13.

Female body changes during puberty

During puberty, the following changes occur in females' bodies and reproductive organs.

- Hips widen up in a circular shape
- Increase in height and weight gain
- Breasts start growing
- The labia thicken, the clitoris starts to grow and reaches its final size around the age of 18
- Hair starts to grow around reproductive organs and in the armpits
- The uterus increases in size
- Voice starts to change
- Ovaries grow and start producing ovum
- The wall of the uterus becomes ready to host the foetus
- Face may develop pimples
- Monthly menstrual flow begins Note: If a girl has unprotected sex at the young adolescents' stage, she might become pregnant. Girls may become pregnant before they even begin to see their first menstruation.
- Sexual feelings – excitement when touching our private parts

Male body changes during puberty

During the young adolescence stage, the following changes occur in males' bodies and reproductive organs

- Voice starts to change
- Face develops pimples
- Increase in height and weight gain
- Shoulders and chest widen up
- Hair starts to grow around reproductive organs and in the armpits, beard starts to grow
- Penis and testicles start to grow
- Sperm starts being produced
- Sexual arousal / feelings – excitement when touching our private parts
- Wet dreams can occur *(see page 14)*

Hormonal changes

Growth hormones cause quick growth and body change. They control how and when the body will grow, which body part will change first. Growth hormones are produced starting from the stage of young adolescence onwards.

Sexual hormones are produced during puberty. They a) determines the male and female body shapes; and b) direct and controls the growth and function of reproductive organs. Under the brain's command, hormones will be produced in the female's ova gland (oestrogen and progesterone). They also influence behaviour.

Hormones cause a quick change in body and feelings during puberty. Because of that, sometimes emotional instability is observed in young adolescents. However, as they grow older, because the production of hormone decreases, they will become more settled again.

11 Puberty – physical changes

Activities

Body mapping

1 Put group into single sex groups. Ask one person to lie on the ground or stand against a wall and draw around them with a stick or chalk. (Or just draw the outline of a body on the ground.)

2 Ask them to mark on the body all the changes that happen to people of their sex (male or female) during puberty.

3 Ask them to discuss:

- ▲ *What are the good things about growing up?*
- ▲ *What are the bad things about growing up?*
- ▲ *Why do those changes happen?*
- ▲ *How do people feel about them?*
- ▲ *What questions do we have about growing up?*
- ▲ *What problems do we have with the changes?*

Collect the questions to answer later.

4 Bring the group together and invite them to share their body maps, if they are happy to do so. Share ideas about the good and bad things about growing up, the changes and why they happen.

5 Add any additional information, using pictures if you have them.

6 Read out the questions that people gave one by one. Invite members of the group to answer them and share the ideas. Correct or add information, as it is needed. If you don't know the answer to the question, say you will find out.

Getting help during puberty

1 Divide into pairs and ask people to talk about who they would talk to if they had a problem about puberty or sexuality. Ask them to tell each other why they chose that person. Ask:

- ▲ *Do we have some worries that we do not get good help for? What is the reason for this?*
- ▲ *Who might help us with this worry?*

2 Ask the group to do some role-plays to practise asking these people for help with different puberty problems.

3 Tell them that, when they go home, they should practise talking to a parent or close relative about puberty or a sexuality issue.

4 At the next meeting, discuss how it went.

Wet dreams

Clarifying the myth: Wet dreams do not mean that a boy should start having sexual intercourse. It is safer to let wet dreams take care of sperm production until boys are mature enough to have a safe, caring sexual relationship.

Ejaculation means that a boy is capable of making a girl pregnant. It does not mean that he is ready to become a father.

When a boy reaches the age of about 12, the male sex hormone or 'messenger' is produced and tells the testes to start producing sperm.

The sperm passes through a long tube (urethra) to the prostate, where it is mixed with a milky liquid (seminal fluid) to become semen. This is stored until it comes out through the penis in quick, short bursts: this is called ejaculation.

Sometimes a boy's first ejaculation happens at night when he is asleep. This is called a wet dream and the boy may have a dream related to sex when it happens. Some boys have regular wet dreams and others hardly ever have them. Both cases are normal.

Wet dreams are the body's way of practicing to make a baby. They are normal and not a disease. A boy should not feel shy or worried about wet dreams. They are a sign that he has reached puberty and his reproductive organs are working well.

Girls can also have sexy dreams and some might find that they are wet between their legs at these times. This wetness is made in the vagina. When the girl is grown up, it will protect her vagina during sex. This is normal.

13 Wet dreams

Aims

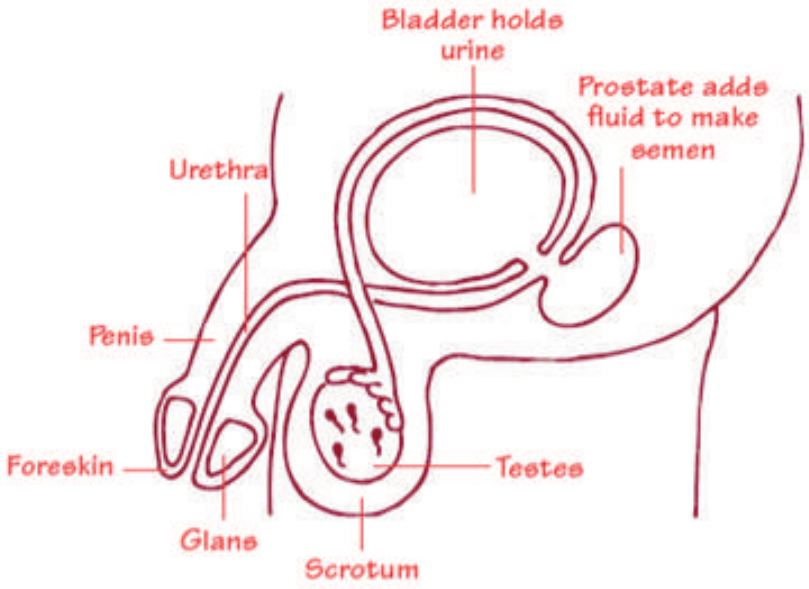
- To understand why boys and girls have wet dreams.
- To feel happy about having wet dreams.
- To know that wet dreams do not mean that boys and girls should have sex.

Group

All ages. Separate and then mixed sex groups.

Time 30 minutes

Male reproductive organs



Key facts

- When a boy reaches the age of about 12, the male sex hormone or 'messenger' is produced and tells the testes to start producing sperm.
- The sperm pass through a long tube to the prostate, where they are mixed with a liquid, like milk, to become semen. This is stored until it comes out through the penis.
- Semen comes out in quick, short bursts. This is called ejaculation.
- Sometimes, a boy's first ejaculation happens at night when he is asleep. This is called a wet dream and the boy may have a sexy dream when it happens.
- Some boys have regular wet dreams and others hardly ever have them. Both are normal. Wet dreams can continue into young adulthood.
- Wet dreams are the body's way of practising for making a baby. They are normal and not a disease. A boy should not feel shy or worried about wet dreams. They are a sign that he has reached puberty and his reproductive organs are working well.
- Wet dreams do not mean that a boy should start to have sexual intercourse. It is safer to let wet dreams take care of sperm production until boys are mature enough to have a safe, caring sexual relationship.
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Wet dreams 13

Activity

Agony aunt letter

1 Read the letter.

2 In pairs, discuss and agree on a reply for Chipili.

3 In the whole group, share and discuss some of these replies.

Dear Aunty,

I am a 13 year old boy. Last week I woke up with a wet patch on my bed. It smelled funny and I noticed that it was on my penis too. I remembered that I had a sexy dream about a girl in my class. I wanted to touch her body!

My older brother noticed the wet patch and laughed at me. He said that the only way I can stop this happening is to get the girl to agree to have sex with me. Now I am afraid. Can you help me?

Chipili

Developing from a child to an adult Understanding mental, emotional, social, and behavioural developments during puberty

Mental development

As adolescents, we gain a whole new set of mental tools. We are now able to analyse situations logically, thinking about cause and effect. We can imagine situations that are not real. This enables us to plan for the future and compare different possibilities. We can make good decisions. These new thinking skills enable adolescents to:

- become more independent
- take on increased responsibilities
- consider future jobs
- ask for information and advice
- develop a social conscience (considering what is right and wrong)
- develop values and ethical behaviour
- exercise new reasoning skills.

Emotional development

Adolescents have to establish a sense of identity. We think about who we are and what makes us special.

Self-concept is the set of beliefs that we have about ourselves, our qualities, gender, ethnic identity, roles, goals, interests and values. **Self-esteem** is how we feel about our self-concept. As we grow up we experiment with different ways of appearing, sounding and behaving to develop our identity.

As adolescents, we also have to develop skills such as recognising and managing feelings, relating to others and showing empathy so that we can make friends and co-operate with others.

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1.3 Menstruation and pregnancy

The onset of the menstrual cycle (also called menarche) is one of the major landmarks of puberty among females. It begins for many girls at the age of 12. However, others might experience their first menstruation even earlier or later. It is important that young adolescents are well-informed about menstruation in order to know how to handle it and how to best react.

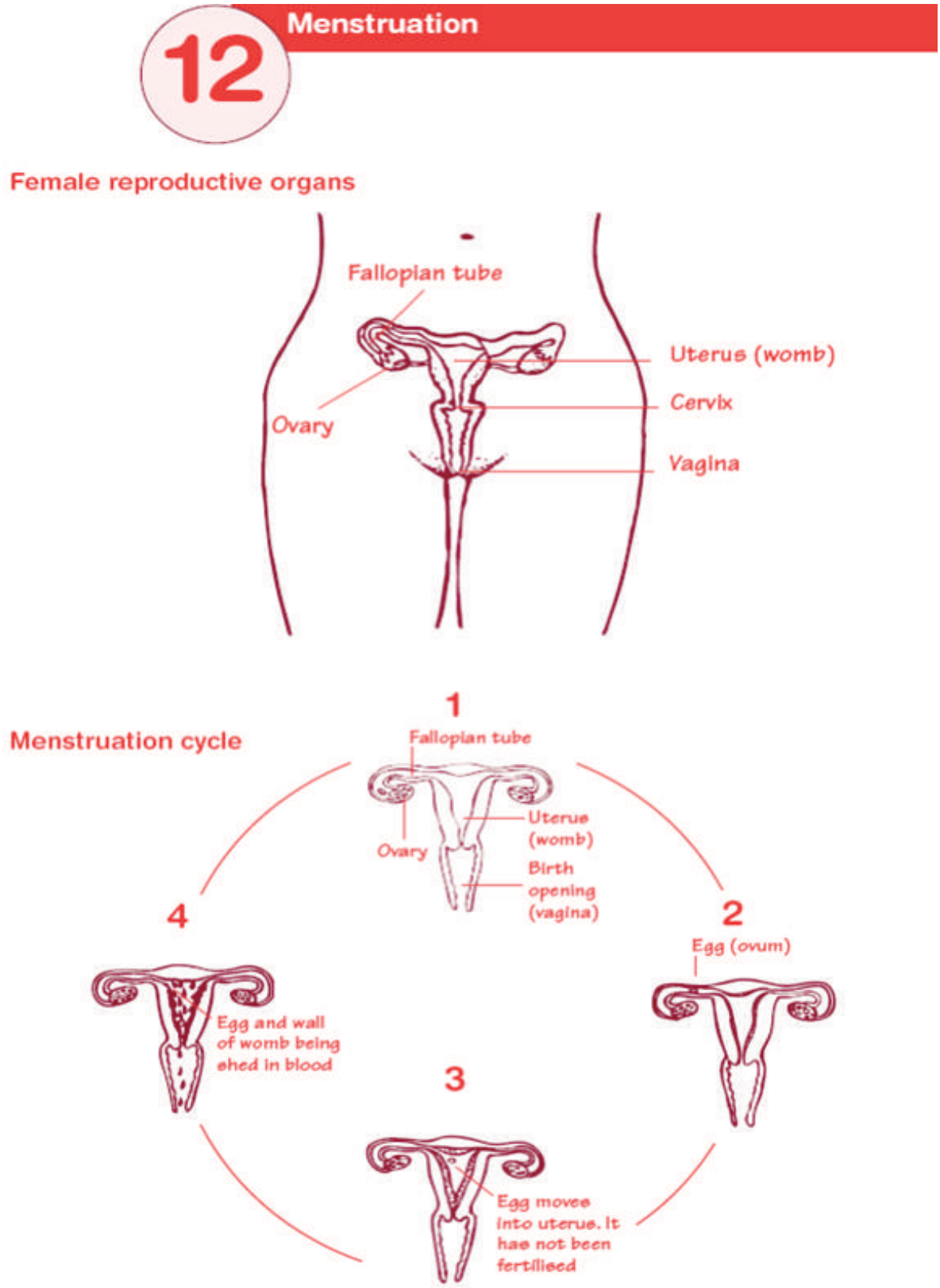
Exercise 4: Understanding the menstrual cycle

Objective: Enable participants to better understand menstruation
Method: Large group work
Tools: Menstrual cycle graph
Time: 30 minutes

Facilitator's tasks:

1. Prepare before the beginning of the session (or ask participants to help you) separate papers/cards by photocopying or drawing with the different phases of the menstruation cycle
2. Invite volunteers to come to the middle and distribute the papers/cards randomly to each of them
3. Ask them to read the text on the sheet of the paper and line up according to the menstrual cycle
4. Ask each volunteer to explain the phase of the cycle described on his/her paper.
5. Ask entire group the following questions
   - What causes menstruation?
   - What are the good and bad things about menstruation?
   - How and when can pregnancy occur during the menstruation cycle? What is conception?
6. Correct answers where necessary and provide more missing facts and information according to background knowledge
7. Summarise shortly the main points learned about:
   - Menstruation cycle
   - Conception and pregnancy
   - Ovulation

Menstruation cycle graph



Exercise 5: Understanding menstruation and the situation of girls

Objective: Enable participants to better understand menstruation
Method: Large group work
Tools: Maria's story
Time: 30 minutes

Facilitator's tasks:

1. Ask the group to sit together
2. Read yourself or asks a trainee to read out Maria's story, which is a personal experience with menstruation.

Maria's story

"I was 14 when I experienced my first menstruation. I used to pull up my skirt and place a plastic sheet on my bench so that the menstrual blood does not stain my skirt. I was so stressed out about others realizing that I barely focused on my education. All I was worried about was 'What if it stains my skirt? What if the students see it?' The next day, our maid gave me a piece of cloth and I used it as a sanitary tissue. But as I was returning to class from the break, the cloth dropped off my underwear. I walked off pretending that was not mine but it was in vain as some students had watched it drop off my skirt. They embarrassed me asking 'what is that smell?' It took me a while before I got used to managing it properly. Even if I was able to manage it, the period was always stressing me out. I did not want to go to school when I was in my period. I did not want to socialize or study during those moments. My younger sister's menstruation started even earlier than mine. She was only 13 when she first experienced menstruation. She would sit in the restroom for a very long time so that, as she told me later, it would all flow out till the last drop before she went out of there. But because I was already experienced then, I was able to help her."

Maria also said that many of her friends had gone through the same troubles and that they were sometimes ashamed of standing up from their seat.

3. Ask the following questions to the entire group and discuss the answers and comments
   a. Is Maria's story realistic?
   b. Can someone share a similar story?
   c. When does menstruation start in a girl's life, how does it begin?
   d. What problem does it cause?
   e. What are the existing cultural attitudes regarding menstruation?
   f. What should be done when menstruation starts?
   g. What can girls do to manage their menstrual hygiene?
   h. How can we help each other to manage menstruation happily?
   i. How can boys help? How can we help girls?
   j. How can families, teachers, and elders help?
4. Share background knowledge, your own experiences and correct information with participants and encourage them to practice tolerance and understanding

Basic information

Menstruation and Pregnancy

Menstruation is a normal, healthy part of a woman's life. It is not an illness, dirty or shameful. All young females and women have monthly bleedings. When it happens, it means that a girl is biologically able to get pregnant. It does not mean that she is automatically mature enough to have sexual intercourse or to become a mother.

The menstruation cycle

Days 1-5: Menstruation (period): The lining of the womb together with an unfertilized egg leave the body in form of blood fluids and tissue lining through the vagina. The bleeding can last from 2-8 days, on average 4-6 days. The length of each period, as well as the amount of bleeding, varies from woman to woman.

1. Days 5-7: Every month, one egg grows and matures in the ovary.
2. Days 7-11: The lining of the womb starts to build up and makes its inside wall thick like a nest and ready to house a baby. (The lining continues to thicken until about day 21)
3. Days 11-14: When the egg is ready, it leaves the ovary. This moment is called ovulation.
4. Days 14-21: The egg moves through the fallopian tube into the womb.
5. Days 21-28: The egg can only survive for about 24 hours in the fallopian tube after the ovulation. Menstruation occurs when the egg is not fertilised by a sperm following sexual intercourse. If the egg reaches the womb and is not fertilized, the lining of the womb begins to dissolve.
6. Days 1-5: Menstruation: The lining of the womb together with an unfertilized egg leave the body in form of blood fluids and tissue lining through the vagina.
7. And then it starts all over again.
   The length of one menstrual cycle is the interval from the beginning of one monthly menstruation to the beginning of the next one. It is usually 28 days long, but it can vary between 21 and 35 days.

Conception

The process of conception involves the fusion of an egg (ovum) from a woman's ovary with a sperm from a man. Every month during a woman's fertile years, her body gets prepared for conception and pregnancy. In one of her ovaries an egg ripens and is released from its follicle. The egg - about the size of a pinpoint, 1/250 inch in diameter – is then drawn into the fallopian tube through which it travels to the uterus. The journey takes three to four days. The lining of the uterus has already thickened to assist the implantation of a fertilized egg, or zygote. If the egg is not fertilized, it lasts 24 hours and then disintegrates. It is expelled along with the uterine lining during menstruation.

Sperm cells are produced in the man's testes and ejaculated from his penis into the woman's vagina during sexual intercourse. Sperm cells are much smaller than eggs (1/1800 inch in diameter). The typical ejaculate contains millions of sperm, but only a few complete the long

journey through the uterus and up the fallopian tube to the egg. Of those that reach the egg, only one will be allowed to penetrate the outer layer of the egg. As the sperms approach the egg, they release enzymes that soften the outer layer of the egg. The first sperm cell that bumps into a spot that is soft enough can swim into the cell. It then merges with the nucleus of the egg and fertilization occurs.

While still in the tube, the fertilized egg begins to divide and grow. At the same time, it continues to move through the tube towards the womb. It takes an average of five days to reach the inside of the womb. Within two days of reaching the womb, the fertilized egg attaches itself to the lining of the womb. This process is known as implantation.

The ovum (egg) carries the hereditary characteristics of the mother and her ancestors; sperm cells carry the hereditary characteristics of the father and his ancestors. Together they contain the genetic code, a set of instructions for development. Each cell - egg or sperm - contains 23 chromosomes, and each of these chromosomes contains genes, so small that they cannot be seen through microscope. These genes are packages of chemical instructions for designing every part of a baby. They specify the sex and determine, among others, whether it will tend to be (depending also on its environment) short, tall, thin, fat, healthy, or sick. Together, they provide the blueprint for a new and unique person.

The usual course of events at conception is that one egg and one sperm unite to produce one fertilized egg and one baby. But if the ovaries release two (or more) eggs during ovulation, and if both eggs are fertilized, two babies will develop. These twins will be more alike than will be siblings born from different pregnancies, because each of the latter comes from a different pregnancy, and therefore from a different fertilized egg.

Twins who develop this way are referred to as fraternal twins; they may be of the same sex or of different sexes. Twins can also develop from a division of a single fertilized egg into two cells that develop separately. Because these babies share all genetic material, they will be identical twins.

Conception can be avoided by using contraceptives.

Important things to note on menstruation

- Menstrual blood is neither dirty nor a dangerous occurrence. The first menstrual blood takes longer to flow out and the ovary may begin producing more eggs before the occurrence of the first menstrual blood flow. Therefore, girls may become pregnant before they even begin to see their first menstruation.
- A woman can get pregnant when she has sexual intercourse with a sexually mature male just before ovulation or shortly after. In an average 28-cycle, a woman can get pregnant if she has sexual intercourse on days 11-14. (However, these days are not fixed, as the length of menstrual cycles varies. It is important to use contraceptives to exclude an unwanted pregnancy and prevent an infection with HIV and AIDS or other STIs.
- Menstruation continues throughout women's reproductive life (menarche). The menstrual cycle stops between the age of 40 and 50. This is known as menopause.

- After a girl has had her first menstruation, her menstrual cycle does not necessarily follow a regular pattern right from the beginning. This does normally change over time leading to a regular cycle.
- There are many situations that cause menstrual irregularities, for instance, diet, stressful situations, mourning, sickness, insomnia or extreme happiness etc.
- Menstruation is not a disease, hence a girl in her menstruation period is capable of engaging in all activities she normally engages in.
- Some girls may experience some discomfort during menstruation like stomach aches (as the muscles of the womb push out the blood) or headache. This is normal, not a curse or a disease. Discomfort can be eased by resting or doing some physical exercises. It is important that the girl understands that the symptoms are only temporary. However, if she does not see changes and suffers a lot, she needs to consult a Doctor.
- In some cultures girls' during their menstrual periods are advised to eat some things and not other things. In others they are told not to enter sacred/ religious places during their menstruations. In yet other cultures, they are asked to stay in secluded places during their menstruation period. But all these attitudes are now changing.

How can a girl keep herself clean during menstruation?

In order to catch the blood from the vagina, there are different ways to do that:

- Sanitary pads/towels: they are especially made for the menstruating days of women and made out of cotton wool. They are put into the under wear and catch the blood. Sanitary towels are sold in drug stores. There are two types of them, disposable ones, that have to be thrown away after one use, or re-usable ones that can be washed and used several times. Girls may also use cotton wool wrapped in thin cloth. Used sanitary pads should be disposed of in the pit latrines.

- Tampon: these are tubes of cotton wool that can be inserted into the vagina to catch the blood. They can be used only one time and need to be changed regularly (latest after 8 hours, if not soaked with blood before) to avoid infections. At the end of the period, girls need to ensure that the last tampon has been removed.

Exercise 6: How to make your own re-usable sanitary towel

Objective: Participants make a sanitary pad from local materials
Methods: Explanation, step-by-step guidance and supervision
Tools: Pieces of cotton cloths, strands of cotton, needle, thread, knickers, dis posable sanitary pad.
Time: 30 minutes

How a girl can keep clean during menstruation

There are different ways for girls to keep themselves clean during menstruation (see background information). Some girls stay away from school while menstruating if they do not have access to any sanitary towel or other hygiene products.

Facilitators' tasks:

Important: Collect all needed materials and tools before the session and prepare it in advance.

Step 1:

- Tell the trainees they will need to listen, watch and follow step by step as you demonstrate the steps to make a re-usable sanitary towel out of local materials.
- Provide each participant with 2 pieces of cotton cloths, a strand of cotton and a needle.
- Demonstrate each step and provide a verbal description accordingly:
  1. Fold one of the squared cloth in half and then in half again (2 folds in total)
  2. Take the second cloth and fold it diagonally (corner to corner)
  3. Put the folded cotton cloth inside the squared diagonal cotton cloth.
  4. Then fold top corner in to meet the bottom side.
  5. Fold the left and right side in to meet the top piece and place it under the top piece like an envelope.
  6. Lastly sew the points together in the middle 4 times to hold it firmly and now it is ready for use.
  7. Check to see if they will absorb liquids
  8. Tell the trainees - After use, you should un-tie the cloth, wash it properly, dry it in the sun and iron it if possible. Repeat the steps above to use it again.

Tell the trainees if they have a heavy flow then they should make the inside cloth thicker, and that they can use any cloth of any colour they like to make a sanitary towel, but that it should be cotton and no synthetic material. They can also fix a button or a ribbon to close the outer bag and be creative !

Step 2

- Find 2 volunteers to come in the front, probably a boy and a girl.
- Tell them to make a sanitary towel following all the steps from the first step to the last step in order to find out whether they have understood all the steps of making a sanitary towel, if they haven't repeat the above steps in order for them to understand.

Step 3

- Provide girls with tips and information on how to take care of them during menstruation. *(See background information)*
- Prepare and store a sanitary pad or a piece of cloth made of cotton material.

- Keep the sanitary pad or the piece of cotton cloth in your bag when going to school or other places.
- Change the sanitary pad/piece of cloth as soon as it gets wet. Otherwise, it may develop germs or leak.
- If it is a re-usable sanitary towel, then it has to be washed and dried up under the sun.
- Wash/bath more often during menstruation period. Washing only the outer side and edge of the sexual organ/vagina is enough.
- It is advisable to wash downwards from the sexual organ/vagina to the anus. If you wash from the anus towards the sexual organ/vagina, then harmful bacteria and germs coming out of the anus might go into the sexual organ/vagina and cause infection.
- Use minimal soap and be careful to avoid getting soap inside the vagina because soap tends to dry-out the mucus membrane of the inside of the vulva which may cause irritation, and toxins that may be present in some soaps that are easily absorbed through the mucus membrane. Also soaps affect the natural pH balance of the vagina - this can lead to bad smell and increase the risk of infections.
- Even if a girl has a regular menstruation, this does not mean that the girl should start having sex. It is important that girls stay away from sex during young adolescence as their sexual organs are yet not strong enough to bear sex and, therefore, might be damaged.
- It is also advisable/possible to discuss menstruation with parents.
  Conclude the session by informing the participants that they can discuss menstruation related issues with their parents, peers, sisters, and friends. Ask male participants if they have learned something new and would like to express their commitment to help girls/women during their menstruation period.

1.4 Sexuality and Reproductive Health

Exercise 7:	What is sexuality?
Objective:	Participants understand that we are have our sexuality from the time we are born up to when we die and that we do not only need sexual intercourse to enjoy our sexuality.
Methods:	Group work
Tools:	Flip chart and markers
Time:	30 minutes

Step 1: Divide participants in six small groups and give each group one of the following to discus

- A baby boy and a baby girl
- A baby boy and girl aged 6 years
- A baby boy and girl aged 15 years
- A married man and woman aged 22 years
- A woman and man with a baby
- An Elderly man and woman

Ask every group to discuss how the person they have been given might feel and express his or her sexuality. For example a 6 year old boy or girl plays mummy and daddy roles.

Step 2: Ask the group to tell the plenary their ideas about sexuality in the age group they talked about. Other groups may add their ideas.

Step 3: Ask the participants what they have learnt from this activity.

Step 4: Point out that we can enjoy our sexuality at all ages even without having sexual intercourse. We should be in a hurry to have sexual intercourse, but wait until our minds and bodies are mature. We should trust ourselves that when the time comes, we shall do it well.

1.4.1. Sex and sexuality

During puberty the need for being in a relationship, feelings of love and readiness for sexual involvement with the opposite sex become stronger. As a result, boys begin to have wet and erotic dreams accompanied by night-time semen emission. Likewise, girls can also have wet dreams and experience lubrication of the vagina resulting into an internal urge to satisfy the dissatisfied sexual need.

In addition to that, there is sometimes peer group influence, erotic movies and music, pushing towards sexual activity. Young adolescents therefore, need knowledge on SRH and life skills (see Module 2) to cope with the changes that occur at this stage.

Young adolescents' may experience sexual feelings and this is a natural feeling. These feelings however may provoke many questions about sex: "What is sex? How would I feel if I had sex? What is love? Will I find someone I love and who loves me?

What is sex?

Sex refers to whether or not a person is male or female, whether a person has a penis or a vagina. Many of you may have noticed on different forms you have completed for school or at the doctor's office that there is often a question on the form called "Sex." You are required to check either male or female. Sex is also commonly used as an abbreviation to refer to sexual intercourse.

What is sexuality?

Sexuality may be defined as the way

- People think and the attitudes they hold about others,
- The way they relate with each other and the opposite sex,
- The way they behave, as a result of being females or males.

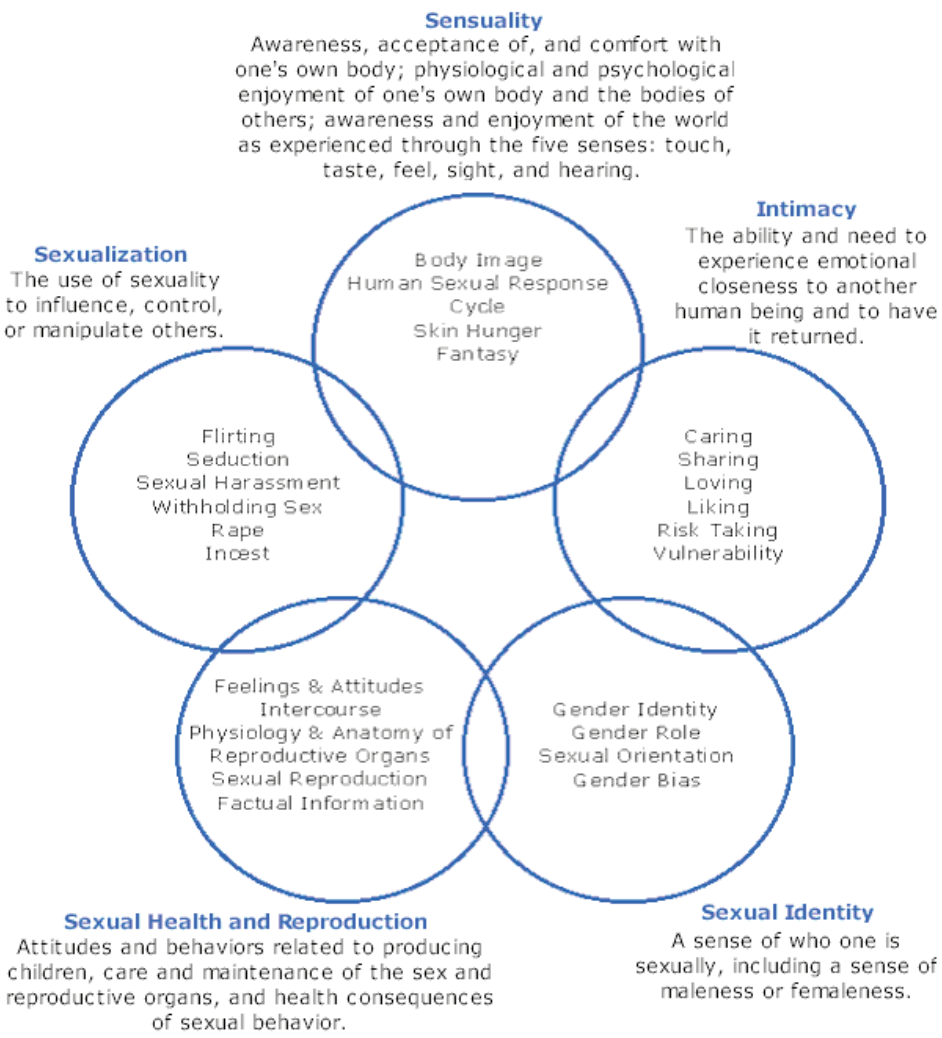
Sexuality begins at birth and stops at death. However, it differs with age and social exposure. Sexuality refers to the total expression of who you are as a human being, your femaleness or your maleness. Everyone is a sexual being. Your sexuality is interplay between body image, gender identity, gender role, sexual orientation, eroticism, genitals, intimacy, relationships, and love and affection. A person's sexuality includes his or her attitudes, values, knowledge and behaviours. How people express their sexuality is influenced by their families, culture, society, faith and beliefs.

A very narrow view of sexuality has been limited to sexual relationships and reproduction among people. It is important to re-examine this concept in the light of working with adolescents or any group of children at any stage of development. Sexuality is not synonymous with sex; rather it is part of a person's entire life from birth to death. It does not only entail genital and reproductive processes but encompasses gender roles, social roles, self-esteem, feelings and relationships. Sexuality is how one feels about him/herself as being a male or female, how one consequently relates to members of the same and opposite sex, and how one feels about her/himself as a totals person.

The Circles of Sexuality
Source: http://www.advocatesforyouth.org/lessonplans/circlesofsexuality3.htm

NOTE TO THE FACILITATOR: When explaining the circles of sexuality, consider the cultural context of your group as this section contains very sensitive aspects.

An Explanation of the Circles of Sexuality



Sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who a person is and what she/he will become. It includes all the feelings, thoughts, and behaviours associated with being female or male, being attractive and being in love, as well as being in relationships that include sexual intimacy and sensual and sexual activity. It also includes enjoyment of the world as we know it through the five senses: taste, touch, smell, hearing, and sight.

1.4.2 Factors leading to young adolescents engaging in sex

- Lack of knowledge on the possible consequences of sexual activity
- Sexual abuse: rape, incest
- Poverty
- Lack of life skills: assertiveness, self-awareness, negotiation skills, self-esteem and decision-making.
- Alcohol and substance abuse
- Peer pressure
- Environmental social setting: poor housing, slums
- Influence of media
- Insecurity

Possible consequences of young adolescents' engaging in sex

- Early or unwanted pregnancy
- STI's/HIV & AIDS
- Emotional consequences: shame, guilt, fear
- Social consequences: dropping out of school, stigmatisation, forced marriage, stunted growth for the young adolescent, low social status

1.4.3 How to protect oneself from an unwanted pregnancy?

There are various ways to protect oneself from unwanted pregnancies. Modern contraceptives offer a high level of protection. For young adolescents it may be too early to know them in detail. However, it might be useful for those between 12 and 14 to see a condom and to know how it is used correctly once before they are sexually active.

Exercise 7: How to use a condom
Objective: Participants know how to use a condom
Method: Condom demonstration
Tools: Condoms, wooden penis
Time: 20 minutes

Facilitator's task:

1. Demonstrate to participants how a condom looks like and how it is used.

(Refer to Module 7 pages 5-9)

Basic Information

Detailed explanation of the "Circles of Sexuality"

Circle #1 Sensuality

Sensuality is awareness and feeling about your own body and other people's bodies, especially the body of a sexual partner. Sensuality enables us to feel good about how our bodies look and feel and what they can do. Sensuality also allows us to enjoy the pleasure our bodies can give us and others. This part of our sexuality affects our behaviour in several ways.

Body image: Feeling attractive and proud of one's own body and the way it functions influences many aspects of life. Adolescents often choose media personalities as the standard for how they should look, so they are often disappointed by what they see in the mirror. They may be especially dissatisfied when the mainstream media does not portray or does not positively portray physical characteristics the teens see in the mirror, such as colour of skin, type or hair, shape of eyes, height, or body shape.

Experiencing pleasure: Sensuality allows a person to experience pleasure when certain parts of the body are touched. People also experience sensual pleasure from taste, touch, sight, hearing, and smell as part of being alive.

Satisfying skin hunger: The need to be touched and held by others in loving, caring ways is often referred to as skin hunger. Adolescents typically receive considerably less touch from their parents than do younger children. Many teens satisfy their skin hunger through close physical contact with peers. Sexual intercourse may sometimes result from a teen's need to be held, rather than from sexual desire.

Feeling physical attraction for another person: The centre of sensuality and attraction to others is not in the genitals (despite all the jokes). The centre of sensuality and attraction to others is in the brain, humans' most important "sex organ." The unexplained mechanism responsible for sexual attraction rests in the brain, not in the genitalia.
Fantasy: The brain also gives people the capacity to have fantasies about sexual behaviours and experiences. Adolescents often need help understanding that sexual fantasy is normal and that one does not have to act upon sexual fantasies.

Circle #2: Sexual Intimacy

Sexual intimacy is the ability to be emotionally close to another human being and to accept closeness in return. Several aspects of intimacy include

Sharing: Sharing intimacy is what makes personal relationships rich. While sensuality is about physical closeness, intimacy focuses on emotional closeness.

Caring: Caring about others means feeling their joy and their pain. It means being open to emotions that may not be comfortable or convenient. Nevertheless, an intimate relationship is possible only when we care.

Liking or loving another person: Having emotional attachment or connection to others is a manifestation of intimacy.Emotional risk-taking: To have true intimacy with others, a person must open up and share feelings and personal information. Sharing personal thoughts and feelings with someone else is risky, because the other person may not feel the same way. But it is not possible to be really close with another person without being honest and open with her/him.

Vulnerability: To have intimacy means that we share and care, like or love, and take emotional risks. That makes us vulnerable: the person with whom we share, about whom we care, and whom we like or love, has the power to hurt us emotionally. Intimacy requires vulnerability, on the part of each person in the relationship.

Circle #3: Sexual Identity

Sexual identity is a person's understanding of who she/he is sexually, including the sense of being male or of being female. Sexual identity consists of three "interlocking pieces" that, together, affect how each person sees him/herself. Each "piece" is important.

Gender identity: Knowing whether one is male or female. Most young children determine their own gender identity by age two. Sometime, a person's biological gender is not the same as his/her gender identity: this is called being transgender.

Gender role: Identifying actions and/or behaviours for each gender. Some things are determined by the way male and female bodies are built or function. For example, only women menstruate and only men produce sperm. Other gender roles are culturally determined. There are many "rules" about what men and women can/should do that have nothing to do with the way their bodies are built or function. This aspect of sexuality is especially important for young adolescents to understand, since peer, parent, and cultural pressures to be "masculine" or "feminine" increase during the adolescent years. Both young men and young women need help sorting out how perceptions about gender roles affect whether they feel encouraged or discouraged in their choices about relationships, leisure activities, education, and career.

Gender bias means holding stereotyped opinions about people according to their gender. Gender bias might include believing that women are less intelligent or less capable than men, that men suffer from "testosterone poisoning," that men cannot raise children without the help of women, that women cannot be analytical, that men cannot be sensitive. Many times, people hold fast to these stereotyped opinions without giving rational thought to the subject of gender.

Sexual orientation: Whether a person's primary attraction is to people of the other gender (heterosexuality) or to the same gender (homosexuality) or to both genders (bisexuality) defines his/her sexual orientation. Sexual orientation begins to emerge by adolescence although many gay and lesbian youth say they knew they felt same sex attraction by age 10 or 11. Between three and 10: percent of the general population is probably exclusively homosexual in orientation. Perhaps another 10 percent of the general population feel attracted to both genders.

Heterosexual, gay, lesbian, and bisexual youth can all experience same-gender sexual attraction and/or activity around puberty. Such behaviour, including sexual play with same-gender peers, crushes on same-gender adults, or sexual fantasies about same-gender people are normal for pre- teens and young teens and are not necessarily related to sexual orientation.

Negative social messages and homophobia in the wider culture can mean that young adolescents who are experiencing sexual attraction to and romantic feelings for someone of their own gender need support so they can clarify their feelings and accept their sexuality.

Circle #4: Reproduction and Sexual Health

These are a person's capacity to reproduce and the behaviours and attitudes that make sexual relationships healthy and enjoyable.

Factual information about reproduction: Is necessary so youth will understand how male and female reproductive systems function and how conception and/or STD infection occur. Adolescents often have inadequate information about their own and/or their partner's body. Teens need this information so they can make informed decisions about sexual expression and protect their health. Youth need to understand anatomy and physiology because every adolescent needs the knowledge and understanding to help him/her appreciate the ways in which his/her body functions.

Feelings and attitudes: Are wide-ranging when it comes to sexual expression and reproduction and to sexual health-related topics such as STD infection, HIV and AIDS, contraceptive use, abortion, pregnancy, and childbirth.

Sexual intercourse: Is one of the most common behaviours among humans. Sexual intercourse is a behaviour that may produce sexual pleasure that often culminates in orgasm in females and in males. Sexual intercourse may also result in pregnancy and/or STDs. In programs for youth, discussion of sexual intercourse is often limited to the bare mention of male-female (penile-vaginal) intercourse. However, youth need accurate health information about sexual intercourse: vaginal, oral, and anal.

Reproductive and sexual anatomy: The male and female body and the ways in which they actually function is a part of sexual health. Youth can learn to protect their reproductive and sexual health. This means that teens need information about all the effective methods of contraception currently available, how they work, where to obtain them, their effectiveness, and their side effects. This means that youth also need to know how to use latex condoms to prevent STD infection. Even if youth are not currently engaging in sexual intercourse, they probably will do so at some point in the future. They must know how to prevent pregnancy and/or disease. Finally, youth also need to know that traditional methods of preventing pregnancy (that may be common in that particular community and/or culture) may be ineffective in preventing pregnancy and may, depending on the method, even increase susceptibility to STDs. The leader will need to determine what those traditional methods are, their effectiveness, and their side effects before he/she can discuss traditional methods of contraception in a culturally appropriate and informative way.

Sexual reproduction: The actual processes of conception, pregnancy, delivery, and recovery following childbirth are important parts of sexuality. Youth need information about sexual reproduction: the process whereby two different individuals each contribute half of the genetic material to their child. The child is, therefore, not identical to either parent. [Asexual reproduction is a process whereby simple one-celled organisms reproduce by splitting, creating

two separate one-celled organisms identical to the original [female] organism before it split.] Too many programs focus exclusively on sexual reproduction when providing sexuality education and ignore all the other aspects of human sexuality.

Circle #5: Sexualisation

Sexualisation is that aspect of sexuality in which people behave sexually to influence, manipulate, or control other people. Often called the "shadowy" side of human sexuality, sexualisation spans behaviours that range from the relatively harmless to the sadistically violent, cruel, and criminal. These sexual behaviours include flirting, seduction, withholding sex from an intimate partner to punish her/him or to get something, sexual harassment, sexual abuse, and rape. Teens need to know that no one has the right to exploit them sexually and that they do not have the right to exploit anyone else sexually.

Flirting: Is a relatively harmless sexualisation behaviour. Nevertheless, upon occasion it is an attempt to manipulate someone else, and it can cause the person manipulated to feel hurt, humiliation, and shame.

Seduction: Is the act of enticing someone to engage in sexual activity. The act of seduction implies manipulation that at times may prove harmful for the one who is seduced.

Sexual harassment: Is an illegal behaviour. Sexual harassment means harassing someone else because of her/his gender. It could mean making personal, embarrassing remarks about someone's appearance, especially characteristics associated with sexual maturity, such as the size of a woman's breasts or of a man's testicles and penis. It could mean unwanted touching, such as hugging a subordinate or patting someone's bottom. It could mean demands by a teacher, supervisor, or other person in authority for sexual intercourse in exchange for grades, promotion, hiring, raises, etc. All these behaviours are manipulative. The laws provide protection against sexual harassment. Youth should know that they the right to file a complaint with appropriate authorities if they are sexually harassed and that others may complain of their behaviour if they sexually harass someone else.

Rape: Means coercing or forcing someone else to have genital contact with another. Sexual assault can include forced petting as well as forced sexual intercourse. Force, in the case of rape, can include use of overpowering strength, threats, and/or implied threats that arouse fear in the person raped. Youth need to know that rape is always illegal and always cruel. Youth should know that they are legally entitled to the protection of the criminal justice system if they are the victims of rape and that they may be prosecuted if they force anyone else to have genital contact with them for any reason. Refusing to accept no and forcing the other person to have sexual intercourse always means rape.

Incest: Means forcing sexual contact on any minor who is related to the perpetrator by birth or marriage. Incest is always illegal and is extremely cruel because it betrays the trust that children and youth give to their families. Moreover, because the older person knows that incest is illegal and tries to hide the crime, he/she often blames the child/youth. The triple burden of forced sexual contact, betrayed trust, and self-blame makes incest particularly damaging to survivors of incest. *Source: Adapted from Life Planning Education, a comprehensive sex education curriculum. Washington, DC: Advocates for Youth, 2007.*

Unwanted pregnancy

Unwanted pregnancy is a pregnancy that occurs when it is not wanted, mostly by the woman or her partner or both. There are various factors determining whether a couple wants to have a child at a certain point, including the age of partners, influence of the family and the community, financial constraints and a person's plan for life. An unwanted pregnancy is different from an

unplanned pregnancy: pregnancy can be unplanned, or unexpected, and the woman or her partner are very happy about it. And of course a pregnancy can also be both unplanned and unwanted. Lastly, an unwanted pregnancy is different from an early pregnancy, a pregnancy which takes place in a young girl whose body is not mature enough to handle it well, and who is also not emotionally ready to be a mother. An early pregnancy can be wanted or unwanted, planned or unplanned – but it is always a danger to the girl and her baby.

Causes of unwanted pregnancy

The following are possible factors leading to unwanted pregnancy:

- Early marriage
- Peer pressure
- Sexual experimentation
- Unavailability of contraceptives
- Misinformation or myths on male/female sexuality
- Fear or myths about contraceptive use
- Not using contraceptives
- Lack of knowledge or information
- Wish to express love
- Failure to use contraceptive methods properly
- Sexual abuse or sexual violence, such as rape and defilement
- Lack of ability to negotiate contraceptive use or safer sex
- Poverty

Early/Teenage pregnancy

Teenage pregnancy refers to pregnancy in a female under the age of 20 (when the pregnancy ends). A pregnancy can take place at any time before or after puberty, with menarche (first menstrual period) normally taking place around the ages 12 or 13, and being the stage at which a female becomes potentially fertile. Teenage pregnancy depends on a number of societal and personal factors. Teenage pregnancy rates vary between countries because of differences in levels of sexual activity, general sex education provided and access to affordable contraceptive options. Early pregnancy poses a serious health risk to both mother and baby. However, there are also social, psychological and economic consequences of early pregnancy.

Medical risks

The risk of having serious complications during pregnancy or childbirth is much higher for girls in their early teens than for older women. Ages of 20–30 years are the safest period of women's life for child bearing. The major difference between girls in their early teens and older women is that girls aged 12–16 years are still growing. The pelvis or bony birth canal of a girl can grow wider by as much as 20% between the time she begins menstruating and the time she is 16 years old. This widening of the pelvis can make the crucial difference between a safe delivery and obstructed labour. It is not surprising, therefore, to find that obstructed labour due to disproportion between the size of the infant's head and the mother's pelvis is most common among very young mothers.

Obstructed/Prolonged labour: Labour is said to be obstructed when there is absence of progress in the presence of strong uterine contractions. The baby cannot pass through the pelvis because the pelvis is too small. Before the girl reaches 16 years, her pelvis is not fully developed and is therefore narrow. Obstructed labour might make a Caesarean section necessary. This is a surgical operation carried out to remove the baby from the uterus. If the operation is not done in time, the baby may die inside the uterus and the mother become very ill or even die. Prolonged labour may take up to 7 days. The uterus may tear (rupture) and the mother dies of blood loss. The head of the baby may tear the vagina, resulting in obstetric fistula.

Obstetric fistula: Obstetric fistula is an injury of childbearing that is usually caused by several days of obstructed labour, without timely medical intervention. Unattended obstructed labour can last for up to six or seven days, although the foetus usually dies after two or three days. During the prolonged labour, the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bone. The lack of blood flow causes tissue to die, creating a hole between the mother's vagina and bladder (known as a vesico-vaginal fistula), or between the vagina and rectum (causing a recto-vaginal fistula) or both. The result is a leaking of urine or faeces or both. The consequences of fistula are often life shattering: In about 95 % of cases, the baby dies. The woman is left with chronic incontinence. Because of her inability to control her flow of urine or faeces, she is often abandoned or neglected by her husband and family and ostracized by her community. Without treatment, her prospects for work and family life are greatly diminished, and she is often left to rely on charity. Fistula is treatable as well as preventable. Reconstructive surgery can mend the injury, and success rates are as high as 90 % for uncomplicated cases (For complicated cases, the success rate is closer to 60%). Two weeks or more of post-operative care is needed to ensure a successful outcome.

Other health complications: Very young women who become pregnant face a higher risk than older women in developing a number of other complications such as

- Excessive vomiting
- Severe anaemia
- Hypertension
- Convulsions
- Difficulty in breast feeding (if the girl is too young to produce milk)
- Infection
- Higher maternal and infant mortality

Early birth: The baby may be born too early before it is fully developed or have a low birth weight.

Chapter 2: Unhealthy relationships, harmful practices and sexual violence

2.1 Healthy and unhealthy relationships

Exercise 8:	Healthy and unhealthy relationships
Objective:	Sensitize participants for healthy and unhealthy relationships
Method:	Open discussion
Tools:	Cards, 2 large sheets of paper or flip charts, markers, pins
Time:	20 minutes

Facilitator's tasks:

1. Write down different characteristics of healthy and unhealthy relationships
2. Write on two large papers/flip charts "healthy relationship" and "unhealthy relationship"
3. Distribute cards to the group and ask participants to pin their cards to the paper/flip chart they think it belongs to.
4. Discuss the results in the group, ex change experiences (if adequate) and identify ways of how to avoid unhealthy relationships.

What makes a healthy relationship?

Good relationships are based on love, respect and willingness to put effort into the relationship. In a good relationship, partners are honest with each other. Both individuals feel safe in the relationship and do not worry that the other one will betray his or her trust. Both partners usually find enjoyment and pleasure in the relationship, and neither tries to control or push the other into doing things. Neither person exploits or uses the other in any way. There are several qualities that make a relationship special. The best relationships are between partners who contribute all of the following qualities:

Respect -To respect others means to honour them, to hold them in high esteem, to treat them as valuable even when they are different from you.

Responsibility-To be responsible means that others can depend on you, that you will do as you said you would, and will be able to distinguish right from wrong. For example, you take care of your own health and well-being and that of your partner or your young brother, too.

Understanding -To be understanding means to be knowledgeable about another person, and to try to understand him or her feelings and position. It means trying to 'put yourself in someone else's shoes' in order to understand what life looks like from their point of view.

Work -To work on a relationship means to put effort into the relationship, and not take the other person for granted.

Caring -To be caring means to be concerned and interested in others' feelings and needs, and to want for them what is best for them. It also means feeling love or a liking for a person and wanting to protect that person.

Mutual respect - Mutual respect in a relationship means that each person values the other and knows - and would never challenge - the other person's boundaries.

Trust - You are talking with another person, and your boyfriend walks by. Does he completely lose his cool or just keep walking because he knows you would never cheat on him? It is normal to get a little jealous sometimes - jealousy is a natural emotion. But how a person reacts when he or she feels jealous is what matters. There's no way you can have a healthy relationship if you do not trust each other.

Honesty - This one goes hand-in-hand with trust because it is tough to trust someone when one of you is not being honest. Have you ever caught your girlfriend in a major lie? Like she told you that she had to work on Friday night but it turned out she was somewhere else with her friends? The next time she says she has to work, you will have a lot more trouble believing her and the trust will be on shaky ground.

Support - It is not just in bad times that your partner should support you. Some people are great when your whole world is falling apart but ca not take being there when things are going right (and vice versa). In a healthy relationship, your significant other is there with a shoulder to cry on when you find out about a problem and to celebrate with you when you are happy.

Fairness/equality - You need to have give-and-take in your relationship, too. Do you take turns choosing which new movie to see? As friends, do you go out with your partner's friends as often as you go out with yours? It is not like you have to keep a running count and make sure things are exactly even, of course. But you will know if it is not a pretty fair balance. Things get bad really fast when a relationship turns into a power struggle, with one person fighting to get his or her way all the time.

Separate identities - In a healthy relationship, everyone needs to make compromises. But that does not mean you should feel like you are losing out on being yourself. When you started going out, you both had your own lives - your own families, friends, interests, hobbies, etc. - and that should not change. Neither of you should have to pretend to like something you do not, or give up seeing your friends, nor drop out of activities you love. And you also should feel free to keep developing new talents or interests, making new friends, and moving forward.

Good communication You have probably heard lots of things about how men and women do not seem to speak the same language. We all know how many different meanings the little phrase "no, nothing is wrong" can have, depending on who is saying it. But what is important is to ask if you are not sure what he or she means, and speak honestly and openly so that the

miscommunication is avoided in the first place. Never keep a feeling bottled up because you are afraid it is not what your boyfriend or girlfriend wants to hear or because you worry about sounding silly. And if you need some time to think something through before you are ready to talk about it, the right person will give you some space to do that if you ask for it.

What makes an unhealthy relationship?

A relationship is unhealthy when it involves mean, disrespectful, controlling, or abusive behaviour. Some people live in homes with parents who fight a lot or abuse each other - emotionally or physically. For some people who have grown up around this kind of behaviour it can almost seem normal or okay. It is not! Many of us learn from watching and imitating the people close to us. So someone who has lived around violent or disrespectful behaviour may not have learned how to treat others with kindness and respect or how to expect the same treatment.

Even though you may feel bad or feel attached to someone who's been mistreated, you need to take care of yourself - it is not healthy to stay in a relationship that involves abusive behaviour of any kind.

What are signs of an unhealthy relationship?

Ask yourself, does my boyfriend or girlfriend:

- Get angry when I don't drop everything for him or her?
- Criticize the way I look or dress, and say I will never be able to find anyone else who would date me?
- Keep me from seeing friends or from talking to any other guys or girls?
- Want me to quit an activity, even though I love it?
- Ever raise a hand when angry, like he or she is about to hit me?
- Try to force me to go further sexually than I want to?

These aren't the only questions you can ask yourself. If you can think of any way in which your boyfriend or girlfriend is trying to control you, makes you feel bad about yourself, isolates you from the rest of your world, or - this is a big one - harms you physically or sexually, then it is time to get out, fast. Let a trusted friend or family member know what is going on and make sure you are safe. It can be tempting to make excuses or misinterpret violence as an expression of love. But even if you know that the person hurting you loves you, it is not healthy. No one deserves to be hit, shoved, or forced into anything he or she doesn't want to do.

2.2 Harmful practices and sexual violence

Many young adolescent girls and boys are affected by harmful practices and/or (sexual) violence. Some girls are forced into early marriage, and others are exposed to harmful practices like female genital mutilation (FGM). As a result they are hurt physically and psychologically.

Exercise 9: Dealing with (sexual) violence

Objective: To show young adolescent girls and boys ways to deal with violence

Method: Story telling and experience sharing

Tools: Discussion in pairs, using provoking questions

Time: 35 minutes

Facilitator's tasks

1. Prepare in advance for this session and get informed about relevant national laws.
2. Introduce the activity.
3. Post discussion questions/points on the wall so that the participants share their own experiences.
4. Read out each question and ask if there is anyone who has related experience. (if necessary, pair the participants up and let them discuss the following questions).
   - Do you know any adolescent who has been naively persuaded into having sex? Have you heard such story? Ask participant who has heard such a story to share with the other participants
   - Do you know adolescents who were exposed to rape attempts? Have you heard such a story? Ask participant who has heard such a story to share with the other participants.
   - Do you know anyone who was married off at early age? Have you heard such story in your community, among your relatives or neighbours? Ask any participant who has heard such a story to share with the other participants
   - Do people in your area practice female genital mutilation? How?
   - Which type of violence is a threat to you personally?
5. Provide information on how to handle violence
   a) Demonstrate skills (Please see Module 2 for applicable life skills) that help participants prevent violence when they feel threatened.
   b) Ask participants to role-play taking different roles as a boy trying to attack a girl and the girl crying out for help and escaping from his grip…(it's important to demonstrate that violators often fear light and a shouting victim)
   c) Ask all participants to rise from their seats and shout out to get rid of their fear and shyness to be able to cry out loud when under threat.
   d) Ask participants how much the shouting out helps in preventing impending threat of violence.
6. Summarise the most important issues:
   a) Encourage individuals to get over their fear and shyness and

use whatever options they have to prevent any type of physical or emotional violence.

b) Highlight that sexual abuse and harmful practices increase the risk of getting infected with sexually transmitted infections, such as HIV.

c) Point out that every country has laws that shall protect individuals from harmful practices or violence.

d) Explain that there are places where young adolescents can find help in case of violence and encourage them to not be ashamed to talk about incidences of violence and to seek professional help.

Basic information

Harmful practises

Traditional practices

In different societies there are several traditional practices involving young people as they grow up. Some practices are detrimental to human health and wellbeing while others are not. In some societies, use of herbs, pulling and cutting of parts of sexual organs are practiced. The use of herbs as such and other practices that do not involve physical injury are comparably harmless and may not pose a medical risk. However, in various societies and parts of the world, there are certain traditional practices which pose a health risk, of which some have been stopped while others are still going on.

Male circumcision

This is a practice where the outer covering at the tip of the penis, the prepuce covering the glans, is cut. In many societies, circumcision is done as a tradition, but also in the modern world circumcision is largely practiced for hygiene related and medical reasons. Whether male circumcision reduces the chances of acquiring STDs including HIV during sexual intercourse is controversial. Male circumcision, if carried out professionally and performed under sterile conditions, is a minor surgery whose impacts are far from being equal to those of the traditional practise of female circumcision.

Female genital mutilation/cutting/ circumcision

This is a practice where part of or the whole clitoris is cut from the vagina. In some societies, the vaginal opening is sewn and a small opening is left, in addition to the clitoris cutting. Female Genital Mutilation (FGM) is a bad practice, because it denatures the physical parts of the genitalia. It causes pain to the victim especially during the process, when having sex and giving birth. It endangers the health of an individual because during and after the process and in the life time it can ease the infections. FGM is discouraged by international laws. Societies which still practice it should be sensitized to stop it. According to the World Health Organization (WHO), female genital mutilation (FGM) includes procedures that intentionally alter or cause injury to the female genital organs for non-medical reasons. The procedure has no health benefits for girls and women. Procedures can cause severe bleeding and problems urinating, and later cysts,

infections, infertility as well as complications in childbirth increased risk of newborn deaths. Long-term consequences can include: recurrent bladder and urinary tract infections; cysts; infertility; an increased risk of childbirth complications and newborn deaths; the need for later surgeries. For example, the FGM procedure that seals or narrows a vaginal opening needs to be cut open later to allow for sexual intercourse and childbirth. Sometimes it is stitched again several times, including after childbirth, hence the woman goes through repeated opening and closing procedures, further increasing and repeated both immediate and long-term risks.

Early Marriage
Despite national and international laws relating to minimum ages of marriage, marriage of girls below these legal limits (generally set at around 18 years of age for girls – the age is usually higher for boys) is still common in many countries, particularly in rural areas, and among poor or poorly educated communities.

The greatest risks associated with early marriage are that the girl will be forced to leave school and end her education, and that an early marriage also means early pregnancy. Early pregnancies, as we have seen in previous sessions, carry risks for both the young mothers and their children. Children born to adolescent mothers are more likely to die during their first year of life than those born to women in their twenties, and are at even greater risk during their second year.

Wife (widow) inheritance
This practice is most common in cultures where men pay a "bride-price" for their wives. If the man dies, several factors converge. Women are more likely to be seen as possessions, something which has been "purchased" by the man and his family and therefore another (male) family member simply "inherits" the wife, just as he might a house or cattle. The second is that in cultures where a woman, once married, may not return to her father's home, there is little choice for the woman (and her children) but to accept whatever security (social, financial) is offered by remaining within her husband's family. The practice not only devalues women, but is now to contribute widely to the spread of STIs, including HIV/AIDS.

Sexual Violence

There are several forms of sexual violence. Three of the most common ones are described below.

Sexual abuse
Sexual abuse is defined as "Violation perpetrated by a person who holds, or is perceived to hold, power over someone who is vulnerable" (Shanler 1998:1). The abuse may have physical, verbal and emotional components. It includes such sexual violations as rape, sexual assault, sexual harassment, incest, and sexual molestation.

Sexual harassment
Sexual pressuring of someone in a vulnerable or dependent position - a youth, employee, or student for example - is termed as sexual harassment. Employers, teachers, or other people in

authority may use their ability to control or influence jobs or grades to coerce people into sexual relations or punish them if they refuse. In extreme cases, a person may be threatened with being fired or being given bad grades if she or he will not submit to the demand. Sexual harassment can take a variety of forms, including verbal sexual remarks about clothing or appearance, unnecessary touching or pinching, and demands for sexual favours.

Sexual assault: Rape

Sexual coercion that relies on the threat or use of physical force or takes advantage of circumstances that render a person incapable of giving consent to sexual intercourse (such as when drunk) constitute sexual assault or rape. When the victim is younger than a legally defined "age of consent," the age at which a young person is said to be capable of fully understanding and consenting /agreeing to sexual intercourse. Many countries set 16 as the legal age of consent. The act constitutes statutory rape (often referred to as "defilement"), whether or not coercion is involved.

Rape victims suffer both physical and psychological injury. For most, physical wounds are not severe and heal within a few weeks. Psychological pain lasts longer and is often considered to be worse than the physical suffering. Often young adolescents are abused by someone they know and trust. Sexual abuse occurs in rural, urban and suburb areas and among all social economic groups.

Perpetrators of violence including sexual violence include:

- Parent
- Boyfriend
- Family member
- Another person at home
- Teacher
- Neighbour
- Stranger
- Teacher

Why sexual abuse is a reproductive health issue

- It causes injuries to body parts including the reproductive organs
- Leads to unwanted pregnancies and its consequences
- Can result into STIs including HIV/AIDS
- Abortion related injuries
- Sexual dysfunction

Support services for young adolescents who have been abused

- Health workers
- Trained counsellors
- Police
- Legal services
- Local leaders
- Teachers
- Youth centres and youth clubs

Chapter 3: Sexually Transmitted Infections (STI's) including HIV and AIDS

In order to prepare young adolescents for a healthy lifestyle it is important to inform them about all consequences that first sexual intercourse and contact can have. As such, they also learn how to avoid risky situation before becoming sexually active.

For more detailed information on STIs and HIV and AIDS, please see Module 6 of this Manual

Exercise 10:	Learning more about Sexually Transmitted Infections (STI's)
Objective:	Help participants understand HIV and Aids as well as STI's and methods of preventing an infection.
Method:	Open discussion using a question and answer method
Tools:	Pieces of papers with the common STI's
Time:	30 minutes

Facilitator's tasks

1. Write on pieces of paper the names of the most common STI's, e.g. HIV, syphilis, gonorrhoea, Chlamydia, genital warts, etc. and fold the pieces of paper for participants to randomly select one.
2. Ask participants to discuss with the person sitting next to him/her about the STI they have on their piece of paper.
3. Following the discussion, asks questions:
   - What do you know about the STI (e.g. mode of transmission, symptoms and treatment)?
   - What have you heard about it?
4. Correct answers and add correct information if participants do not know about it. (Please use basic information on Module 6 STI's and HIV and AIDS). Then,
   a. Discuss with participants ways of preventing an infection with HIV and Aids as well as STI's. Do this separatelyin order to clearly state that HIV can be transmitted through various ways – not only through sexual intercourse.
   b. Explain participants what to do in case of an infection and about the importance of VCT.
5. Summarizing: Summarise the ways of transmission for HIV andAIDS as well as other STI's from person one person to another. Mostly, these infections are transmitted through unprotected sex. Explain how the resulting diseases impact on people's health. (See Module 6 for further information)
6. Conclusion: The best way to prevent STI's is to abstain from sex or use a condom.

Basic Information

Sexually Transmitted Infections (STI's) are infections passed on by intimate body contact, by sexual intercourse with an infected person and by non-penetrative genital contact. They are caused by different tiny organisms/germs and viruses. Some are harmless, some can cause severe illness - and an infection with HIV may result in AIDS, up to now a non-curable, lethal disease.

After infection, a disease will develop, which is why people often also refer to Sexually Transmitted Diseases (STD's). For example one can contract HIV (the infection) that will eventually lead to AIDS (the disease). Sexually transmissible diseases or sexually transmissible infections are any diseases that are passed from one person to another by sexual contact. This includes all forms of penetrative sex (oral, vaginal and anal) as well as some forms of foreplay such as genital touching. Some STI's can be passed through skin-to-skin contact; others require contact with infected body fluids such as blood, saliva, vaginal secretions or semen. Some STI's can be passed from mother to child during birth. STI's can be caused by viruses (for instance the HIV virus that causes AIDS), bacteria (such as Chlamydia and gonorrhoea), while others can be caused by parasites (wildlife) such as pubic lice. Many STI's (such as the more common ones like Chlamydia) are known as the "Silent Infections", because you may be infected but not have any symptoms such as genital sores. Because you may not know whether you or your partner has an STI, it is important to use a condom and to have regular check-ups at your doctor or local family planning clinic. If left untreated STI's can cause infertility, poor health, problems in having a healthy baby and, in some cases, can lead to cancer. Condoms are very effective in preventing the transmission or passing on of sexually transmissible infections (STI's). Using condoms, when having sex, is practicing safer sex.

You are at risk of getting a STI if you have:

- Unprotected sex with casual partners or people unknown to you
- Unprotected sex with a partner who has had unprotected sex with other partners
- Unprotected sex when your partner uses injectable drugs

How to avoid STI's

It's simple. If you don't want to catch an STI, stay abstinent or use a condom. Although they don't eliminate the risk they greatly reduce it. If you have vaginal or anal sex without a condom then you run the risk of catching an infection. The risk of contracting STI's is reduced by practicing safe sex : using a condom when having sex. Some STI's can be transferred through oral sex so it is a good idea to use a condom when having oral sex too.

There are around 25 STI's in total. Having one infection can make it easier to catch another, more serious one. The most frequent STI's of them include the following:

- Chlamydia
- Genital warts
- Gonorrhoea
- Genital herpes
- Non-specific Urethritis

- Syphilis
- Pubic lice
- HIV/AIDS
- Hepatitis B

Effects of STI's if not treated can lead to

- Infertility
- Mental disturbance
- Transmission to the baby during pregnancy and birth (for example: blindness in babies, skin problems, abortion, miscarriage, still birth, deformities in babies)
- Death (e.g. HIV and Aids)
- Increased risk of HIV infection

What to do in case of STI's

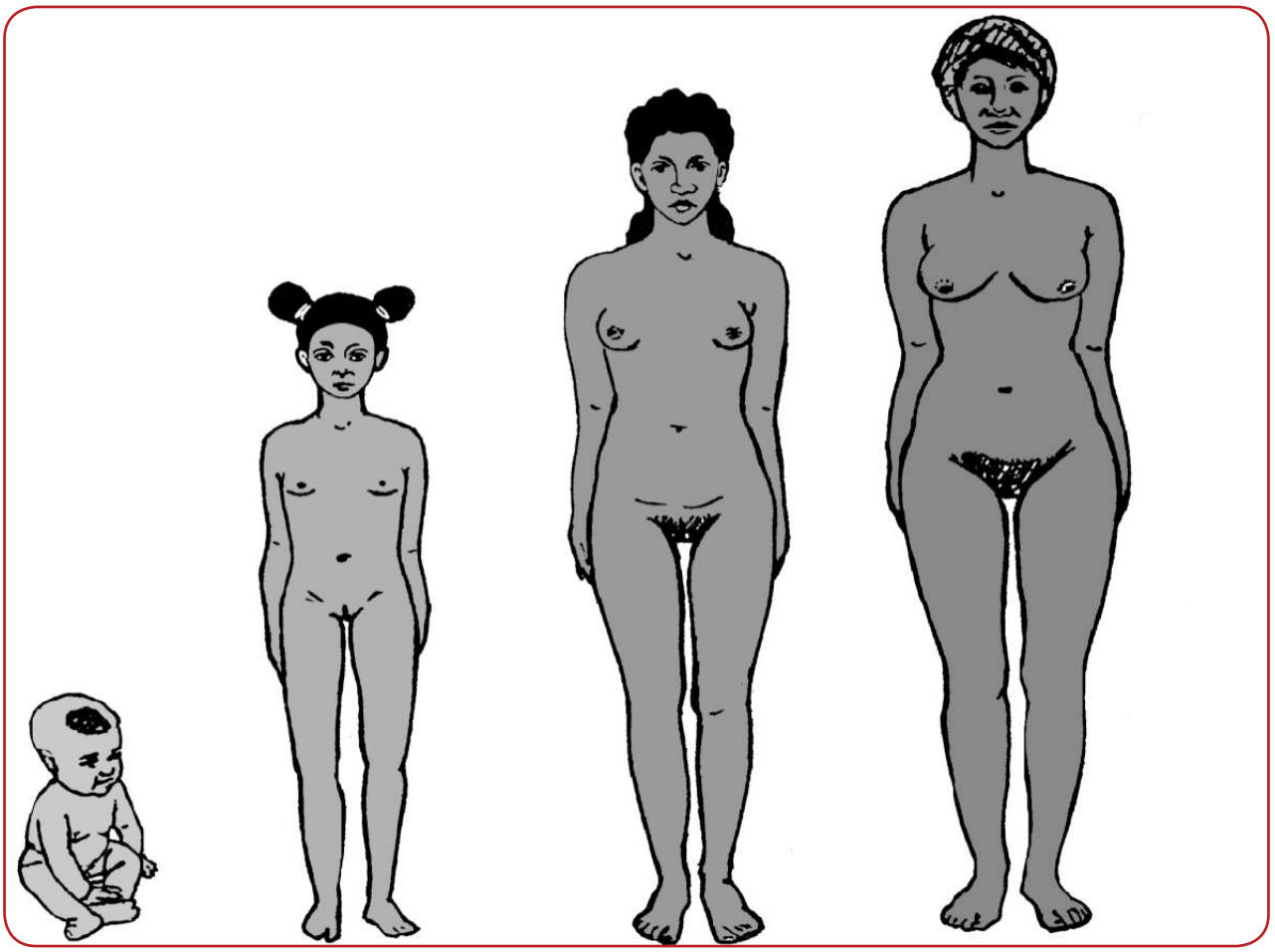
- Seek treatment as soon as possible from a qualified health care provider
- Inform your sexual partner (s) in order for them to seek treatment as soon as possible
- Complete the treatment prescribed
- Seek counselling and HIV testing

Annex - Tools and master copies for Module 3

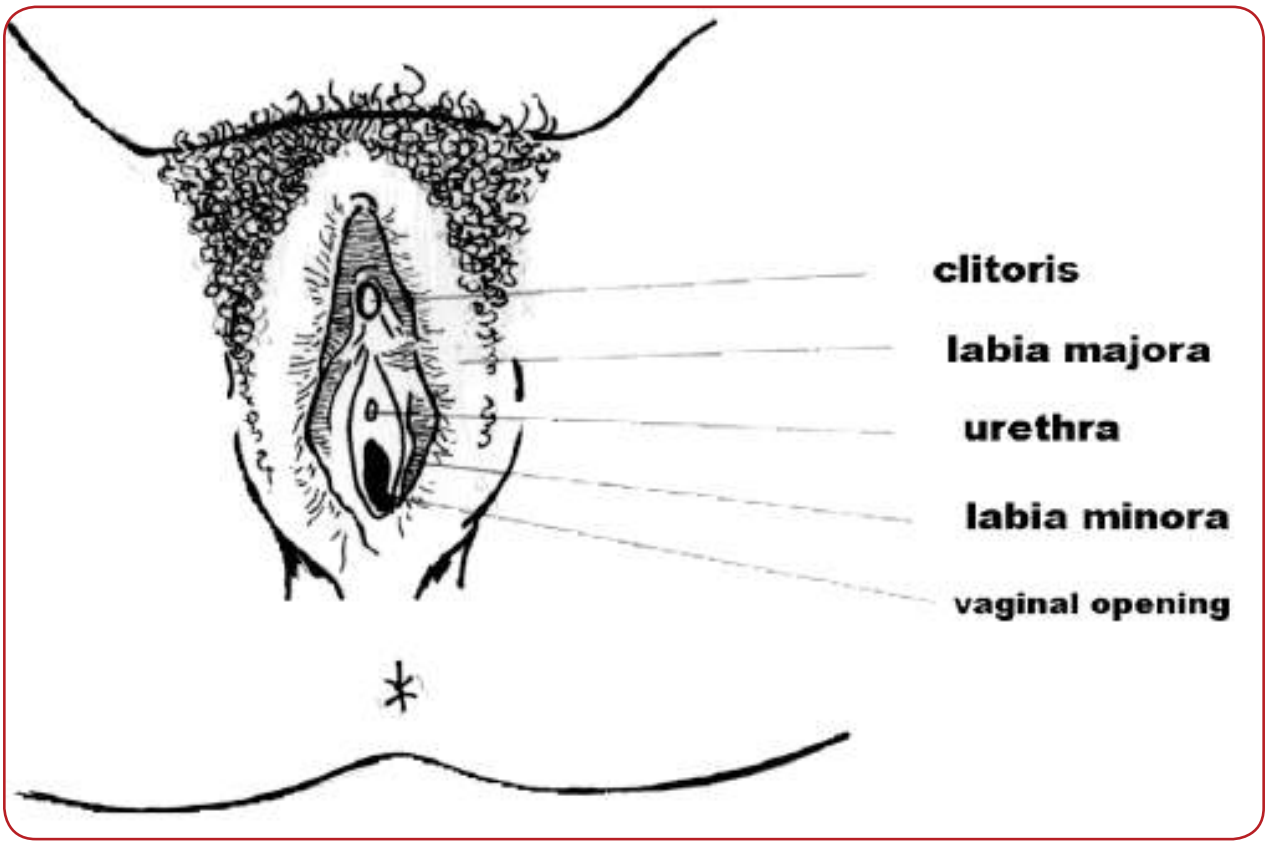
List of learning tools

- SRH facilitators' training manual
- Flip chart, flip chart paper or large sheets of paper
- Markers in different colours
- Chalk to write on the floor or a black board
- Note paper
- Glue stick, pins, cello tape
- Scissors
- Pieces of cotton cloths, strands of cotton, needle, threads, knickers, disposable sanitary pad
- Cartons to be cut into facilitation cards
- Cards or slips of paper, scrap paper to cut notes
- A pointer
- A variety of contraceptives for demonstration purposes
- Any other demonstration or supporting tool that may be useful
- Dildo

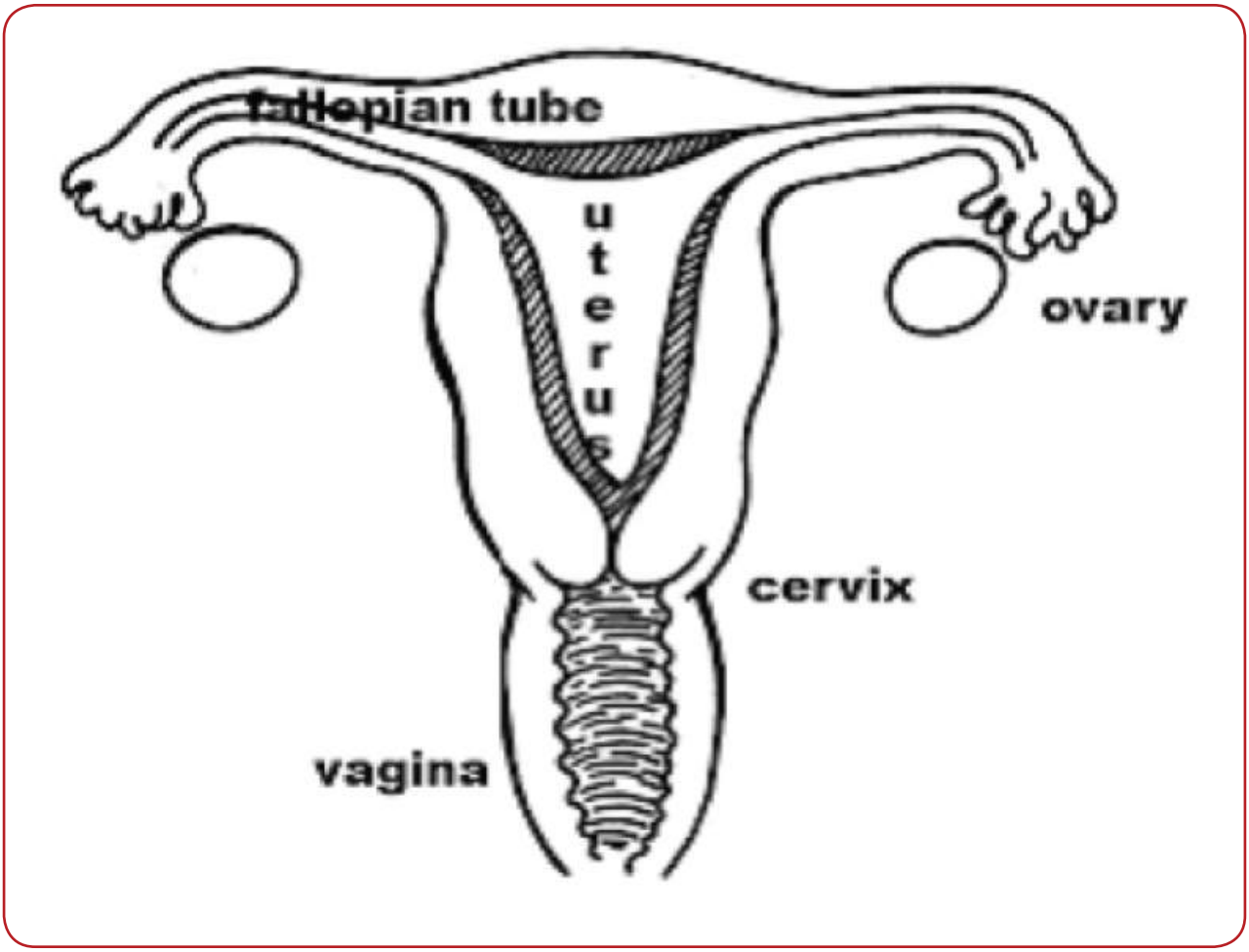
Female Anatomy and Development



External Female Reproductive Organs



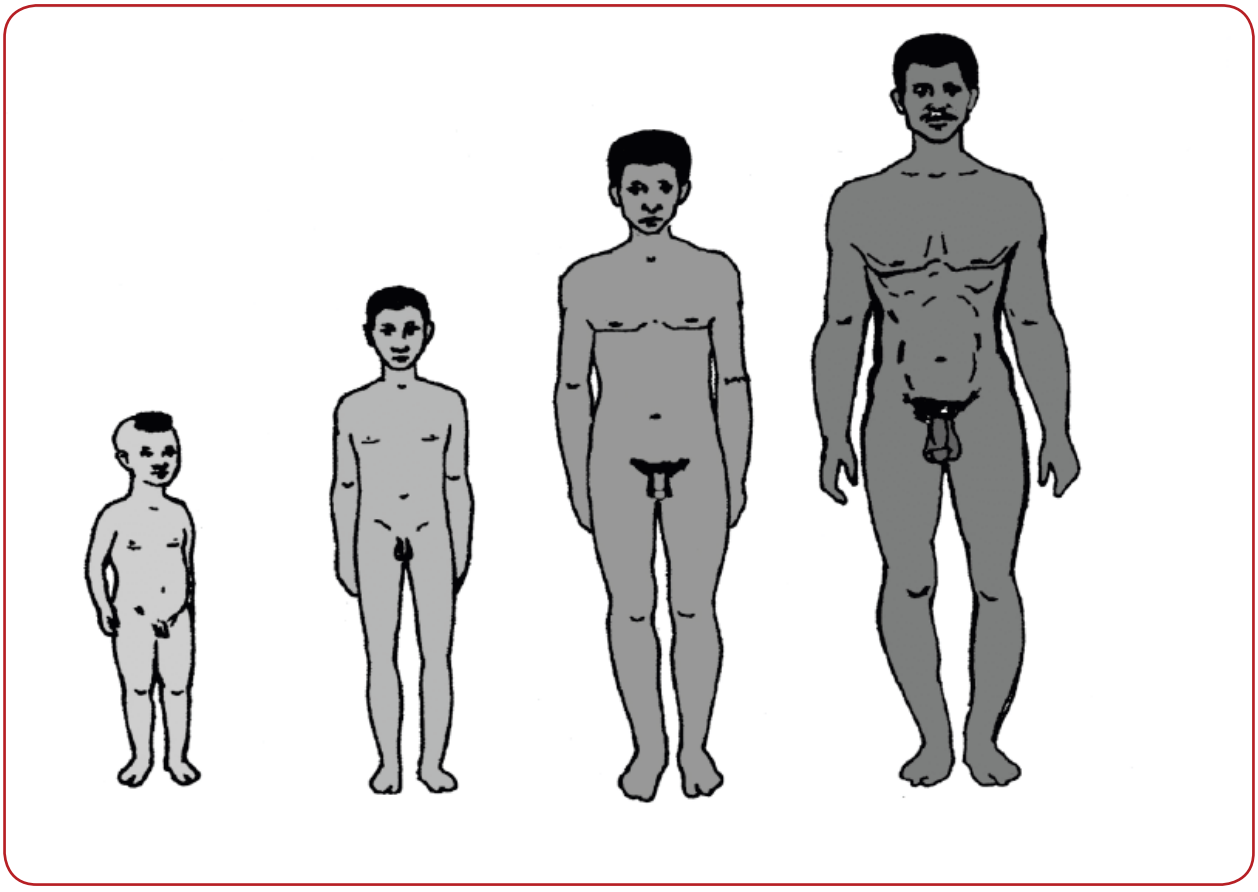
Internal Female Reproductive Organs



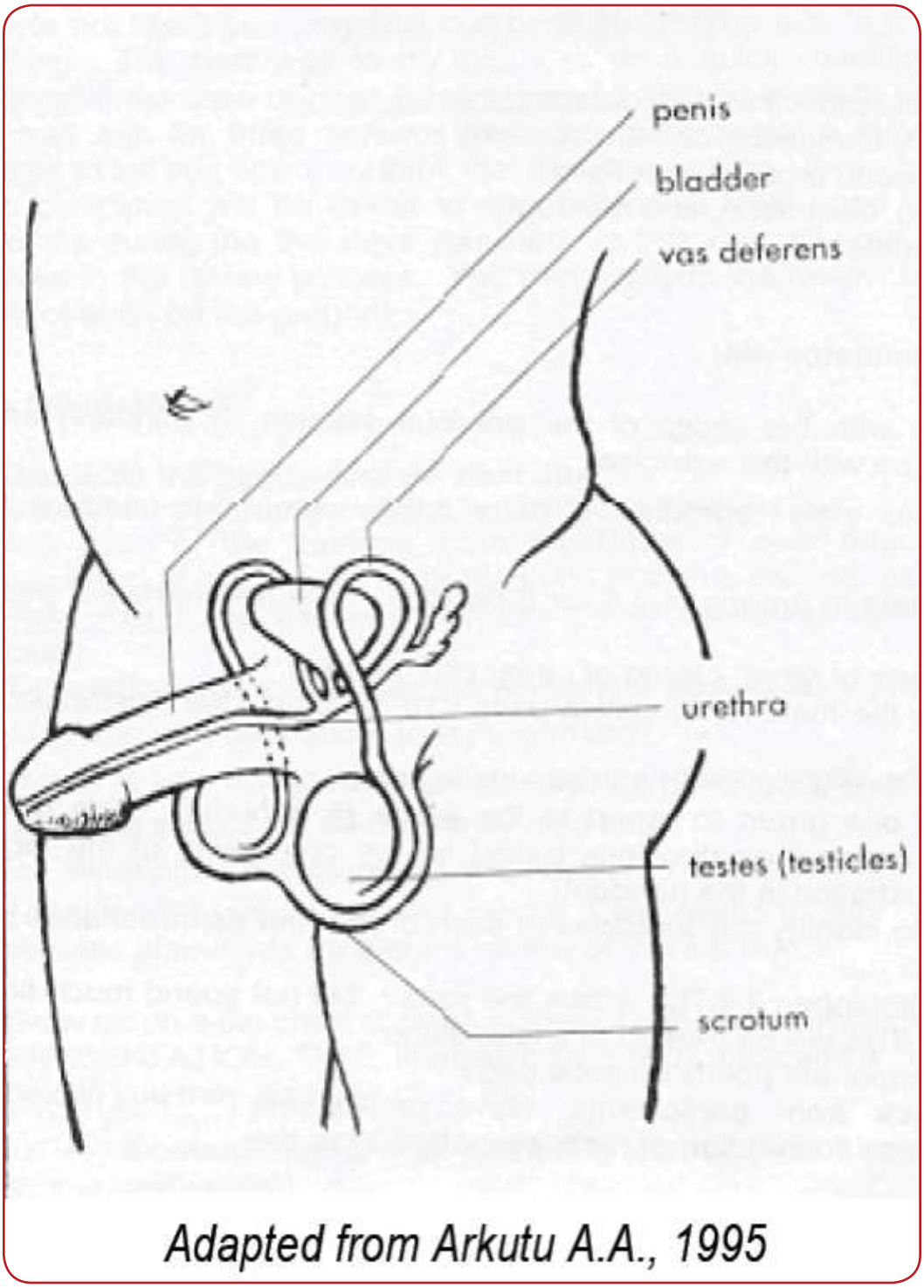
Card game

Female reproductive organs	Corresponding description/function
Uterus	Implantation takes place and holds a growing baby. The inner lining of it sheds blood once every month during menstruation and comes out as blood.
Fallopian tubes	Are two hollow like structures that connect the ovaries to the uterus on either side.
Cervix	The neck or opening of the uterus. The lower end of the womb connecting with the upper part of the vagina.
Vagina	Is the passage from the outside of the body to the mouth of the uterus. The penis is placed in it during sexual intercourse and the baby passes through it during delivery.
Vulva	The external parts of the female genital organ.
Clitoris	It is a small, sensitive organ above the vagina that responds to stimulation during sexual intercourse.
Vaginal fluid	Fluid produced by a pair of glands in the vagina to moisten the vagina.
Labia majora	The outer lips of vulva covered with hair that protects labia minora and internal structures.
Labia minora	The two inner lips covering and protecting the vaginal opening.
Pelvis	The bones containing and protecting the internal genital organs.
Ovaries	Produce eggs and two major hormones, estrogen and progesterone .
Urethra	Narrow tube for passage of urine to the outside.
Hymen	Thin membrane covering the opening of the vagina.

Male anatomy and development



Male reproductive organs



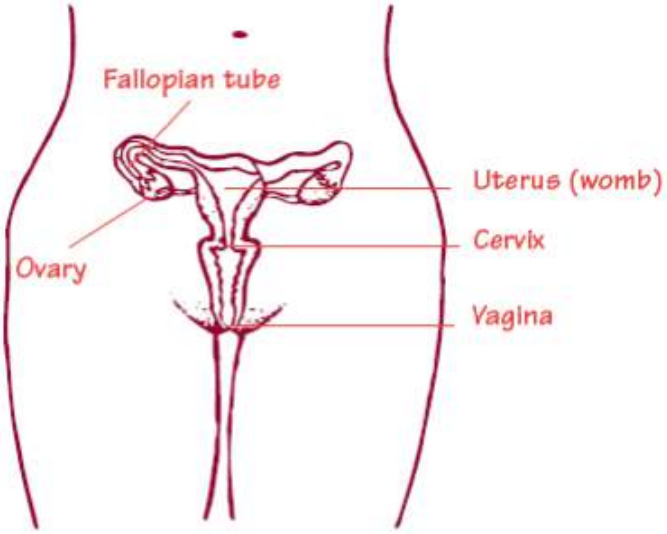
Adapted from Arkutu A.A., 1995

Card game

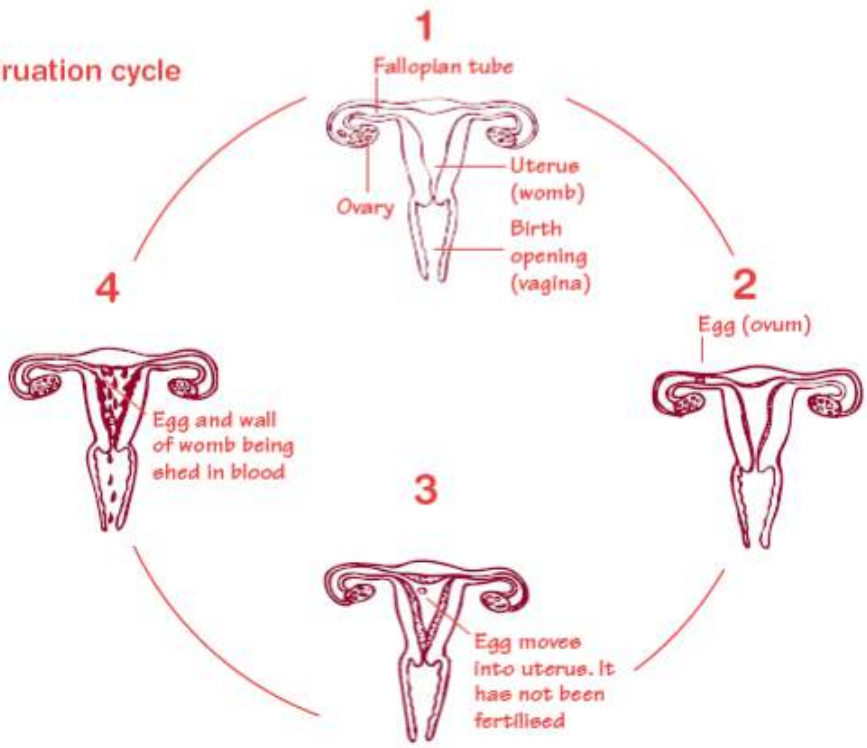
Male reproductive organs	Corresponding description/function
Penis	Male organ for sex used for placing sperms into the vagina and also for passing urine.
Prepuce	Foreskin that protects the head of the penis.
Urethra	Long narrow tube inside the penis through which both sperms and urine pass.
Testes	Two sex glands that produce sperm and male hormones. They are responsible for the development of secondary sexual characteristics in a man.
Seminal vesicles	Are like pockets or glands where the white fluid (semen) is produced and the sperms stored.
Prostate	Produces fluid, which helps create a good environment for the sperms in the vagina.
Vas deferens	Are tubes through which the man's sperms pass from the testicles to the penis.
Scrotum	It is a sac, which holds the testes, and protects them against extreme temperature.
Epididymis	Coiled tubes leading from the testes to the vas deferens where sperm mature.
Cowpers gland	Produces fluid, which helps create a good environment for the sperm in the penile urethra

12 Menstruation

Female reproductive organs



Menstruation cycle



Module 4

Sexual and Reproductive Health Information for Youth (15 - 24)

DSW

Table of Contents

Introduction

This Module is divided into six Chapters. The first Chapter addresses general matters of adolescent reproductive health and seeks to enable participants understand physical and emotional changes a young person undergoes in his/her sexual life.

Chapter 2 concentrates on female anatomy and reproductive organs; Chapter 3 provides information on male anatomy and reproductive organs and their respective functions.

Chapter 4 is about pregnancy. It tells how pregnancy occurs in human beings and is designed to help participants to address the challenges related to (unwanted) pregnancy.

Alcoholism, drugs and substance abuse is dealt with in Chapter 5. This Chapter aims at providing young people with basic knowledge on how addictive behaviour can develop (the driving forces behind such behaviour) and the skills needed to resist drug abuse. (Also see Module 2)

The last Chapter deals with harmful traditional practices. It indicates the effects of those practices on young people's physical and emotional health and seeks to equip them with the means to address the challenges associated with such practices.

The facilitation of this module with all its exercises is expected to take about 8 hours

Learning objectives

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

- Understand physical and emotional changes that a young person undergoes in his or her sexual life, Understand the female and male reproductive organs and their respective functions,
- Understand reproduction and pregnancy and how to prevent unwanted pregnancies,
- Understand the effect of addictive substances to the health, emotional and social life of users,
- Identify harmful traditional practices, their effect on young people's physical and emotional health and learn coping mechanisms

Chapter 1: Adolescent Sexuality

1.1 The Sexual and reproductive health life of young people

A human being from birth to old age undergoes a huge amount of physical and emotional changes associated with the different stages of life: infancy, childhood, youth/puberty, adulthood and old-age. At young adolescent age i.e. at the age of between 10 – 14 years, fast physical and emotional changes take place in human biological development culminating in puberty that usually happens from the age of 14 – 18. However, to become a fully grown adult, the growth and development of the body and reproductive organs will continue until the age of 18.

Youth, or adolescence, is a period of transition from childhood to adulthood. The human body is ready for pregnancy and delivery only after the age of 18. As a result, marriage is legally prohibited before 18. A person is only legally able to elect or being elected as a citizen in political participation and assumes public positions only after 18, and young people should not need to shoulder the responsibility of a family neither physically nor mentally before having become a grown up and responsible member of society.

Having a sexual life is essential and meaningful for human beings. It is pleasant and entertaining. A healthy sexual life that is free from forceful acts, stigma and violence is a natural right of every human being. At the stage of adolescence, a young person experiences rapid physical growth and blooming of reproductive organs. Along with this growth, psychological and emotional developments like the development of feelings of love or sexual attraction towards the opposite (or same) sex, sexual desire and the aspiration to give birth may arise.

However, such natural desires may be suppressed by cultural restrictions or taboos and the absence of free and open discussion with peers or family. Due to this, young people may suffer from ambiguous feelings of enjoyment and anxiety regarding their sexuality. Sometimes, this may result in risky behaviour. A happy and healthy sexual life is a human right (see below). Hence, sexual relationships should be free and informed. Sexuality which is not based on goodwill and mutual care of the partners involved is not only unpleasant but also implies several risks to the young people and society at large, ranging from mental problems such as depression, feelings of guilt, fear and embarrassment to unwanted pregnancy, abortion, the spread of physical diseases including STIs, HIV and AIDS and social problems such as high crime rates, school drop-outs etc. Therefore, it is essential to empower young people to utilize critical thinking, communicate and take responsible decisions in order to exercise their human right to a healthy sexual life.

Exploring the level of knowledge and experience of the participants regarding sexuality

Exercise 1:	Let's talk about sex
Objective:	To enable participants name their sexual and reproductive organs openly.
Method:	Discussions about sexual organs and their functions
Tools:	Labelled charters of human reproductive organs, discussion, questions, flip chart, markers or piece of chalk
Time:	30 minutes

Facilitator's tasks:

1. Introduce the exercise
2. Ask participants to draw a male and a female body including reproductive organs
3. Ask participants to label the drawings in detail and include terms like vagina, penis, testicles, uterus, breasts, pelvis, pubic hair, mouth, rectum/anus, genital lips, cheeks, eyes, etc on the flip chart.
4. Raise questions for discussion and encourage participants to express themselves openly. The following questions could be raised:
   - *What value does this body part (including sexual organs) have for you?*
   - *What is its use in sexual relationships? What is it for? How can it be stimulated?*
   - *How can this organ be affected by sexually transmitted infections, HIV and AIDS and unwanted pregnancy?*
   - *How can they be protected?*
5. Briefly summarize the points raised in relation to the reproductive organs by stating:
   - *The above mentioned parts are identified as reproductive or sexual organs*
   - *They are sexually stimulating and enticing organs when they are seen, touched with lips and hands.*
   - *They are natural, biological and pleasant organs.*

Call for Action:

- We have to take care to protect our bodies from STIs, HIV and AIDS, unwanted pregnancy, fistula or abortion.
- Practice - Encourage participants to study the functions of the reproductive organs an how to protect them in the following exercises, as this will help them to make their sexual lives healthy and safe.

Note that: when talking about sex young people may react differently; there may be shyness, laughter, making dirty jokes etc. it is important that the facilitator understands this and learns how to react effectively.

1.2 Seeking options for a healthy sexual life

Sexuality and reproduction are basic physical functions of human beings. Sexual rights are incorporated in international human right documents, constitutions and laws as fundamental human rights. These rights clearly show that sex may and should be practiced without obligation, stigma and violence. If having a sexual life is a basic human right, how can we exercise this right be exercised without causing harm to oneself and to others? We shall discus it in the following exercise.

Exercise 2:	Healthy sexuality
Objective:	To enable the participants to name different ways to practise healthy sexuality.
Method:	Discuss comparing different options to protect oneself and enjoy sexuality in a in a healthy way
Tools:	List of options, questions for analysis, discussion with all participants
Time:	30 minutes

Facilitator's tasks:

1. Introduce the exercise.
2. Raise questions for discussion whether the below mentioned sexual options are suitable for young people or not.
3. Ask participants to discuss the options in pairs for five minutes. Is practicing these options a right? Do they affect the health and rights of other people?
4. Write the following options on a flipchart and post them on the wall for discussion
   - Virginity
   - Abstinence from having sexual intercourse for one's whole life
   - Abstinence from having sexual intercourse for a certain/ limited period of time
   - Have sex whenever possible and enjoy it
   - Abstain from sexual intercourse until marriage
   - Use condoms
   - Go for HIV and AIDS testing
   - Be faithful to one sex partner
   - Homosexuality (gay and lesbianism)
   - Delaying sex
   - Finding sexual pleasure in masturbation (rubbing/ massaging own genitals)
   - Petting (hugging, caressing, and kissing each other)
   - Using modern contraceptives
   - Withdrawal, other traditional and natural contraceptive methods

Summary

Ask participants if they have understood the idea of safe sex and encourage them to use their critical thinking skills and choose from the following safe sex options.

- Abstain from sexual intercourse
- Using condoms
- Going for regular HIV testing
- Being faithful to one sex partner
- Delay sex and masturbate instead
- Finding sexual satisfaction by caressing and kissing only (Petting)
- Abstain from sexual intercourse until marriage

Basic Information

Sexuality

Sexuality is one of the essentials of human life. It includes sex, gender roles, sexual pleasure and giving birth, which are manifested in ones thinking, faith, desire, interaction and behaviour. Sexual pleasure is essential for life;

Sexual Rights

Sexual rights are incorporated in international human rights documents, national constitutions and laws to ensure that every human being may practice sexuality without obligation, stigma and violence. The following are sexual and reproductive rights:

- People's right to respect the safety of the reproductive body
- People's right to choose their sexual partner
- People's right to have or not to have sexual intercourse
- People's right to make love with the other person's consent
- People's right to decide when to give birth or not to give birth
- People's right to have a satisfying, pleasant, and healthy sexual life
- People's right to access to quality reproductive health care, information and services
- People's right to seek, access and distribute sex related information (not pornography)
- People's right to access to sex related education

Important life skills to exercise sexual and reproductive rights

Critical thinking - Not being the ox going for the grass without noticing the ditch

Sexuality is broadly commercialised and advertised more or less explicitly in e.g. cinema ads, video screening houses and by prostitutes, which poses challenges and temptation to young men in particular. Informed adolescents are able to recognize and assess the situation when confronted with sexuality through critical thinking. Raise questions like: What is sex? With whom should I have sex? How is it performed? When is it performed? What consequences can it have? Am I ready for it?

Decision making

On the issue of deciding whether or not to practice sex, smart young people are able to identify healthy sex options and decide to go for it. (More information on decision making and other useful skills can be found in Module 2 on Life Skills). Healthy sex takes place at the right time and in the right situation. We will learn more about healthy sex options below.

Healthy sexuality

Knowing about your and your partner's HIV status and abstaining from sex until marriage is a safe option. If this is not possible, there are other healthy sex options as mentioned below.

1. Abstain

Abstaining from having sexual intercourse until marriage provides a basis for healthy sex. As the saying goes 'an ounce of prevention is worth a pound of cure', abstaining from sex can lay the groundwork for having healthy sex at a later stage. Of course many people abstain from sex and start it at the right time. But when is a good time to start having sex? It advisable not to start sex at a very young age. Wait until you, not only your reproductive organs, are ready for it. Whereas reproductive organs may develop during puberty, this is not enough for healthy sex: Healthy sex requires information and a stable mind. If abstaining from sex is difficult other healthy sex options can be sought.

2. Being faithful to one sex partner

Sex should not be practiced with a stranger. Healthy sex may be practiced with a partner who is responsible, able to communicate effectively (see Module 2) and openly discuss risks such as unwanted pregnancy and sexually transmitted infections to prevent them from occurring.

Sexual intercourse is made between lovers, but not

- With a person whose hiv status is not recognized
- By force and through cheating
- With relatives/family members
- By deception
- For financial or material gain

3. Using contraceptives;

It is widely observed that young people engage in sex with a wrong perception and insufficient knowledge about sexuality, human reproduction and contraception. This aggravates the sexual and reproductive health problems of youth. In order to practice safe sex, you have to use a condom, be informed and able to negotiate with your sex partner. (See Module 2 on Effective Communication).

4. Being able to quit a relationship

Rather than having sex with a negligent person and deliberately practice unsafe sex, it is advisable to quit such a relationship and abstain from sex or look for other options.

5. Discussing sex with parents

Sexual desire is one of the most favourable feelings for everyone. However, adults or parents may not understand the value young people attribute to love. Discussing about sex with parents, peers and friends must not be seen as a taboo/shameful act. It is very important not to be embarrassed and start to discuss frankly. Parents often do not discuss issues like physical changes in young people, menstruation, love and contraception with their children. They fear that if they did, they may tempt the children to practice or try it out. Girls often do not consult to or seek advice from their mothers on issues like love related problems, or how to prevent pregnancy. It is well known that no parent wants his/her children to get involved in sexual practices before marriage. So what should be done? Shouldn't the new generation encourage parents for open discussion? Discuss.

1.3 Understanding young people's different levels of information regarding SRH

Based on their physical maturity and their knowledge and experience, young people's level of understanding of sexual and reproductive health issues varies widely. We divide young people into four categories based on their knowledge and experience:

Level 1 - Instinctive youths
Level 2 - Negligent youths
Level 3 - Deliberate / Intentional wrong-doers
Level - 4 - Conscious and careful youths

Exercise 3: Understanding young people's different levels of understanding regarding SRH

Objective: To enable participants to identify young people's different levels of information on SRH.

Method: Discussion, categorizing

Tools: Plenary, large sheets of paper, four levels of information, statements (images)

Time: 25 minutes

Facilitator's tasks:

1. Recap the previous exercise in brief and introduce this one.
2. Put the four levels of understanding up on the wall, each on a separate sheet.
3. Give a brief explanation on each level.
4. Ask participants to think about their peers and find out at which level they can be categorized (2 minutes).
5. Request participants to stand under the level the others have identified for him/her.
6. Request participants to discuss and explain why one or the other is standing under one or the other level.
7. Ask participants whether they fully understand the levels.
8. Eventually, use the information provided below and the illustrations to summarize the four levels of understanding briefly.
   - We realize that to arrive at the fourth level of understanding, we need to learn a lot.
   - To protect oneself from risky situations, there is a need to develop the skills to seek options, make decisions and stick to commitments/decisions.
9. Practice Ask participants to:
   - Discuss with their brothers, sisters and friends and let them know their levels of understanding
   - Work to arrive at the level of 'Conscious and Careful' and become a role model to others.
   - Support those at a lower level and help them understand and decide.

Basic information/Handout

Level - 1

Instinctive youths – Youth is symbolized by a river that shows its beauty and pleasantness. But the presence of a crocodile in this pleasant river reminds us of the presence of risks in our youthful and pleasant life. A significant number of young people have limited, wrong and rumour based knowledge of sexuality and reproduction. They start sex at an early age, and they do not bother about doing it safely. Others take actions like having unprotected sex or taking

drugs, feeling very courageous in doing so. Some are even tempted to conduct rape in bravado. As they lead their life guided by their instincts, they do not have the guts and the will to change their wrong behaviour. They are highly vulnerable to unwanted pregnancy, drug addiction, STIs including HIV and AIDS, etc.

Level 2

Negligent youths – They are categorized to be at the second level of understanding. They have limited or inadequate knowledge. Their understanding of risky behaviour is low. They are not ready to identify different options and protect themselves. As they are not motivated and not careful, they are vulnerable to diseases and unwanted pregnancy.

Level 3

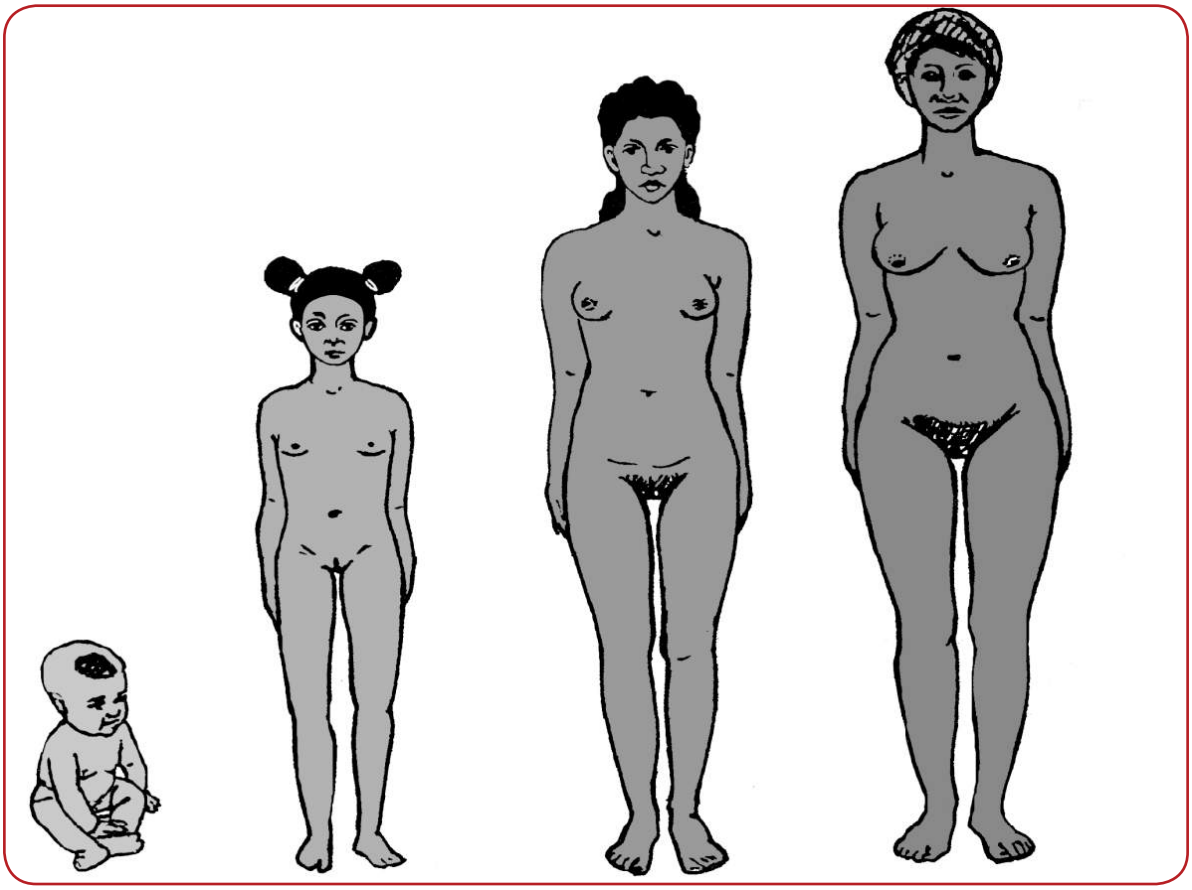
Deliberate / Intentional wrong-doers – Young people who are categorized in this level have ample knowledge of risky behaviour. They are well aware of negative consequences. They scrutinize their solutions and are ready to take measures. They even provide advice to others, but in practice they commit mistakes deliberately. They deliberately and boldly practice unsafe sex, are receptive for peer pressure and vulnerable to drug and alcohol abuse.

Level 4

Conscious and careful youths
Youths categorized in this level are able to look for different options and make informed decisions to protect themselves from risky behaviours. They challenge peer pressure and lead their sexual life carefully. As they are capable of changing and monitoring their behaviour and attitudes, they can be role models to others. They can give advice to others.

Chapter 2: Female Anatomy

A. Child B. Young adolescent C. Adolescent D. Adult



2.1 Female Anatomy

Both girls and boys show a very rapid body growth as soon as they reach puberty. However, girls reach this stage of rapid growth relatively earlier than boys. This growth, which begins at the young adolescent age, continues until the age of 18, which marks the beginning of adulthood. Hence it is important and useful to have enough knowledge about the reproductive organs of the female in order to better understand their role in sexual intercourse and pregnancy. Therefore, this Chapter is dedicated to the female reproductive organs.

Exercise 4: Assessing existing knowledge on female anatomy

Objective: To enable participants distinguish between facts, myths and attitudes with regard to female reproductive organs.

Method: Assessment of past experience and discussion.

Tools: Discussion in pairs; Brainstorming; Ranking.

Time: 30 minutes

Facilitator's tasks:

1. Make a brief summary of what has been dealt with in the previous exercise and introduce this one.
2. Group participants into pairs or trios.
3. Each pair /trio will be asked to identify four (4) wrong perceptions and myths that go around within their communities regarding the female reproductive organs and their functions (for instance, regarding the monthly menstruation as non hygienic, or believing that a girl who has not been circumcised will be restless and will go about breaking household items etc…)
4. 5 minutes will be allotted for this.
5. Each pair / trio will make a list of the identified attitudes.
6. Ask each pair/trio to read out the attitudes identified to the rest of the group.
7. Write down each idea raised by the different groups on a flip chart.
8. Cluster similar ideas. *(See example below)*
9. Wind up the exercise by explaining wrong attitudes and beliefs regarding female reproductive organs based on correct, evidence-based, scientific information. *(See example and charters below)*
10. For individual practice- ask participants whether based on what they have learnt they feel they can make a commitment to act upon the wrong beliefs, by intervening and informing people about the true facts whenever wrong believes and attitudes are expressed around them. A case for intervention would be, for example, that in Southern Ethiopia, women are marginalized and made to live in isolation in a small hut as long as they have their menstrual flow.

Myths reflecting wrong beliefs that might be identified through discussing past experiences (examples)

Myths and Misconceptions

1. Menstrual flow is not hygienic. The women stink.
2. A woman who has not been circumcised is restless and sexually aroused all the time.
3. A woman or girl who starts menstruating shows that she has had sexual intercourse.
4. The hips enlarge because of having sexual intercourse.
5. Menstrual flow destroys virginity (the hymen).
6. Women with small breasts do not have enough milk to feed their baby.
7. Girls are never children. They are mature and ready at any stage.
8. Breasts enlarge if touched by men.
9. A woman cannot have orgasms.

10. A woman who does not give birth is like a mule with an arid womb.
11. During the rainy season, every woman will be fertile.
12. One should have children while very young.
13. Sexual intercourse helps against spots and pimples.

Facts

1. Menstrual flow does not have any odour unless it gets in contact with the air. Odour can be totally prevented by using and regularly changing sanitary pads or towels, and washing more frequently.
2. Emotional turmoil happens not because of the clitoris but because of hormonal changes that occur during young adolescence and adolescence. Breaking household items may happen to everyone and has nothing to do with mutilation of any organ (except in case someone has cut off your hand, for example).
3. Menstruation is triggered by hormones, not by sexual intercourse.
4. The hips enlarge because of hormones produced within the body.
5. The hymen is broken during sexual intercourse, not by menstrual flow.
6. Any breasts of any size can produce enough milk for the baby.
7. Girls also need to reach at the age of 18 to mature physically, until then a girl is just a child like any boy at that age.
8. The breasts grow because of a hormone known as estrogene.
9. A woman can have orgasms, and a hormone produced through the commands of the pituitary gland triggers her arousal.
10. Women are usually fertile at reproductive age, if protected from infections and physical harm.
11. One can have children after the age of 18.
12. Skin problems during puberty are triggered by hormones. Having sexual intercourse cannot prevent them from appearing.

2.2. Functions of the female reproductive organs

Basic information/handout

The female sexual reproductive organs are those body parts which play a role for sexual intercourse, pregnancy and birth giving. They are classified as internal and external reproductive organs, depending on their situation. External reproductive organs of a woman include the labia majora, the labia minora, the clitoris and the breasts. Internal sexual reproductive organ consist of the pair of ovaries, the tubes that connect the ovaries to the uterus (fallopian tubes), the uterus commonly known as the womb, the vagina and the neck or entrance to the womb (cervix).

These internal organs for female reproduction are protectively located deep within the body between the hips and inside the bony pelvis. Many people lack correct knowledge about these body parts. The basic female reproductive organs will therefore be discussed based on a charter showing the female anatomy in order to facilitate the understanding of female reproductive health, which also includes questions of gender, contraceptives, early and/or unwanted pregnancy and much more. Correct information helps to correct wrong attitudes and misconceptions about female reproductive health.

Exercise 5: Participatory Learning about female reproductive organs

Objective: To inform participants about the functions of female reproductive organs

Method: Comparison of the functions of each reproductive organ

Tools: Cards and group discussion

Time: 20 minutes

Facilitator's tasks:

1. Briefly explain the objectives of the exercise, methods and tools to be used and the time to be allotted.
2. Depending on the condition of the participants, see to a refreshing interaction to motivate and energize them.
3. Shuffle the cards showing the reproductive organs and their functions and put the card deck in front of the participants. *(See below)*
4. Ask each participant to pick a card, read it out and explain it to the others.
5. Ask other participants who have a card on a similar body part to stand up and explain his/her card.
6. Encourage participants to ask any question they may have. Clarify and discuss.
7. Ask whether participants found the learning effective. Reply to any questions using the charters of female anatomy.

Name of the reproductive organ	**Related explanation**
Uterus	Uterine lining; tube, canal.
Fallopian Tube	Where the egg is met by the sperm for fertilization.
Cervix	Opening of the uterus into the vagina.
Vagina	Can easily expand during birth giving.
Clitoris	Very sensitive to sexual stimulation.
Vaginal Fluid Secretion (mucus)	This acidic fluid secretion is produced by the glands that are located besides the vaginal opening and in addition to lubricating the vagina, also protect from virus.
Labia majora	Large and fleshy lips part that is covered with hair after puberty. Protect the vagina and the internal reproductive organs from infection and physical injury.
Labia minora	They lie just inside the labia majora, and surround the openings to the vagina, protective.
Pelvis	Bone structure whose primary function is to protect, support and hold the internal reproductive organs.
Ovaries	Produce eggs (ova).
Sex hormone	Controls the growth and functioning of the reproductive organs.
Estrogens	Is a type of hormone that has a decisive role on the female reproductive organ by also initiating the production of ovaries
Progesterone	A type of hormone that, among many other functions, triggers the building up of the uterine lining to provide blood and nutrition to the fetus and prevents labour from being triggered prematurely.
Pituitary Gland	Part of the brain that commands the production of gender hormones.
Uterine lining	Where the embryo attaches itself.

Exercise 6: Participatory learning about the health of female reproductive organs

Objective: To inform participants of how to keep female reproductive organs healthy

Method: Discussion in pairs and groups; brainstorming

Tools: Cards and group discussion

Time: 25 minutes

Facilitator's tasks:

1. Form groups of 5-6 participants for discussion.
2. Based on the list and information provided on female reproductive organs, start a discussion about how to respect and protect female reproductive organs.
3. Ask each group to come up with four (4) ways of protecting female sexual and reproductive health based on either traditional knowledge or the basic information they have read. *(See below)*
4. Then ask participants how much and in which ways males can be involved in the protection of female reproductive organs. *(7 minutes)*
5. At the end, ask a representative of each group to make a presentation on what has been discussed in the group.
6. Write down the methods identified by the groups on a flip chart.
7. Wind up the discussion by comparing the methods stated with the basic information. *(See below)*
8. Then ask what the role of males can be in protecting female reproductive organs from health implications.
9. Ask participants to discuss and share with their friends and family.

Basic information/handout

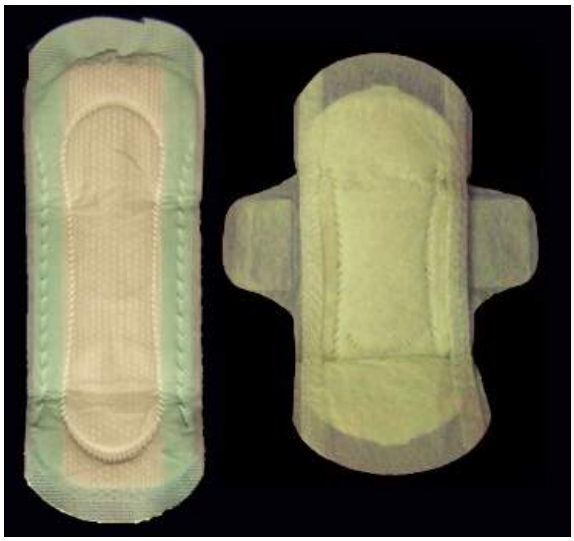
How to protect the female reproductive organs

1. The vaginal fluid keeps the vagina clean, protects it from infections and prevents it from drying out.
2. The vagina should not be washed more than twice a day to prevent it from drying out, which makes infections more likely.
3. Do not try to wash the vagina inside but limit the washing to the external parts.
4. The inner part of the external parts should not be washed with chemicals or soap.
5. Wash from front to back, e.g. from the sexual organ towards the anus to prevent germs from entering the vagina.
6. Use a sanitary pad or a clean piece of cloth to catch menstrual flow.
7. Wash more frequently during menstruation and change sanitary pads regularly.
8. Carry a sanitary pad in your bag, so that you have one available at school or the places where you are going.
9. You can have sexual intercourse during menstruation; however, most women don't like it as they also might not feel well.
10. Female reproductive organs are very sensitive. Infections, diseases and negligent or even wilful injury (including certain traditional practices and birth injury) of these organs may have serious impacts on a woman's mental and physical health and limit her ability to work, care for household and children and making a meaningful contribution

to family and social life. If there is any sign of infection (e.g. unusual discharge, itching), a doctor should be consulted for testing and treatment. The doctor might take a smear sample, which is also done for cancer screening. Women/ girls should examine breasts and armpits with their fingertips regularly. If there is a swell, wound or fluid coming out from the tip of the nipples, please consult your doctor. Breast cancer can be treated in many cases but the earlier it is detected, the better.

11. Be against female genital mutilation which constitutes an infringement of a person's bodily integrity with severe health consequences.

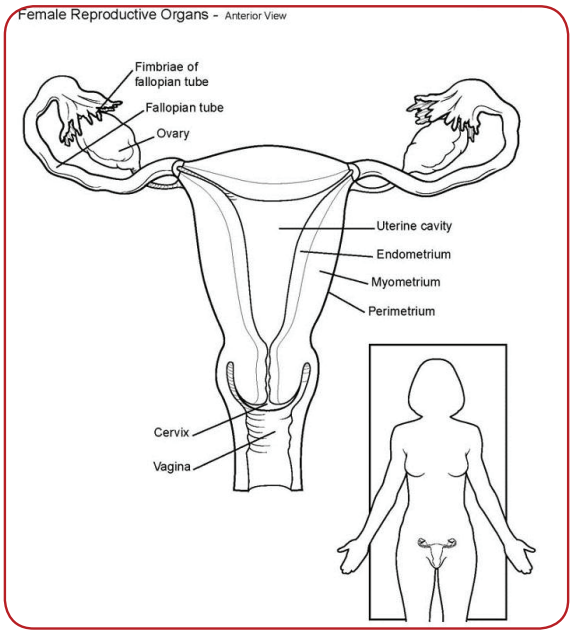
Modern sanitary pad



2.3. Basic Information

Internal female reproductive organs

Hormones and their functions; female physical growth during puberty



Growth hormones

Our bodies produce hormones non-stop. A hormone is a technical messenger produced through our brain's command. Mostly hormones are produced in glands. Through the command of the brain, hormones are transported in the body via the blood to reach at different body organs. Arrived there, the hormones, which have different kinds of messages, determine when and how the body will change, and bring about the characteristic changes. Growth hormone is produced abundantly starting from the age of young adolescence. It will cause fast change on the body and the mind of the person. During puberty, emotional turmoil may be noted in young people. However, when they grow up, the hormonal production will slow down thereby regularizing their emotions.

Sex hormones

In addition to the growth hormone, sexual hormones determine femininity or masculinity. Two hormones known as estrogens and progesterone are produced in a woman's ovaries through the command of the brain. These hormones determine the typical physical shape of a woman and they also guide and shape the growth and the functions of the reproductive organs.

Hormones

- The brain, by sending out messages to the ovaries, incites the production of hormones.
- Hormones trigger the growth of pubic hair, the enlargement of the breasts, the widening of the hips, the growth in height and the occurrence of ovulation and menstruation.
- Female hormones

Growth of reproductive organs

The growth of the reproductive organs begins when the body starts producing gender hormones. When a girl reaches the age of about 10, the pituitary gland, which is located in the brain, begins to produce gonad tropic hormones that will increase in number and, under the pituitary glands' orders, proceed to the ovaries via the blood.
Inside the ovaries:

- High production of estrogens and progesterone takes place.
- Due to these hormones, at the age of between 10 - 14:
- Girls' height and weight increase fast;
- The hips will widen pear shaped to be able to host a fetus;
- The breasts protrude and enlarge;
- The ovaries grow;W
- The tiny ovules grow as well;
- The ovaries begin to produce ova;
- The uterus wall prepares to host a pregnancy;
- Menstruation begins;
- Until the age of 18, the labia thickens and the clitoris increases in size;
- Pubic hair grows around the vagina and under the armpits;
- Until the age of 18, the uterus also grows to host pregnancy;

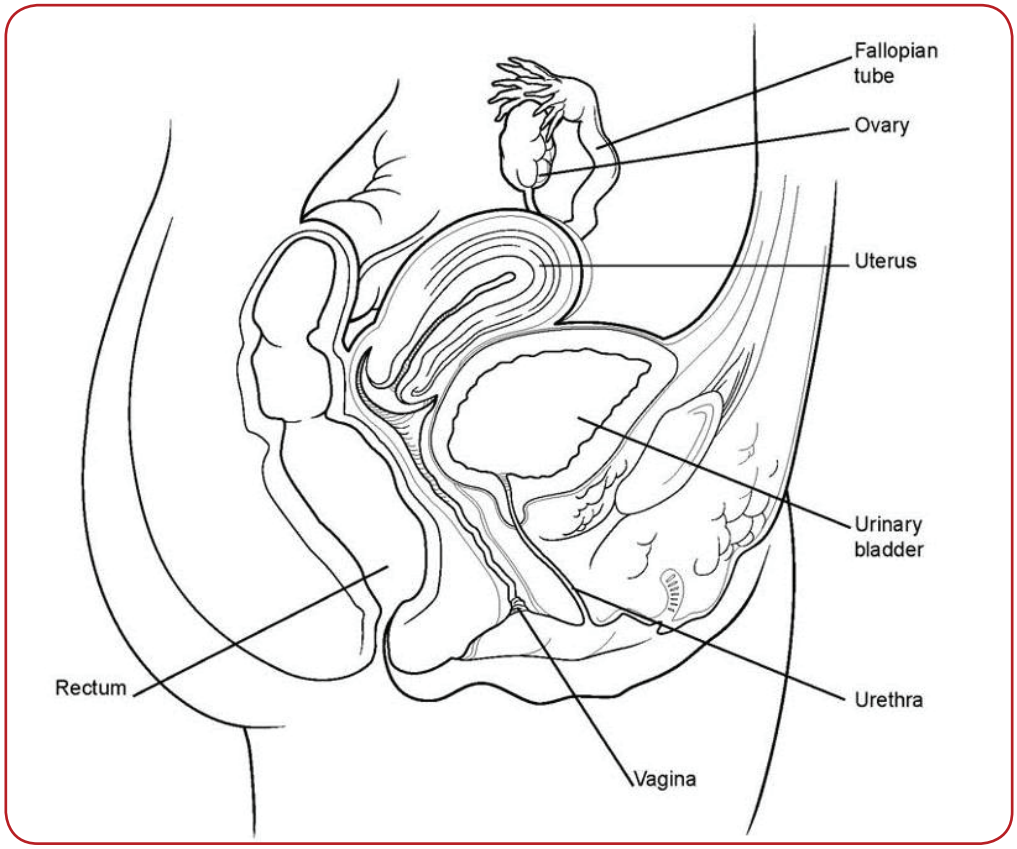
With these changes, sexual arousal, hastiness, depression and mood swings may occur. Even if the development of the sexual organs begins before adolescence, they are fully developed when the person reaches adulthood at the age of about 18. During puberty when the body undergoes changes at a very fast rate, young people may be worried as to what is happening to them. This is however not surprising and will normalize as hormone levels decrease after puberty.

Ovaries

In the female reproductive organ, in the right and left side of the uterus, there are the ovaries, reproductive organs often found in pairs (See picture) and of the size of a small peanut. Before a baby girl is born, all of the cells that will later grow into eggs are already formed in her ovaries. The ovaries contain hundreds of thousands of tiny ovules.

The function of the ovaries is to produce ovules. In a woman's life, pregnancy can occur any time from the time the ova start to grow in the ovaries. Under the command of the brain, the hormones estrogens and progesterone are produced. In the life span of a woman, these hormones will be responsible for the growth of her different body parts and their functionalities by each bringing about a particular occurrence on the sexual organ like the monthly menstruation. A girl is born with hundred thousands of tiny immature ovules that will be activated by the hormones at the age of puberty, thereby producing a matured ovum. Every month, an ovum comes out ripe, of a tiny size that is not visible to the eyes. Even if invisible, the ovum is bigger than the sperm and if the ovum is fertilized by the sperm on its way to the cervix, pregnancy occurs. This will be explained in more detail later on.

Inner female reproductive organs



Fallopian Tube

The two fallopian tubes begin from the upper uterus' left and right sides to go up to the ovaries. (See picture). Each tube can be 10 to 12 centimetres long. Each side of the tube alternates to release one ovum every month, and these ova will come down the fallopian tube and be pushed throughout the tube down the uterus by hairy cells in the fallopian tube. During sexual intercourse, millions of spermatozoids are released from the male reproductive organ to go inside the female reproductive organ. Most of them will proceed to the tubes once they get into the vagina. They reach at the tubes in less than a minute, and the ones who manage to get inside the tube will proceed towards the ovum and the first one which will meet it will fuse with it and fertilize it. After fertilization embryogenesis begins with the genes dividing themselves into twos, fours, eights etc. Therefore, fertilization of the ovum by the sperm occurs in the fallopian tube. An ovum fertilized by a sperm in the fallopian tube, will be pushed by hairy cells and muscles till it reaches the uterus. It can take this fertilized ovum up to 5 days to reach there. Once there, it attaches itself to the uterine lining (implantation) where as a fetus, it continues its growth.

Uterus

Before pregnancy, the size of the uterus may equal that of a small mango or peach. The inside is empty. The uterus can be 9 centimetres long and weigh 60 grams. When a girl reaches puberty, through the hormonal triggers, the uterine lining prepares to host a fertilized ovum by building up the uterine lining which is well supplied with blood. If a fertilized ovum implants in the uterine lining, then the placenta begins to develop to provide nutrition from the mother to the fetus. The uterus will become the home for the fetus and for 9 months and will expand to provide for enough space for the growing fetus. It exerts pressure on other body parts including the urinary bladder. As a result, pregnant women need to urinate frequently. During pregnancy, the uterus will carry the fetus and the placenta. After the baby is born, the uterus can weight up 1 kg. However, including the fetus, the placenta and the amniotic fluid (water), the uterus can carry up to 5 kilos of weight. If pregnancy does not occur, the uterine lining, which is well supplied with blood, will dissolve and is expelled from the body through the vagina as the monthly menstrual flow.

Cervix

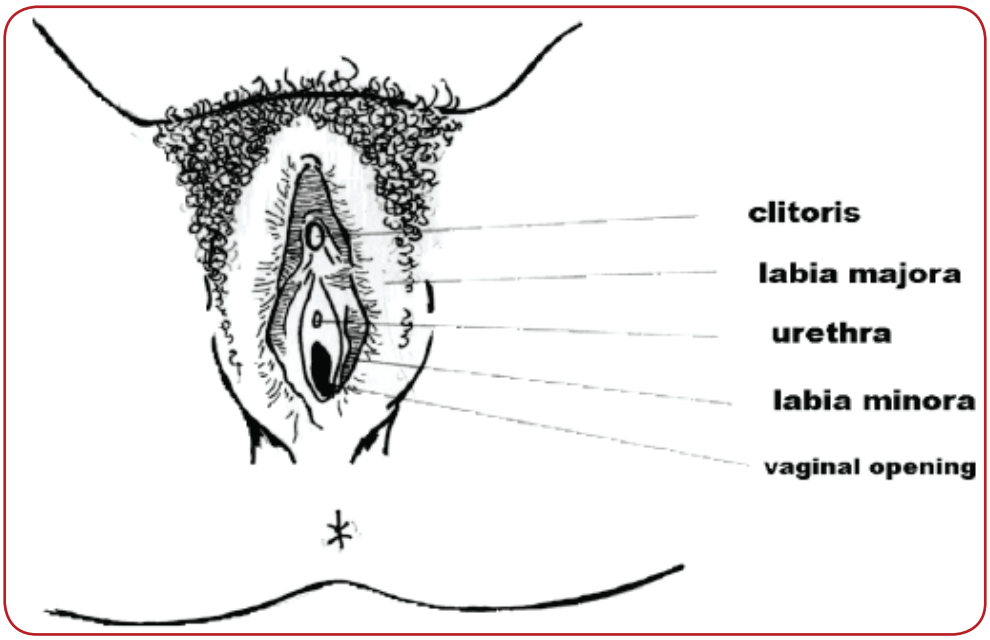
The narrow part which is at the neck of the womb is called the cervix. It is the lower, narrow portion of the uterus where it joins with the top end of the vagina. It temporarily opens up, only to let the menstrual flow out and the spermatozoid in, otherwise it blocks out any foreign thing. However, because germs are very small, they can get in. There are people who believe that during sexual intercourse, the condom can slip away and remain in the uterus. But this can never happen as the neck of the uterus is very narrow. During pregnancy, the opening remains closed, so that the fetus remains inside, and will open up only during labour to release the baby. The cervix is very sensitive and can easily be harmed. During sexual intercourse, it is exposed to germs and certain viral infections that may cause infertility or cancer. Frequently changing partners without condom use increase that risk.

Virginity

Virginity is the state of a person who has never engaged in sexual intercourse. There are cultural and religious traditions which place special value and significance on this state, especially in the

case of unmarried females, associated with notions of personal purity, honour and worth. Like chastity, the concept of virginity has traditionally involved sexual abstinence before marriage, and then to engage in sexual acts only with the marriage partner. Unlike the term premarital sex, which can refer to more than one occasion of sexual activity and can be judgment neutral, the concept of virginity usually involves moral or religious issues and can have consequences in terms of social status and in interpersonal relationships[1]. Female virginity is often determined by the existence of the hymen, a membrane that surrounds or partially covers the external vaginal opening leaving a small hole. It forms part of the vulva, or external genitalia, and its shape differs from female to female. The hymen is torn during the first sexual intercourse resulting in bleeding, so much bleeding is considered as a proof of virginity. However, also without sexual intercourse, the hymen can tear during physical exercises including sports like cycling. Some girls might even have been born without a hymen. Although being a virgin at the time of marriage is valued socially, in fact, the basic question should not be whether there is an intact hymen or not but rather whether the person has ever had sexual intercourse or not. A man who never had sexual intercourse before is also considered a virgin even if he does not have an equivalent of a hymen.

External female reproductive organs



The Vagina

The vagina is a fibromuscular tubular tract which is a sex organ and has two main functions; sexual intercourse and childbirth. In humans, this passage leads from the opening of the vulva to the uterus (womb), but the vaginal tract ends at the cervix. Unlike men, who have only one genital orifice, women have two, the urethra and the vagina. The vaginal opening is much larger than the urethral opening, and both openings are protected by the labia. The inner mould of the vagina has a foldy texture which can create friction for the penis during intercourse. During arousal, the vagina gets moist to facilitate the entrance of the penis[2]. It leads from the opening of the vulva to the uterus (womb). It lies midway between the anal tract and the urethra. It is made out of a very soft and folded skin. Its depth can go up to 7 centimetres, and its width from 3 to 4

[1] *More at http://en.wikipedia.org/wiki/Virginity*

[2] *http://en.wikipedia.org/wiki/Vagina*

centimetres. Triggered by hormones during labour, the vagina of an adult woman will become more elastic and expand during delivery to let the baby pass through. The vagina of adolescent girls in puberty is not as expandable, because the tissue is more sensitive and thin than in adult women. It can easily suffer birth related injuries that can lead to a serious health condition called fistula. This is why unequal and early marriage resulting in early pregnancy are not healthy for young women. Staring from young adolescence age, due to many glands, the vaginal wall produces sticky saliva like fluid. The amount and colour of this fluid varies during the menstrual cycle. The purpose of this vaginal discharge is to protect the vagina from bacteria or infections. Moreover, during sexual intercourse, this fluid will also serve as a lubricant to protect the vagina from injury. Unless a medical professional says otherwise, washing the internal side of the vagina disrupts the normal functioning of the vagina and may cause problems. To prevent the entry of intestinal germs from the anus to the vagina, washing direction should go from the vagina to the anus.

Babies come to this world through this alley, which is why it is also known as the birth canal. It is a respectable body part.

Labia Majora and Minora

The female genital consists of bigger and smaller lips. Both protect the vaginal entry and the internal reproductive organs from injury and infections. As the name points out, these parts look like lips and are found on the right and left side of the female external reproductive organ. The labia majora is very thick with oily fat accumulation and with folded skin. Its size differs with age. When a girl reaches puberty, pubic hair will grow on the labia majora. The labia minora consist of sensitive tissue and are made of hairless, folded skin. To avoid friction soreness, the lips are normally humid thanks to the fluid producing glands. The labia play an essential role in protecting the opening of the vagina. Removing these lips comes down to mutilating the body, making it handicapped.

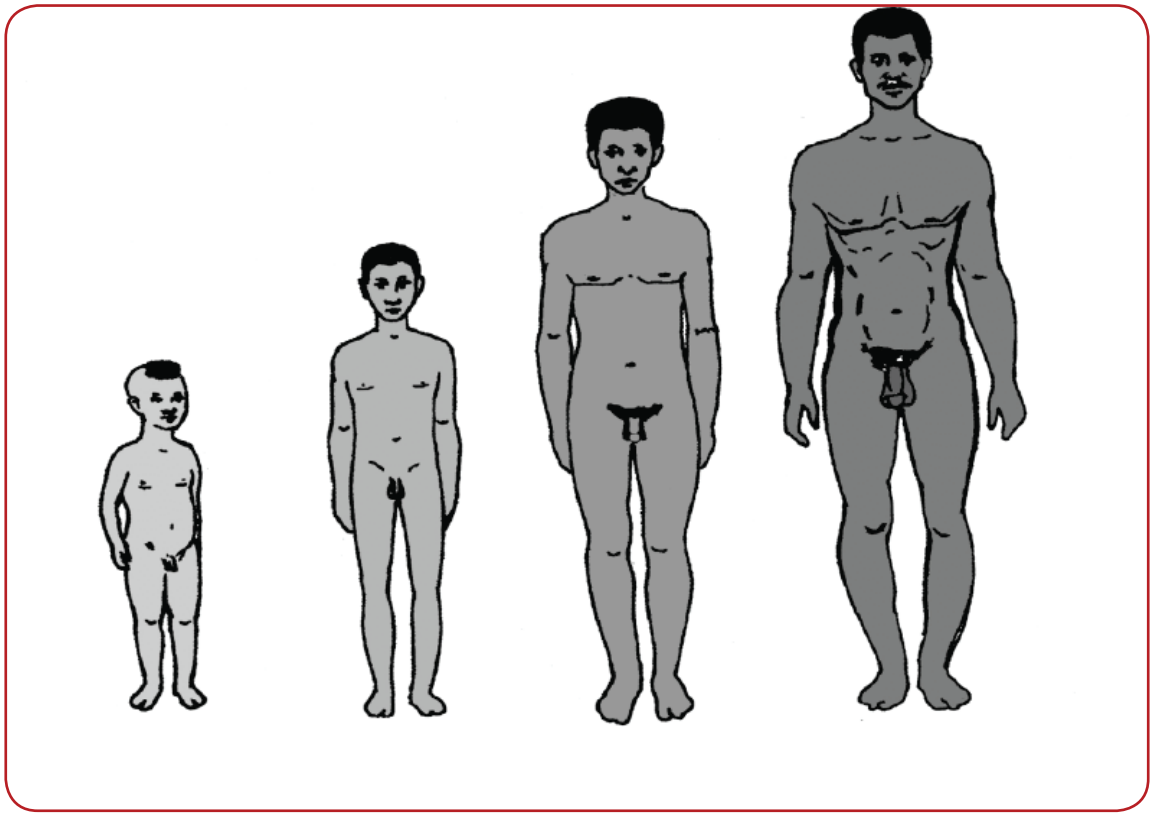
The clitoris is the visible button-like portion that is located near the anterior junction of the labia minora, above the opening of the urethra and vagina. The clitoris, located between the vagina and the urethra, is full of nerve ends that make it very sensitive. The stimulation of it produces fast sexual excitement and clitoral erection. The labia minora, labia majora and the clitoris are exposed to dangers of Female Genital Mutilation (FGM). One type of female genital mutilation is removal of the clitoral hood, almost invariably accompanied by removal of the clitoris itself; the second type is the removal of the clitoris and the inner labia while the third and worst case consists of a removal of all or part of the inner and outer labia, and usually the clitoris, and the fusion of the wound, leaving only a small hole for the passage of urine and menstrual blood. Through female circumcision, a girl will lose body parts that are essential to her sexual response and have important functions in protecting her reproductive organs. FGM or circumcision may also cause serious problems during childbirth. Among other effects, the resulting wound prevents the vagina from expanding to let the baby pass through. In Ethiopia, Female Genital Mutilation (FGM) is classified among the most harmful traditional practices. More information on FGM/circumcision can be found in Chapter 6.

Breasts

A female's breasts grow and change during puberty. Growth of breasts may occur from the age of eight or nine years onwards. The breasts enlarge due to the increasing level of progesterone during puberty. The areola begins getting larger and darker and then the size of the breasts starts to change. There is an individual difference in the timing when this starts and the rate at which growth takes place, among different females. A breast may take in average 4 years to develop. At times, it may even take until the age of 16 or 18. Breasts have different shapes and sizes. Each female is unique. As the breasts' development is determined by biological factors, it cannot be changed. In most cases, the size of the two breasts is different. The saying that a man's touch will enlarge breasts is a wrong belief. The size of a breast is determined not by a man's hands but by hormones. It is essential to understand that regardless of size, a breast will produce enough milk to feed a baby. The inner side of the breast is composed of the lactiferous duct made of white fat that produces the milk. The breasts increase in size during breastfeeding, as they are filled with milk. Women/ girls should examine breasts and armpits with their fingertips regularly. If there is a swell, wound or fluid coming out from the tip of the nipples, please consult your doctor.

Chapter 3: Male Anatomy

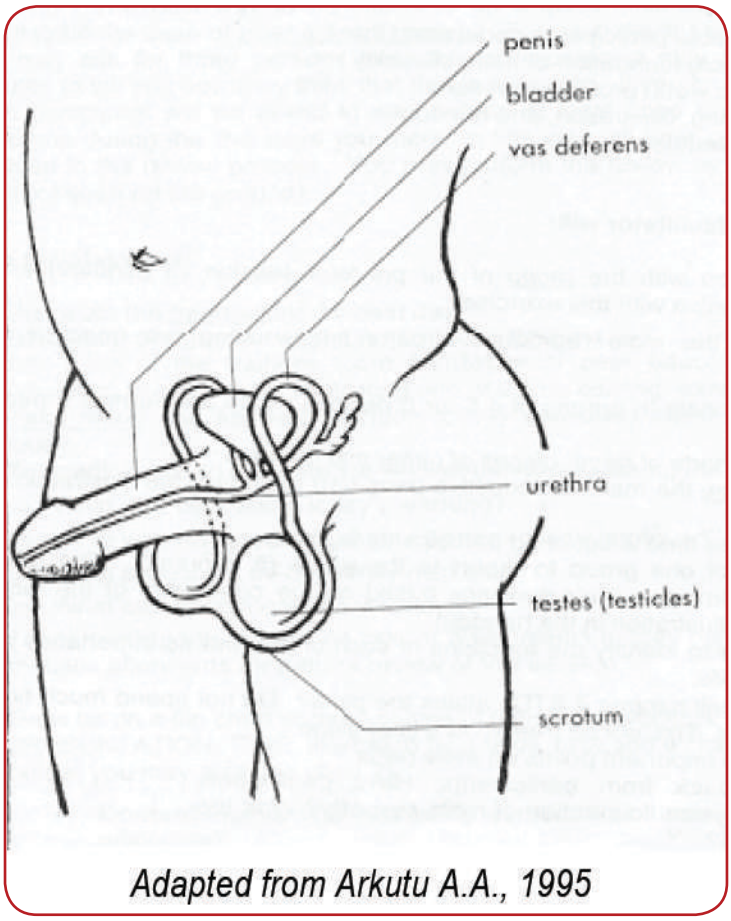
A. Child B. Young adolescent C. Adolescent D. Adult



3.1 Male reproductive organs

Internal male reproductive organs

A – Penis
B – Testis
C – Bladder
D – Vasa deferentia
E – Prostate
F – Urethra
G – Male reproductive organs



Adapted from Arkutu A.A., 1995

Exercise 7: Understanding male reproductive organs

Objective: To acquire in-depth knowledge on male reproductive organs
Method: Group discussion
Tools: Drawing, short description, flip chart, marker
Time: 30 minutes

Facilitator's tasks:

1. Divide the participants into groups
2. Provide paper and markers for each group
3. Request each group to the draw internal and external male reproductive organs and label the names.
4. Request each group to make themselves ready to read and explain to all about one of the reproductive organs. (See basic information below)
5. When the allotted time is over, ask participants to come together.
6. Every team leader:
   - Explains the drawing/picture of the group;
   - Describes the types and functions of each reproductive organ one by one; 5 minutes.
7. Give a brief explanation about the development of male reproductive organs, hormones, their shapes, penis, sperm, etc.; and ask the participants whether they have fully understood the male reproductive organs.

3.2. The development of male and female reproductive health systems

Exercise 8:	The development of the reproductive life cycle in males and females
Objective:	To develop in-depth knowledge on growth of male reproductive life cycle
Method:	Group work
Tools:	Drawings, short description, flip chart, marker
Time:	30 minutes

Facilitator's tasks:

1. Write down and post the following development stages (ages ranges) on the wall or floor:

0 – 5	10-14	15-18	19-24

2. Write the reproductive/sexual phenomena/changes occurring at each stage as listed bel low on separate papers and distribute them to the participants.
3. Each participant picks one or two papers, sorts them under the correct age level and gives a brief explanation; other participants to approve the correctness of the answer.
   - Sexual desire occurs
   - Female reproductive organs reach maturity
   - Menstruation begins
   - Menopause occurs
   - Male nocturnal wetting
   - Production of testosterone hormones begins in the testicles
   - Implantation of an ovum
   - Sperm meets ovum
   - Ovulation of ovum
   - Uterus/womb becomes ready for pregnancy
   - Testicles begins producing sperm
   - Breasts grow
   - Genitals/vagina easily harmed during delivery
   - Sperm meets ova
   - Starts production of sex hormones
   - Female hips and thighs grow
   - The appropriate age for pregnancy
   - Growth of clitoris and vaginal lips
   - Appearance of pubic hair
   - Erection of penis begins
   - Erection of penis weakens
   - Sexual desire begins
   - Age of grand-parenthood

4. *Summary* – Read out what has been written under each column and conclude the session by asking participants whether they have understood the development of the reproductive cycle in males and females.

3.3 Basic Information/handout

The development of male reproductive organs

The period at which reproductive organs begin to develop is referred as adolescence. The time when the development begins vary from person to person. Some may reach adolescence early and others later. In boys, this development usually starts a bit later than in girls, at the age of 12 until around 21. The development of the male reproductive organs begins when the body starts to produce sex hormones. Male sex hormones are called androgens. When a boy reaches the age of adolescence, the pituitary gland in the brain will start secreting androgen through gonadotrophic hormones. This androgen of the gonadotrophic hormones, directed by the brain, travels through the blood cells and produces testosterone in the testicles. During adolescence, testosterones are responsible for the development of the reproductive organs. It enables testicle growth and sperm production, and the penis, the vasa deferentia and other reproductive organs increase in size. Besides it gives males the visible characteristics of manhood like physical strength, a beard, perhaps chest hair and stronger muscles. Testosterone has an impact from puberty until the end of a man's life. The development of the reproductive organs, although it starts during puberty, extends up to 21 years. The main changes of characteristics during adolescence or puberty because of the influence of hormones are outlined below.

Male hormones

In relation with this physical change, an emotional swing may occur between happiness and sadness. They carefully observe the changes that are taking place in their bodies. Struggling to understand their emotions, they may find it hard to control their feelings. When the body changes due to hormones and growth occurs at a fast pace, young people may panic as to what is going on with them. When the amount of the hormones decreases, they will stabilize. In human reproduction, the role of the male is to provide sperm. As this sperm fuses with the ovum of the female, conception occurs and creates new life. But when it comes to pregnancy, the man's biological contribution to reproduction ends, even if he is of course still responsible for the mother and the child. As shown in detail below, the larger portion of male reproductive organs are located in the outer part of the body.

Male reproductive organs

Testicles

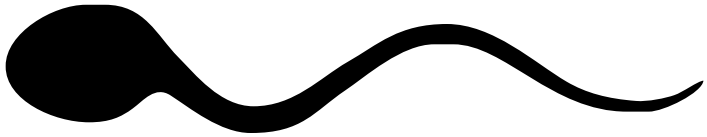
Every man has two testes that are of an egg shape. Testes are contained in the scrotum, hanging in between the man's tights. Each testicle is made up of tightly coiled somniferous tubules that can protect itself from any danger but it is also very impact sensitive because it is made of a network of nerves and blood vessels. In the testicles, there are many intertwined tiny sperm ducts that can be up to 300 metres long. In these lines, starting from puberty, sperm begins to be produced due to the testosterone hormones. This occurs when the male child reaches ages 12 to 15. However, it can also be triggered before or after this age gap. While a woman produces one ovum once a month, a man ejaculates up to millions of sperms in just one sexual intercourse. Ejaculation is the ejection of semen (usually carrying sperm) from the male reproductory tract, and is usually accompanied by orgasm. It is usually the final stage and natural objective of male sexual stimulation, and an essential component of natural conception. The testicles can produce

sperms from puberty to old age however, with age; the number of the sperms will decline. Because the right temperature is important for sperms, the testicles are found hanging outside the body. At an optimum temperature the testes hang down. If it is too hot it will hang away from the body and if it is too cold or if the person is under fear the testes will retreat closer to the body.

Sperm

The sperm cell consists of a head, a middle piece and a tail. It is produced inside the male gonads in the testicles. Then it reaches the male reproductive organ via the vasa deferentia. In the vas deferens there are many small glands that produce a fluid and a seminal vesicle under the prostate produces a fluid. This semen fluid will carry the sperm so that it can migrate through the male reproductive organ ducts, and helps the sperm to swim by moving its tail. At the end of sexual intercourse, this fluid is pushed and expelled into the woman's vagina (ejaculation) and the sperms will proceed swimming towards the fallopian tube.

http://www.shutterstock.com/s/sperm/search.html



10% of the semen consists of millions of sperms, whereas 90% consists of fluid. This fluid enables the sperm to move around by swimming and nourishes it on its way. Among the millions of sperms that will enter the woman's vagina, only one will make it to the ovum and fertilize it while all the others can survive for three days. This means that a pregnancy may also occur if sperm enters the vagina even after sexual intercourse. A sperm consists of cells that are invisible to the eyes. However, there are three parts of it that are visible through a microscope. These are the head, the middle piece and the tail. The tail helps it swim its way up to the fallopian tube. On its head, it contains 46 chromosomes that in turn contain genes that carry the genetic characteristics that differentiate one person from another. The sex of a baby is determined by the chromosomes. In one sperm, there are 46 X and Y chromosomes. Thus, during intercourse, if the sperm containing the X chromosome fertilizes the ovum which is always brining in the X chromosome, the result would be the conception of a baby girl with XX chromosome. Whereas, if the sperm comes in to fertilization process with a Y chromosome, this will combine with the woman's X chromosome to result in the conception of a baby boy with XY chromosome.

The Penis

The male sex organ is a sponge like body part. It consists of the urethral duct that transports and discharges urine but also semen. At birth, the head of the penis is covered by a foreskin (prepuce) that may be removed through circumcision in some cultures. Male circumcision, as opposed to female circumcision, is a minor surgery, and has no health implications if conducted in a sterile environment. It is easier to keep the penis clean, and according to recent research male

[3]*Siegfried N, Muller M, Deeks JJ, Volmink J (2009). Siegfried, Nandi. ed. "Male circumcision for prevention of heterosexual acquisition of HIV in men". Cochrane Database of Systematic Reviews (Online) (2): CD003362.*

circumcision reduces female-to-male HIV transmission [3]. The tip of the penis (glans) consists of many nerve ends so that it is very sensitive to arousal like the female clitoris. An erection occurs when two tubular structures, called the corpora cavernosa, that run the length of the penis, become engorged with venous blood. This may result from any of various physiological stimuli, also known as sexual stimulation and sexual arousal. During sexual intercourse, the urethra blocks to let only the semen flow out. After sexual satisfaction the penis will shrink back to its normal size. The size of the male sexual organ varies from person to person. It has nothing to do with the size of the body. Some boys and men are worried about their penis being too small. The level of satisfaction the man can provide a woman does not depend on its size. The level of sexual satisfaction correlates rather with how much each one can connect and how much the man knows where to touch her, by keeping in mind that her erogenous zones are mostly around her clitoris and the labia majora and minora. Basically, it should be recognized that the major sex organ is the brain.

Vas Deferens

These tiny duct lines connect the left and right epididymis to the ejaculatory ducts in order to move sperm. During sexual intercourse, the muscles that surround these tubes will make a contracting and relaxing movement and with this, they transport sperm from the epididymis in anticipation of ejaculation. During ejaculation the smooth muscle in the walls of the vas deferens contracts reflexively, thus propelling the sperm forward. The sperm is transferred from the vas deferens into the urethra, collecting secretions from the male accessory sex glands such as the seminal vesicles which form the bulk of semen. The ejaculated sperm enters the vagina during sexual intercourse.

Chapter 4: Pregnancy

4.1 How Pregnancy occurs

Pregnancy is the process of conception and development of the fetus. So far, types and functions of female and male reproductive organs have been discussed. The main purpose of the reproductive organs is reproduction. Pregnancy begins when the male's sperm meets the female's egg. The development of the fetus starts when the fertilized egg has implanted in the uterine lining. A fetus will grow on its own within the uterus. In a woman's life, pregnancy has a very big importance. This is not only a matter of interest to females. But pregnancy can never occur without a man's involvement. Therefore, both boys and girls ask "where the babies come from".

Exercise 9:	How Pregnancy occurs
Objective:	To correct myths and misinformation on how pregnancy occurs
Method:	Group discussion, brainstorming, exploring knowledge on pregnancies, group work
Tools:	Drawing illustrations, flip charts, blackboard, chalk, markers, pens, papers
Time:	20 minutes

Facilitator's tasks:

1. Divide participants into groups
2. Ask the groups to openly discuss what they think how pregnancy occurs
3. Ask the groups to present the results of their discussions
4. Write down their ideas on a flip chart or the blackboard.
5. Explain that the purpose of this exercise is to correct misconceptions regarding the beginning of pregnancy by analyzing the menstrual cycle.

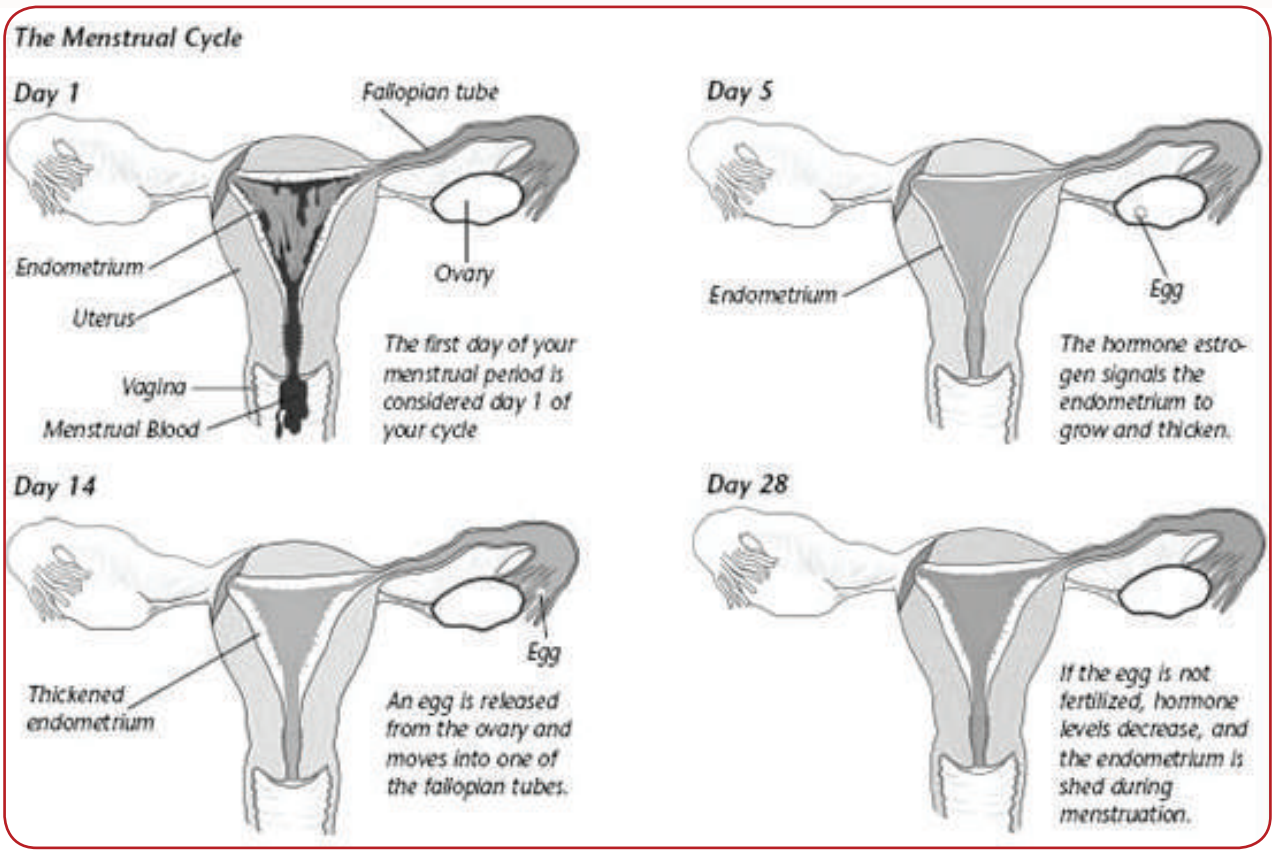
4.2 Menstrual cycle

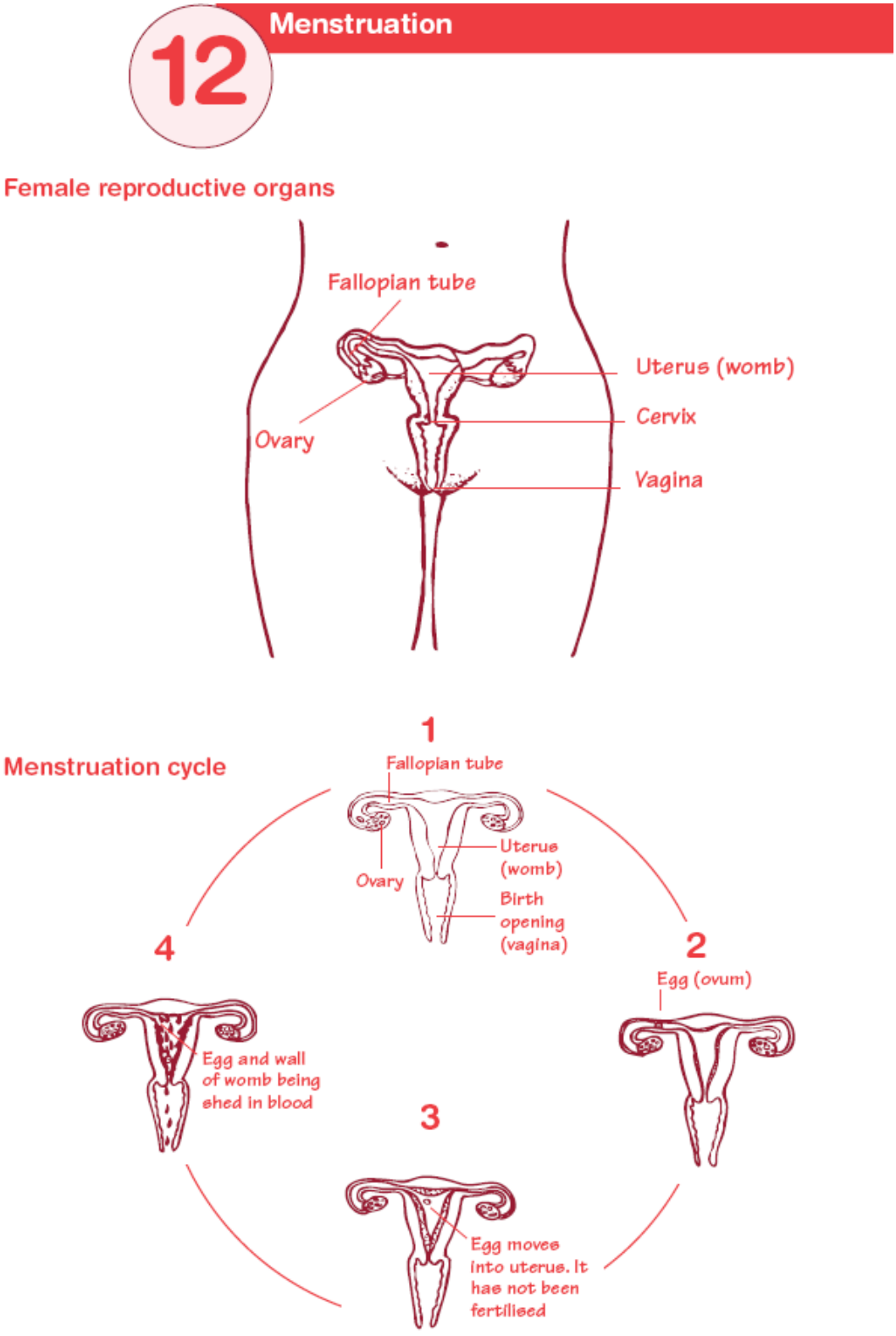
Exercise 10:	Menstrual cycle and pregnancy
Objective:	To enable participants understand the relationship between menstruation and the occurrence of pregnancy
Method:	Group discussion and presentations
Tools:	Drawing pictures, using diagrams
Time:	45 minutes

Facilitator's tasks:

1. Divide p in groups of 4, 5 or 6 persons.
2. Provide the groups with flip charts and markers.
3. Ask them to copy or draw the menstrual cycle chart
4. When the given time is finished, call participants together for presentation
5. Ask each group to make a brief presentation on the following topics
   - About the monthly menstrual flow
   - About ova production
   - About conception
   - About implantation
   - About menopause

Try to collect feedback, comments and corrections on each of the presentations made by the different groups. Then write the cycles on a flip chart.





Source: sexuality and life skills manual – International HIV and AIDS Alliance p.25-31

- Hand the six papers to them randomly
- Ask them to read out the phase of the menstrual cycle written on their papers and stand according to the correct order.

Briefly explain the relationship between menstrual flow and pregnancy.
To conclude:

6. Ask participants whether they have understood about the origins of pregnancy.
7. Explain in brief the relationship between menstrual cycle and pregnancy.
8. Wind up indicating that a healthy pregnancy should only occur between the ages of 18 and 35.
9. Practice - underline the fact that pregnancy consists of a big event in our lives. Ask participants the following questions for discussion:
   - Why is pregnancy not recommended before the age of 18?
   - When are you actually planning to have a baby?
   - How can an unwanted pregnancy be prevented?

Basic Information

As stated above, at the time when the external body parts grow fast with puberty the internal reproductive body parts also begin to change. The harbinger of a girl becoming a woman during puberty is the menarche, the beginning of monthly menstruation. At first, a girl might be shocked and confused to see the blood flow. It thus helps very much to discuss with the mother, her sister or friends beforehand. The menstrual flow cycle is led by the brain. Before a girl starts menstruating, ova are produced in the ovaries. Therefore, a girl can even become pregnant before the first menstruation. Around the age of ten, at the beginning of young adolescence, the pituitary gland sends out a message for estrogens to be produced. Then due to this hormone, also the breasts begin to develop. As we would be seeing in the next part, pregnancy and menstrual flow are linked to the development of the ova.

Ova Ripening

Ova ripening refers to the stage in which an ovum becomes ripe enough and goes out of the ovary. Every month, an ovum comes out from one of the two ovaries. When the pituitary gland sends a message, the fallopian tubes alternates in delivering a ripe ovum that will come out and travel to the uterus through the fallopian tube (this is called ovulation). This happens at half time of the menstrual cycle which means during the period of day 13 to 15. (See image). The ovum can fuse with a sperm within 24 hours from its exit from the ovary. If the ovum is not fertilized during this time period, then pregnancy will not occur. When the ovum has ripened, the cervix will widen in order to let the sperm in. The cervix and the vagina produce a whitish fluid to make it easier for the sperm to enter the uterus. This white secretion can sometimes also be seen as odourless fluid on the entrance of the vagina. For the ovum to enter the fallopian tube, the tube will push it up to the uterus which may cause slight pain on either side of her stomach. Some women can tell when an ovum is produced because:

- They feel pain on their sides;
- The fluid that is discharged from their vagina becomes very clear and sticky.

In consideration of these signs, a girl/woman may feel she can determine her fertile days. However, there are really no safe days for sex. Women ovulate at different times. Some women ovulate right before their periods. Generally speaking, however, women are fertile 14 to 15 days after their period. Also, keep in mind that for "safe sex" you should always use a condom.

Pregnancy signs

- No monthly menstrual flow
- Nausea and vomiting
- Darkening of the dark areas surrounding the nipples
- Feelings of fatigue and discomfort
- Urinating frequently
- Headache
- Abdominal size increases
- Swollen legs
- Breast enlargement and sensitivity
- Mood swings

Note: There are pregnancy self-tests available, but pregnancy is only confirmed after a medical check-up at a health facility.

Fertilization and implantation

Fertilization

For fertilization to take place, a sperm has to fuse with the ripened egg within one day (24 hours). *(See image).*

Implantation

As soon as it is fertilized, the ovum enters the cell division phase while migrating to the uterus. Within five days it reaches the uterus. After arriving in the uterus, within two days the ovum will attach itself to the uterine lining. This process is called implantation. *(See images)*. The egg will continue growing by dividing itself. It takes it many weeks to become visible to the eyes. After weeks of growth, it becomes a fetus. When the ovum reaches the uterine lining and implants, the linen will stay to host the egg, and no menstruation will occur. This is why women do not menstruate during pregnancy. Bleeding during a pregnancy can indicate a problem; if bleeding occurs during pregnancy, you should therefore consult your doctor with some urgency.

Menstrual Flow

Biologically, a woman menstruates only if she is not pregnant. What is the reason for menstrual blood flow? Menstrual flow results from the breaking down of the uterine lining in the uterus. The uterine lining or uterus wall builds up and is well supplied with blood every month when the following occurs:

The pituitary gland sends out hormonal messages (progesterone) to the ovaries for the ova to be produced. This prompts the ovary to produce more ova. The one or two ova that will ripen will send out a message for estrogens production, which in turn will stimulate the uterus wall to prepare a blood support. When the ovum comes out from its tube, the progesterone hormone will be produced in abundance. This process will continue until it is clear if or if not the ovum has implanted itself, whether or not a pregnancy has occurred. If there is no conception, the ovum will dilute. Due to this, the progesterone hormone will stop being produced, and the built up uterine lining will break down and leave the body through the vagina with the menstrual blood flow. Progesterone is sometimes called the "hormone of pregnancy", and it has many roles relating to the development of the fetus: Progesterone prepares the uterus for implantation.

If pregnancy does not occur, progesterone levels will decrease, leading, in the human, to menstruation. During implantation, progesterone appears to decrease the maternal immune response to allow for the acceptance of the pregnancy. A drop in progesterone levels is possibly one step that facilitates the onset of labour. As long as females are in their reproductive age, the menstrual cycle will continue every month. Menstruation or "the period" may last between 4 to 6 days. Some have it longer than others. During this cycle, the first day on which the monthly flow starts is determined as "Day 1" in the menstrual cycle. The duration of the menstrual cycle is measured starting from this first day on which the flow started, up to the day on which the menstrual flow will start again. (See image). Women differ in the duration of their menstrual cycle, which can last between 21 and 35 days. The average is however, 28 days.

The amount of blood discharged differs from woman to woman. Mostly it ranges between 60 to 80 millilitres or half a cup of tea. The body will rapidly replace the blood lost.
At times the menstrual cycle can be irregular. There are many factors that contribute to the menstrual flow or cycle irregularities: For instance, stress, emotional turmoil due to approaching exam periods, mourning, insomnia, high excitement etc. If these irregularities do not correct themselves, it is recommended to consult your doctor.

When the menstrual blood flow comes to an end, another hormone will begin to be produced in the ovaries. Thanks to this hormone, another egg will begin growing, the uterus wall will prepare and a new menstrual cycle begins.

Menopause
Menopause is a term used to describe the permanent cessation of the primary functions of the human ovaries: the ripening and release of ova and the release of hormones that cause both the creation of the uterine lining and the subsequent shedding of the uterine lining (the menses or the period). Menopause typically (but not always) occurs in women in midlife, during their late 40s or early 50s, and signals the end of the fertile phase of a woman's life[4]. The menstrual flow will stop when a woman reaches the age of about 45 to 49. This age differs from woman to woman. The stopping of the menstrual cycle is called menopause. What is it exactly? It is also when the egg stops becoming ripe when the menstrual flow stops all together. This happens because the pituitary gland requests decline up to stopping altogether thereby stopping menstrual flow and ovulation.

[4]*Source: http://en.wikipedia.org/wiki/Menopause*

Infertility

A person is said to be infertile if after having had unprotected sexual intercourse for almost a year, pregnancy still does not occur. Infertility occurs within many men and women. At times the cause is not known. In women however, the most frequent reasons are the blockage of the uterus, disruption of the ovulation, or a problem at the uterus entry. For the man, the reason for sterility could be the inability to produce enough sperm count. By effecting surgical intervention on the uterus wall, by giving medication to stabilize the ovulation process, and by providing testosterone and vitamin E injections, infertility can be treated in some cases.

Because infertility can also be caused by STIs, it is important to prevent infections also with view to reproduction. *(See Module 6)*

4.3 Unwanted Pregnancy

4.3.1 Causes and consequences of unwanted pregnancy

Facilitator's tasks:

1. Briefly revise or brain storm the main points of the discussion on how pregnancy happens
2. Introduce this exercise
3. Request the participants to sit relaxed and read or ask a participant to read out the following story.

Medina is a 17 years old girl. Her father died long ago and her mother is poor. She could not pursue her education beyond grade six. According to Medina, in her residential area, she got acquainted with a young guard of a private company. Initially, she was not aware why the guard wanted to be close to her. Gradually, he became friendly to her and began giving her some money and gifts. Finally he started taking her to his workplace in the evenings and soon after they had sex.

They were together only for three months. Sometime after they had sex, her menstruation did not come and her breasts and belly became bigger. She realized that it was pregnancy and she informed him. But he told her that she should have been more careful and warned her not to come to the compound again. Soon he left the company. She had no money to abort and she did not have the means to even support herself let alone bring up a baby to take care of. The only option left was informing the situation to her poor mother. Her mother was astonished by the news and wondered how such a disgraceful act happened to her daughter and they both cried. Her mother was more concerned to the honour and dignity of the family than the poverty. As a single mother, she could not bear seeing her daughter carrying a so called 'bastard'... Her mother repeatedly warned her not to go out of their small room. But the news reached to the neighbourhood. An act of a single day has a life time repercussion.

4. Option/alternative – the facilitator tells the story of the two drawings below (if possible the facilitator invites volunteers among participants to perform it in drama)

When the two girls came back from school they passed by their friend's house. When they arrived at their friend's home, the father was expelling his daughter blaming her for her pregnancy. They witnessed it with sad feelings. The girl went to her boyfriend and told him what happened crying but he told her that he was very sorry but could not help her. She was expelled from home and had nobody to turn to. What would be her final destiny? They would say - An act of a single day has a life time repercussion.

5. Ask questions for analysis and start a discussion:
   - Do such things ever happen in your community?
   - Do you know any girl who faced the problem of Medina?
   - How did the girl get pregnant?
   - What could she have done? Which skills could have helped her?
   - What could her boy friend have done?
   - What could she do now?
6. Following the discussion, ask participants to think about and indicate five causes and consequences of unwanted pregnancy.
7. List down the points raised under the headings "causes" and "consequences" on the flip chart.
8. Summarize repetitive ideas and read out the main points.
9. Briefly explain the causes and consequences of unwanted pregnancy. (See below)
10. Application – ask and briefly discuss with the participants whether they have under stood the causes and consequences of unwanted pregnancy
    - What can we do to prevent unwanted pregnancy?
    - Which measures can we take once pregnancy has happened?

1. Care for yourself and your partner to avoid unwanted pregnancy
2. If an unwanted pregnancy occurs, you need to communicate with your partner, your parents and your doctor.
4. You can learn more about contraceptives and how to use them to prevent unwanted pregnancy *(Module 7);*
5. Certain life skills will help you to avoid unwanted pregnancy and better cope with it when it occurs despite all precaution. *(Module 2)*

Basic Information

Unwanted pregnancy

Unwanted pregnancy is a pregnancy that occurs when it is not wanted, mostly by the girl/woman or her partner or both. There are various factors determining whether a couple wants to have a child at a certain point, including the age of partners, influence of the family and the community, financial constraints and a person's plan for life. An unwanted pregnancy is different from an unplanned pregnancy: pregnancy can be unplanned, or unexpected, and the woman and her partner are very happy about it. And of course a pregnancy can also be both unplanned and unwanted. Lastly, an unwanted pregnancy is different from an early pregnancy, a pregnancy which takes place in a young girl whose body is not mature enough to handle it well, and who is also not emotionally ready to be a mother. An early pregnancy can be wanted or unwanted, planned or unplanned – but it is always a danger to the girl and her baby.

Factors that lead to unwanted pregnancies

Some of the causes for unwanted pregnancy among young people

- Early marriage
- Peer pressure
- Sexual experimentation
- Unavailability of contraceptives
- Misinformation or myths on male/female sexuality
- Fear or myths about contraceptive use
- Not using contraceptives
- Lack of knowledge or information
- Wish to express love
- Failure to use contraceptive methods properly
- Sexual abuse or sexual violence, such as rape and defilement
- Lack of ability to negotiate contraceptive use or safer sex
- Poverty
- Uncontrolled sexual behaviour
- Early marriage;
- Absence of family support and monitoring due to rural-urban migration
- Early menstruation
- Limited family planning service
- Conduct sexual intercourse with no understanding of how and when pregnancy happens
- Distorted or unrealistic information about pregnancy
- Suspicion or fear to use contraceptives
- Inappropriate use /misuse of birth control mechanisms
- Practice unsafe sex
- Lack of transparent and open discussion about sexual intercourse with sex partner
- Unbalanced gender relations – i.e. forceful sexual intercourse or rape

Early/Teenage pregnancy

Teenage pregnancy refers to pregnancy in a female under the age of 20 (when the pregnancy ends). A pregnancy can take place at any time before or after puberty, with menarche (first menstrual period) normally taking place around the ages 12 or 13, and being the stage at which

a female becomes potentially fertile. Teenage pregnancy depends on a number of societal and personal factors. Teenage pregnancy rates vary between countries because of differences in levels of sexual activity, general sex education provided and access to affordable contraceptive options. Early pregnancy poses a serious health risk to both mother and baby. However, there are also social, psychological and economic consequences of early pregnancy.

Social problems associated with unwanted pregnancy

An unwanted pregnancy, especially among partners who are not married, may cause serious socio-economic problems, especially for the woman as she will be the one who cannot simply disappear or deny her responsibility. It is very demanding for a young woman to shoulder the responsibility for a child, which is easier for an adult women who can rely on their husbands and families. If you ask them about it, most young girls would rather die than having an unwanted pregnancy. The idea of giving birth to a child may have not come to her mind at all. There are many reasons for this. In addition to the fact that she is probably physically not ready to complete a pregnancy, her family may break with her and may not take care of her. In some cases, the pregnant girl will be expelled from home or flee by herself feeling guilty. Pregnant young girls drop-out of school and are unlikely to continue their education later on. As a result, their future life becomes problematic and their chance to get married and lead a decent life declines. This situation makes the young girl unstable and internally disturbed. To avoid social problems, the girl may consider an abortion. However, abortion is often conducted secretly by non-professionals using unsafe equipments which may cause terrible injury or lead to the death of the girl. Some even commit suicide. Many pregnant young girls who do not see any other way out leave their families and end up without any source of income.

I am pregnant and don't want to be what can I do?

Many young people (and older ones, too!) become pregnant or get an STI or HIV because they have sex without thinking first. One of the effects of sexual situations is to reduce thinking and increase feeling. Knowing this, we should try to make our decisions before we get into a romantic or sexy situation. Unprotected sex can have consequences, so we must think before we have sex. But it can happen nevertheless. If you find that you are pregnant but did not plan to be - don't panic and don't hurt yourself. You can take a few days (but not too long) to make a decision. Consult a person you trust, maybe your parents, a relative, your partner, a good friend, a doctor, a counsellor, a family planning service provider or a peer educator, or a telephone hotline. At some point, however, you must decide whether to have the baby or not.

Not to have the baby

- First: Never attempt unsafe abortion by a layperson or even by yourself, since this can permanently damage your reproductive organs and even kill you. Furthermore, illegal abortion done by laypersons is a punishable offense under the laws of many countries.
- Also where abortion is illegal according to applicable law, abortions should only be carried out by health professionals and not by laypersons.
- Seek the support of a family planning service provider, a counsellor or peer educator who can provide you with information, or ask your medical doctor for help.
- Your parents, relatives and your partner should support you by buying the medicines you need, help you to cope with the psychological effects of an abortion and take you to the hospital/doctor if any post-abortion complications arise.

- If done by a health professional in a clinic, an abortion is a relatively safe and simple procedure within the first 12 weeks. Up to that time, it usually does not require an overnight stay in the hospital.

To have the baby

- A young person or a couple with a pregnancy may decide to have the baby. If they love each other, they may get married. If not, the girl's family should see the man and his family and ask him to support his partner and child.
- Family planning service providers, counsellors and peer educators can help young people with a pregnancy to see that it is not the end of the world to have an unplanned child.
- Parents or guardians should support the girl during and after pregnancy and encourage her to seek prenatal care regularly so that she can have a healthy baby.
- When the pregnant girl is under 18 years old, the competent authorities dealing with women's and family matters should be informed for legal support
- The girl must be supported when the time of delivery has come. Wherever possible, Young girls should deliver in hospital under professional medical supervision and not at home wherever possible, as complications are more likely to occur than in older women.
- Girls should be encouraged to go back to school as soon as possible after delivery of the child.

4.4 How to prevent an unwanted pregnancy

1. Information

Young people need correct and reliable information on sexuality, reproduction and their own role in this. One of the reasons for the occurrence of unwanted pregnancy is inadequate knowledge about human reproduction. Young people have a right to live a healthy sexual life, have access to the information they need to protect themselves and their partners from STIs including HIV/AIDS and unwanted pregnancy, to youth friendly reproductive health services, testing facilities and treatment as needed, and affordable contraceptives as needed.

2. Contraception

Young people who have little knowledge of family planning methods may face unwanted pregnancy. They do not know where family planning services are provided and thus have no access to counselling and/or contraceptives. Therefore; it is essential to inform young people about family planning and contraceptives. It is also important to regularly refresh the information provided and monitor whether such information is actually put into practice to avoid negligence, and/or unrealistic expectations. There are various methods to prevent unwanted pregnancies. For detailed information on contraceptive methods, please refer to Module 7.

3. Life skills

Although life at young age is pleasant it is also risky. Certain life skills can help to prevent risky behaviours, protect oneself from unwanted sexual intercourse, unwanted STIs and unwanted pregnancy and better deal with related problems if they occur despite all precaution. See Module 2 on life skills.

4.5 Abortion

Introduction

The general objective of this unit is to help young people get insight into issues that relate to abortion

Specifically the unit will focus on discussing:

- Factors contributing to unsafe abortion among young people and
- Complications of unsafe abortions among the young people

This unit recognizes the diversity of legal and policy framework of Kenya, Tanzania, Ethiopia and Uganda in relation to abortion.

This manual notes that although abortion is restricted by law, there is overwhelming evidence that it is widely practiced in most countries for East Africa even with prohibiting laws say for Ethiopia where Abortion is legal.

Chapter 4 article 26(4) of Kenya constitution states that *"abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger or if permitted by any other written law".*

Uganda's laws permits induced abortion only when pregnancy endangers a woman's life and abortion is the way to save a woman's life. Legal abortions are therefore very rare, given the restricted grounds, the demanding process for obtaining approval (for example, providers typically require certification from three doctors, even though the law does not require this), and the likelihood that many providers and women are unaware of the specifics of the abortion lawand policies on termination of pregnancy.

Indeed under the Ugandan Penal Code of 15 June 1950 (sections 136-138, 205 and 217) the performance of abortions is generally prohibited. Any person who, with intent to procure the miscarriage of a woman, unlawfully administers any noxious thing or uses any means is subject to imprisonment for fourteen years. A pregnant woman who undertakes the same act or consents to its performance is subject to seven years' imprisonment. Any person who unlawfully supplies means to procure an abortion knowing that it is unlawfully intended for that purpose is subject to three years' imprisonment.

Abortion legislation in the United Republic of Tanzania is based on the English Offences against the Person Act of 1861 and the Infant Life (Preservation) Act of 1929. Under the Revised Penal Code of Tanzania (chapter 16, sections 150-152) the performance of abortions is generally prohibited. Nonetheless, an abortion may be performed to save the life of a pregnant woman.

Factors that contribute to unsafe abortion

Exercise 2:	Factors contributing to unsafe abortion
Objective:	To help participants understand the factors contributing to unsafe abortion among adolescents/ youth.
Method:	Group discussion and presentation
Tools:	Flip charts, markers, pens
Time:	45 minutes

Facilitator's tasks:

1. Facilitator provides a background of the topic; define abortion, contextual data and other types of abortion
2. Introduce this exercise.
3. Form groups of five participants and give to each group flipchart and mark pens
4. Ask each group to discuss the local factors contributing to unsafe abortion
5. Facilitator gives 5 minutes for discussion
6. Participants present their discussion finding
7. Provide more explanation about the particular factors; correct wrong statements based on facts. (See basic information).

Suggested questions for discussion:

- Define abortion?
- Explain the meaning of unsafe abortion?
- Why young people procure abortion?

Basic Information

Abortion is termination of pregnancy before viability (age of pregnancy when the foetus has chances of survival if born) – KMA. Unsafe abortion is defined as a procedure for terminating unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (WHO).

Broadly divided into 2 groups:

1. Spontaneous: without outside intervention
2. Induced: with outside intervention

Viability: age of pregnancy when the fetus has chances of survival if born. Traditionally 28 wks but with improved technology can come down o 22-24 wks.

The World Health Organization, and the global community, have long agreed on the definition of unsafe abortion: a procedure for terminating unwanted pregnancy that is performed by someone lacking the necessary skills or in an environment lacking minimal medical standards or both.

Factors contributing to unsafe abortion

Women everywhere seek abortion—those in countries with high and low fertility rates and family size preferences, and those with varying degrees of access to family planning. In any setting, women may find themselves with either an unplanned pregnancy for which they (or their partners) are unprepared, or a pregnancy that they cannot continue for other reasons. Around the world, the reasons for ending pregnancies are very similar.

Both wanted and unwanted pregnancies may be terminated.
For example, even when women want a child, the pregnancy may not be supported by her family or community; the pregnancy may threaten her health or survival, and the fetus may have a severe abnormality.

Wanted pregnancy:

- Pregnancy may not be supported by the woman's family or community
  Certain women – such as those who are young, old, unmarried, in school, and/or with many children already – may find that their parents, community members, religious institutions, and even their partners do not approve of their pregnancies. In these circumstances, they may feel pressured to end the pregnancy.
- Socio-economic factors may make having a child difficult
  Women or couples may feel they cannot afford to have a child at this time.
- Pregnancy may threaten the woman's health or survival
- Fetus may have a severe birth defect

In summary some of the contributing factors include:

- Economical problems
- Level of education
- Social and cultural problems
- Stigma
- Peer pressure/influence
- Marital status
- Repeated abortion
- Medical problems
- Legal obstacles

Exercise 2:	Complications of unsafe abortions
Objective:	Enable participants understand the complications of unsafe abortions
Method:	Group discussion, brainstorming,
Tools:	Card, markers, pens
Time:	30 minutes

Facilitator's tasks:

1. Introduce this exercise.
2. Facilitator provides an overview and asks participants to brainstorm the complication.
3. Facilitator moderates the brainstorming and provides more explanation about the particular complications; correct wrong statements based on facts. *(See basic information).*

Basic information

Complications of unsafe abortion

- Unsafe abortion sounds like it should be an easy situation to avoid. But if we look closer, it is not surprising in our region that unsafe abortion continues to occur.
- Skilled medical personnel who are trained and equipped to provide safe abortion are limited. Policies and laws restrict who can perform uterine evacuation – usually permitting only doctors to perform this simple procedure – and healthcare training institutions do not provide healthcare professionals with adequate relevant skills. As a result, safe abortion services are not accessible to the majority of women in our region. Many women therefore end up in the hands of unskilled personnel who often practice in substandard conditions.
- Unsafe abortion can and often has terrible health consequences: the side-effects of unsafe abortion are: pelvic inflammatory disease, partial or total infertility, psychological trauma, and often death.
- Since a large proportion of unsafe abortion occurs among adolescents, who have not yet had children, it can be deduced that a good number of adolescents will end up with total infertility and therefore be childless. Such young women may suffer the agony associated with the social stigmatization of childless women in some parts of Africa.
- Unsafe abortion has numerous other negative effects on women, their families, children and communities.
- For instance, unsafe abortion results in significant short- and long-term illness and injury--For every death resulting from unsafe abortion, there are countless women who live with pain, infection, and possible infertility.

The cost of treating the complications from unsafe abortion is enormous. In some countries as many as two out of three maternity beds in large urban public hospitals are occupied by women hospitalized for treatment of abortion complications, and as much as one-half of obstetric care budgets are spent dealing with abortion complications (The Alan Guttmacher Institute, Sharing responsibility: Women, society and abortion worldwide. New York, 1999).

And injuries and deaths caused by unsafe abortion harm more than just women—they have numerous ill-effects on families, children and communities. Surviving children are more likely to be malnourished or even to die within two years of the mother's death. And a study in Tanzania found that in households where an adult woman had died, children were half as likely to attend school ref/source?? In many Sub-Saharan African countries, a girl must leave school if she is pregnant, which causes many girls to terminate pregnancies in order to continue their studies. Many young women who seek unsafe abortion end up with severe complications and may be expelled from school if they are caught.

Immediate	**Long term complications**
Haemorrhage	Chronic pelvic inflammatory disease
Social Stigma	-
Acute PID	Psychological trauma
Rapture of the Uterus	Cervical incompetence
Psychological trauma	Infertility

Follow-up Care for Abortion

Women should receive clear information on:

- Follow-up visits needed
- What to expect after the procedure
- How to take care of themselves
- Return to fertility
- STI prevention and contraception, if wanted

Conclusions

Even though many young women wish to avoid or delay their next pregnancy by at least two years, they are not using contraception to make this possible. These women have an "unmet need" for contraception. Young married women in particular do not generally use contraceptives. Women sometimes find themselves pregnant when they do not want to or when it is difficult to continue with one when conditions do not allow.

Chapter 5:
Alcoholism, Drugs and Substance Abuse

Alcohol and Drugs

As said, many young people (and older ones, too!) become pregnant or get an STI or HIV because they have sex without thinking first. Alcohol, drugs and substance abuse often play a role in this, as their influence changes our behaviour, lowers our personal inhibition threshold and the level of risk awareness. According to a recent study, 3 of 4 new HIV infections are drug-related (CDC/Dr. Scott Holmberg, 2004). There are many addictive and stimulant drugs. Tobacco, chat, alcohol and pain killers are permitted and openly available. Some youth get used to drugs since childhood and gradually become addicted to them. There is also a chance to be dragged to more harmful and illegal drugs like cocaine, morphine, amphetamines, marijuana and cannabis. These create more addiction and are more difficult to give up. They affect the health, emotional and social life of users.

Exercise 12: Definition of terms

Objective: To clarify terms that will be frequently used in connection with alcohol and drug addiction

Method: Brainstorming and explanations

Tools: Illustrations, flip charts, blackboard, chalk, markers, pens, papers

Time: 10 minutes

Facilitator's tasks:

1. Identify terms that need to be clarified and have a general/open discussion with participants about them
2. Suggested terms for definition:
3. Drug: A drug is any substance/chemical – other than food - which is taken to alter the way the body/mind functions (psychoactive)
4. A substance that when taken into a living organism may modify one or more of its functions (WHO 1981)
5. Drug abuse: Abuse is the maladaptive pattern of drug use manifested by recurrent and significant adverse consequences related to repeated use of the drug(s).
6. Persistent or sporadic excessive drug use inconsistent with or unrelated to medical practice. Unsanctioned drug use: use of the drug is not approved by society
7. Dysfunctional drug use: is the use of a drug that is leading to impaired psychological or social functioning e.g. loss of job or marital problems.
8. Harmful/Hazardous drug use: is that use of drug that is known to have caused tissue damage or mental illness.
9. Dependence: (Addiction) (W.H.O) A state arising from repeated administration of a drug on periodic or continuous bash. There is psychological and physical addiction.

5.1. Learning about Alcohol and Drugs

In the following exercise we discuss each different types of drugs and their effects.

Exercise 14: Identify types of addictive substances and how they are consumed

Objective: Participants examine types of drugs and how they are taken
Method: Group work, analytical questions
Tools: Markers, flip charts
Time: 45 minutes

Facilitator's tasks:

1. Introduce the exercise
2. Divide the participants into groups of 4 or 5.
3. Request the participants to explain the types of addictive substances and how they are consumed based on what they have known, heard and read.
   - Group one about alcoholic drinks;
   - Group two about cigarettes;
   - Group three about cocaine, heroin, marijuana and hashish
   - Group four about any locally utilised substance e.g. Ethiopia Khat, Uganda Mairungi, Kenya Changaa etc.)
4. When group work is done participants will present their results.
5. Ask them questions and correct their answers based on the basic information provided below.
6. Conclude the activity by highlighting commonly used drugs and substances and how they are consumed

Reasons for and effects of drugs abuse among young people

Exercise 13: Reasons for and effects of drug abuse among young people

Objective: Participants examine why young people get involved in substance and alcohol abuse
Method: Group work, analytical questions
Tools: Markers, flip charts

Facilitator's tasks:

1. Introduce the exercise
2. Divide the participants into groups of 4 or 5.
3. Request the participants to explain what they think why youth tend to get involved in drugs and alcohol abuse, and the effects of abuse based on what they have known, heard and read
4. Ask participants to write on a flip chart under the columns of" reasons for use" and "effects"
5. After group work, allow groups to pre sent their discussions
6. Take Action: Ask participants to indi vidually write on a piece of paper answer for the question below. Ask: How can you protect yourself from abuse of drugs after understanding the reasons for abuse and effects?

Conclusion

When groups are done with their presentations, summarise the reasons for drug and substance abuse among young people and its effects and advise where people abusing alcohol or drugs can seek help.

Basic information/hand out

Mode of administration

- Orally
- Injection
- Smoked
- Sniffed
- Inhalation Intradermally (skin patches)

Reasons for alcohol and drug abuse

For example:

- Seeking ecstasy/excitement
- Peer Pressure, Curiosity, Ignorance, Alienation,
- Changing social structures,
- Unemployment,
- Diet pills,
- Reduce anxiety
- Fall asleep
- Get euphoric
- Enhance information processing
- Stay alert
- Relieve pain
- Relieve stress

Effects of addictive drugs

Alcohol and drugs contain addictive substances. If taken frequently, the body develops a habit of requiring them recurrently. The main effect/impact of alcoholic drinks and drugs is on the brain. The addictive substances reach through our blood cells/veins reach the brain and affect our brain and nerve system. As a, result our central nervous system functions in a different way and our mind may become incapable of controlling and directing our body, depending on the sort and amount of drugs you have taken. It becomes more difficult to monitor your behaviour, the level of self consciousness may decrease or increase, critical thinking may be totally switched off, there may be no risk awareness and false courage etc., all of which may result in inappropriate or even risky behaviour and inability to make sensible decisions. Drugs may affect our skill of memorizing, understanding and learning; have an effect on the glands that produce sex hormones in the brain, and may temporarily strengthen or weaken the desire for and the ability of having sexual intercourse for both men and women. For these reasons, drug users are more vulnerable to unwanted pregnancies and STI/HIV infections, as they are more likely to get "out of control" than people who are sober. Drug use during pregnancy is harmful for the fetus, may

result in miscarriage and disabilities and diseases in the baby. Unless physicians prescribe the use of drugs specifying its type and volume for treating/helping patients, self-motivated use of them invites danger. Research has indisputably confirmed that drugs like cocaine, heroin and morphine cause harm on the health of users. Experience has also proved it. The main harm is incurred on the brain. Causing confusion and weakening the central nerve system, our brain encounters difficulty in controlling and directing the body. For instance it minimizes our memory ability and produces sleep problems. One may not experience a new feeling in using the drugs for the first time. But when it is frequently used, the body forms a habit and wants to have the drugs again and again. If we don't get them the person gets anxiety, become emotionally unstable, restless and upset. This implies that the body becomes dependent on the drug and it is called addiction. When one becomes addicted, the mind does not properly perform its activities and the person encounters difficulty in controlling behaviour. It is due to this disorder of the mind that its impact/damage on the users' duty/task becomes more severe. Severe drug addiction often goes hand in hand with criminal activity and prostitution in order to get money to buy more. Drugs also disorder the functions of other parts of the body; they damage heart, kidney, lung and liver and may cause cancer. We may not be aware of the damage the drugs incur on our reproductive organs but it is proved amply through research. Some drugs seem to temporarily stimulate sexual desire but in fact they abate/weaken the glands that produce hormones that control the sexual desire and in the long term may cause both males and females to absolutely lose interest in having sex at all.

Generally Useful Strategies against Addiction

1. **Talk to others:** Have group members list who they have available to talk with if needed. Plan how they will ask others for help. Preplanning this reduces stress.
2. **Stay active:** Have group members list three activities they can use to take their mind off using drugs or drinking.
3. **Use positive affirmations:** Suggest positive thoughts to replace negative thoughts, for example, replacing "I can't stand this anymore" with "I can do this for today." Have group members list three positive thoughts.
4. **Use substitute rewards:** List ways that people can reward themselves: watching a movie, taking a walk, calling a friend, eating a favourite food, taking a bath, listening to a favourite CD, taking a nap, cooking a meal, exercising, watching TV, reading a book or magazine. Have each group member list three rewards for himself or herself.
5. **Go to a support group meeting:** Have group members specify how many meetings they will attend, where, and what days and times. Planning this out ahead of time gives the individual something to look forward to and reduces the stress of having to decide on a daily basis.
6. **Find and work with a recovery program sponsor.**
7. **Read program or spiritual literature.**
8. **Say the Serenity Prayer or other helpful prayers or slogans.**
9. **Start and end each day with recovery-oriented activity:** Many recovering people who set aside a few minutes for meditation and prayer at the beginning and end of every day find it helps them manage stress and keep anxiety down.

10. **Make a gratitude list.**
11. **Make a list of the good things about being sober.**
12. **Stay in the present:** Focus on what's going on around them and the next task in front of them, instead of worrying about things in the past they can't change or things in the future that may not happen.
13. **Avoid difficult situations when possible:** For parties and so on, ask "Do I really want to go? Do I need to go, or can I skip it?"
14. **Prepare for challenging situations that can‰t be avoided:** Talk about them in advance with a sponsor, recovering friends, or home group, and give them a report of how things went afterward.
15. **Keep a cell phone and a list of phone numbers of support people handy.**
16. **Plan how to leave situations that make them uncomfortable or stressed:** For example, take their own cars to parties where difficult situations may come up so they can leave whenever they need to. For many situations, people may want to plan on making a short appearance and then leaving quickly.
17. **Don't go into tough situations alone if it can be avoided:** For expected trigger situations, it can help to ask another recovering person to come along for support.
18. Plan sober activities or celebrations for holidays or other difficult times.

Where to go if you have drug problems

Detoxification Programs - Intended to provide a safe environment for withdrawal from psychoactive chemicals. Usually take place in either a hospital chemical dependency unit or a detox facility primarily designed for chemical addiction. Duration of these programs vary for two days to 14 days depending on the drug used and the severity of the use.

Residential / Inpatient Treatment - Residential refers to programs that exist outside of medical settings e.g. Therapeutic communities, Inpatient programs, social model recovery homes. Mostly called rehabilitation centers.

Outpatient Programs - Treatment structures that allow patients to continue working, attend school, and manage their daily lives all while remaining at their own homes. Designed for patients who do not need intensive or structured care, but still require assistance with their addictions. The patient usually attends 1 to 2 one and half hours to three hours treatment sessions per week for 6 to 12 weeks. Treatment sessions usually include: Individual counselling, Group counselling and, Family counselling, Educational and vocational components, Intensive outpatient is usually followed by aftercare which includes AA or NA and outpatient counselling.

Exercise 15: The disadvantages of drugs and substance abuse

Objective: Participants realise that there are more disadvantages than advantages

Method: Group work, analytical questions

Tools: Brain storming and open discussion

Time: 20 minutes

Facilitator's tasks:

1. Introduce the exercise
2. Ask participants to identify advantages and disadvantages of alcohol and drug abuse.
3. Ask participants to explain and elabo rate their points
4. Ask a participant to write on the flip chart points raised

Take Action: After realising that there are more disadvantages than benefits, what should we do?

Thinking about change

- Keep track of your drug use, including when and how much you use. This will give you a better sense of the role the addiction is playing in your life.
- List the pros and cons of quitting, as well as the costs and benefits of continuing your drug abuse.
- Consider the things that are important to you, such as your partner, your kids, your career, or your health. How does your drug use affect those things?
- Talk it over with someone you trust. Ask the person how he or she feels about your drug use.
- Ask yourself if there's anything preventing you from changing. What are some things that could help you make the change?

Preparing for change: 5 key steps to addiction recovery

1. Remind yourself of the reasons you want to change.
2. Think about your past attempts at quitting, if any. What worked? What didn't?
3. Set specific, measurable goals, such as a quit date or limits on your drug use.
4. Remove reminders of your addiction from your home and workplace.
5. Tell friends and family that you're quitting and ask for their support.
6. Seek medical advice

Reasons for taking addictive drugs

There are many reasons that lead young people into drug addiction. To enjoy youth life; to establish friendship with others; eagerness to taste, and peer pressure are frequently mentioned as being among the original reasons to start taking drugs. Due to frequent consumption, an addiction occurs sooner or later. The desire to have the substance arises more frequently

and stronger. Occasional abuse has become an addiction. Addiction leads to dependency. Currently unemployment is a source of anxiety for many young people. To avoid the anxiety and exasperation they tend to drinking alcohol, and start using other drugs like cigarette and chat. Gradually, when the situation allows, they may shift to the more addictive ones like hashish, heroine or cocaine. It produces a more compulsive use and dependence on the drug, and makes it difficult to give up without professional assistance.

Some examples for the disadvantages of alcohol abuse

- Problems remembering things you recently said or did
- Getting drunk on a regular basis
- Lying about how much alcohol you are drinking
- Thinking that alcohol is necessary to have fun
- Having frequent hangovers
- Feeling run-down, depressed, or even suicidal
- Having "blackouts"- forgetting what you did while drinking
- Having problems at school or getting in trouble with the law

Watch out if

- Substances are taken in larger amounts or over a longer period than was intended
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
- Important social, occupational, or recreational activities are given up or reduced because of substance use.
- The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
- Recurrent substance use resulting in a failure to fulfil major role obligations at work, school, or home.
- Recurrent substance use in situations in which it is physically hazardous.
- Recurrent substance-related legal problems.
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

Types of addictive substances

Permitted	Illegal
• Alcoholic drinks • Pain killers • Sedatives • Cigarette • Coffee • Chat	• Cocaine • Heroine • Morphine • Amphetamines • Marijuana and cannabis

Alcohol

Category and name	*Examples of Commercial & Street Names*	*How it is consumed*
Alcohol (ethyl alcohol)	Found e.g. in liquor, beer, and wine	By drinking

Acute Effects - In low doses, euphoria, mild stimulation, relaxation, lowered inhibitions; in higher doses, drowsiness, slurred speech, nausea, emotional volatility, loss of coordination, visual distortions, impaired memory, sexual dysfunction, loss of consciousness
Health Risks - Increased risk of injuries, violence, fetal damage (in pregnant women); depression; neurologic deficits; hypertension; liver and heart disease; addiction; fatal overdose

Nicotine

Category and name	*Examples of Commercial & Street Names*	*How it is administered*
Nicotine	Found in cigarettes, cigars, bidis, and smokeless tobacco (snuff, spit tobacco, chew)	Smoked, snorted, chewed

Acute Effects - Increased blood pressure and heart rate

Health Risks - Chronic lung disease; cardiovascular disease; stroke; cancers of the mouth, pharynx, larynx, esophagus, stomach, pancreas, cervix, kidney, bladder, and acute myeloid leukemia; adverse pregnancy outcomes; addiction

Cannabinoids

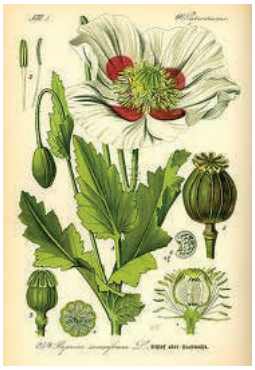
Category and name	*Examples of Commercial & Street Names*	*How it is consumed*
Marijuana	Blunt, dope, ganja, grass, herb, joint, bud, Mary Jane, pot, reefer, green, trees, smoke, sinsemilla, skunk, weed	Smoked, swallowed
Hashish	Boom, gangster, hash, hash oil, hemp	Smoked, swallowed

Acute Effects - Euphoria; relaxation; slowed reaction time; distorted sensory perception; impaired balance and coordination; increased heart rate and appetite; impaired learning, memory; anxiety; panic attacks; psychosis

Health Risks - Cough, frequent respiratory infections; possible mental health decline; addiction

Opioids

Category and name	*Examples of Commercial & Street Names*	*How it is consumed*
Heroin	Diacetylmorphine: smack, horse, brown sugar, dope, H, junk, skag, skunk, white horse, China white; cheese (with OTC cold medicine and antihistamine)	Injected, smoked, snorted
Opium	Laudanum, paregoric: *big O, black stuff, block, gum, hop*	Swallowed, smoked



Opium plant

Opium poppy

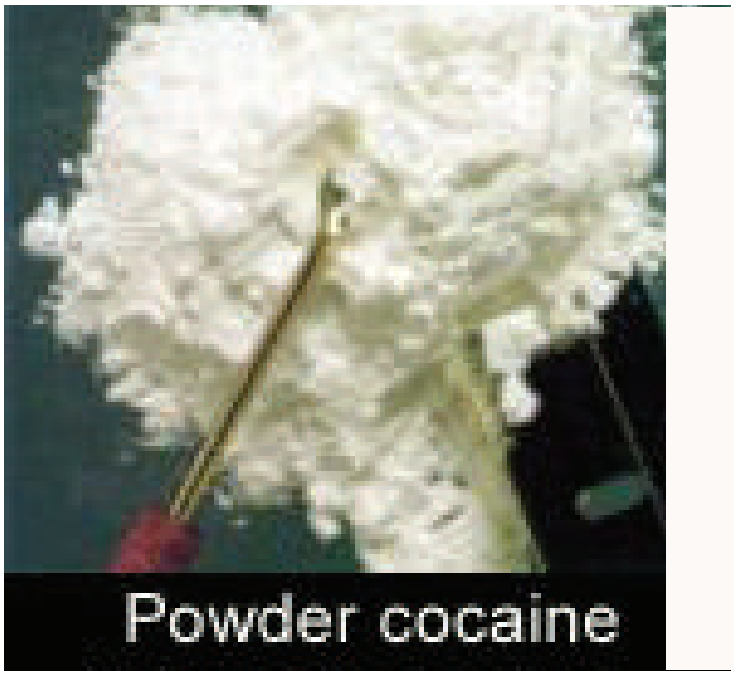
Stimulants

Category and name	*Examples of Commercial & Street Names*	*How it is administered*
Cocaine	*Cocaine hydrochloride:* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	snorted, smoked, injected
Amphetamine	*Biphetamine, Dexedrine:* bennies, black beauties, crosses, hearts, LA turna-round, speed, truck drivers, uppers	swallowed, snorted, smoked, injected
Methamphetamine	*Desoxyn:* meth, ice, crank, chalk, crystal, fire, glass, go fast, speed	swallowed, snorted, smoked, injected

Acute Effects - Increased heart rate, blood pressure, body temperature, metabolism; feelings of exhilaration; increased energy, mental alertness; tremors; reduced appetite; irritability; anxiety; panic; paranoia; violent behavior; psychosis

Health Risks - Weight loss, insomnia; cardiac or cardiovascular complications; stroke; seizures; addiction

Also, for cocaine – Nasal damage from snorting
Also, for methamphetamine – Severe dental problems



Additional information on Alcohol, Nicotine, Khat, Cannabis and Cocaine

Cigarettes, khat, alcoholic drinks and pain killers often work as 'gateway drugs' to more harmful and addictive drugs. Since they are permitted and easily available, many youths get used to them gradually and unintentionally become addicted to them, which will affect their health, emotions and social life.

1. Alcohol

Alcoholic drinks are free to use and available anywhere in big quantities. When it is drunk it creates a euphoric feeling. One may think that drinking alcohol frequently and excessively doesn't lead to addiction, but it does. It may also become uncontrollable and diminishes the ability of the memory. While drinking, we may not realize it but it also diminishes the skill of self-monitoring, one gets rid of shyness and behaves inappropriately. It can encourage us to do the things we don't dare to do at other times, and as a result we will feel guilty when the flush is gone. Under the influence of alcohol, especially young people tend to ignore the common norms and practices and show risky sexual behaviour. We lose our capacity of making sound judgments and decisions. Drinking alcohol during pregnancy is very dangerous. We should realize the fetus is also taking alcohol and can be born with physical disability, premature /weakly developed body parts like heart, bones, brain and face. The fetus can also be deformed/skinny, retarded and poor in learning.

2. Nicotine

Cigarettes contain many substances including nicotine and carbon monoxide tar. Nicotine is highly addictive. Smoking cigarettes does not cause immediate death, but it gradually leads to ill health and death. As the UN health organization announced recently, four million persons die every year due to problems related to smoking cigarettes. Research proves that cigarettes are harmful for the youth. Cigarette smokers affect not only themselves but also the other people around them. As a result, in many places notices that prohibit smoking are posted. In addition to this, in many European and American cities cigarette companies are legally obliged to write the harmfulness of cigarettes on the package. Realizing the harm smoking causes on the society, smoking on e.g. the streets of Tokyo, the capital city of Japan, and Nairobi, Kenya, has been prohibited.

Since nicotine/cigarettes causes harm on the body gradually, the life of smokers is shorter than non-smokers. Smoking cigarettes has many health effects.

- Bronchitis
- Heart attack
- Lips, mouth, tongue and stomach cancer;
- As it affects the pituitary gland that secrets the hormones negatively, smoker women can experience repeated abortion;
- the chance of ovum moving from ovaries to the fallopian tube would be very weak and as a result infertility/sterility may occur;
- as it weakens sex hormones, sexual desire and performance diminishes; etc.

3. Chewing Khat

Khat originates from Ethiopia and is now spread into many neighbouring countries including Yemen. Dr. Mohamed al Kamel of the Medical faculty of Ayeneshames University in Cairo has conducted and published his research on khat. The scientific name of khat is Catha Edulis. It does not produce any fruit. The soft leaves are taken either by chewing them or having them pounded. In the soft leaves of khat there is a substance by the name Cathinone that affect brain and nervous systems. This substance has close resemblance with Amphetamine. After 48 hours of harvest/collection, the Cathinone in the soft leaves converted into its weaker level called Cathine. These substances stimulate the brain and the spinal cord.

Chewing khat causes the following feelings or users claim they experience the following feelings; initially it has unpleasant feeling and causes depression but gradually entails euphoric feelings;

- Under any circumstance chat stimulates mood/feelings/emotions
- It provides a feeling of hallucination/fantasy;
- Some say they become motivated and get clear vision;
- Entails feeling of euphoria
- It makes active/ awake
- Relives from depression and exhaustion;
- Provides self-confidence;
- Creates cordial feeling;
- Has positive impact on sexual desire;
- Minimizes the feeling of hunger;

Khat also has a lot of side-effects

- Insomnia
- Loss of appetite
- Causes problems on the breathing system
- Fastened heart beat
- Gastritis
- Overload on the function of liver
- Changes the colour of teeth permanently
- Depression
- Become easily annoyed, irritated, and restless
- Plunge Into Emotional Dependence
- Puts Children And Persons Above 55 In Danger

When Khat is taken in larger amounts and upon prolonged and repeated use, it becomes an addiction. People addicted to khat cannot stay long without it and get easily fatigued and inactive. Breaking khat addiction is as difficult as getting rid of an addiction from cocaine. It requires similar treatment.

4. Cannabis

Cannabis sativa, as a plant species, is the source of marijuana and hashish. The blossoming/flowering part of the plant produces sticky liquid which has the substances/elements of marijuana and hashish. Hashish is found only in the blossoming/flowering part of the plant; whereas marijuana is found both in the blossoming/flowering part and the leaves of the plant. Both are taken in smoking and their impact on the body is more or less the same. Put in a relaxed mood; give a feeling of prolonged time; feeling of loudness in the voices they hear, and a sense of exaggeration in the items they taste, touch and smell. If taken right before driving a car, it would be extremely dangerous. It also affects the lung. On young users, as it affects their mind, it may disrupt their education and this makes the problem more worrisome.

According to the American National Drug Abuse Institute, there are about 200 types of cannabis. In Ethiopia there is one by the name Hallucinogenic plants. In all of these, there are about 400 different chemicals/ substances and THC is the prominent one. All of them are taken in the form of smoking and their impact in the body is more or less the same. Blend with our blood cells the substance/chemical of marijuana affects/harms our health. Its level in the body is identified through urine test.

Marijuana confuses the activities/function of the mind and as a result it has negative impacts on the learning and remembering process. It affects the ability to understand; decreases the skill of thinking and solving problems; fastens heartbeat; entails anxiety and fright. Smoking marijuana can easily motivate to rebellion and riot. It has also social cost. For instance, as confirmed through research in America students who smoke marijuana scored less result than the others. In a family it generates discord/disagreement with parents.

5. Cocaine

Cocaine is sour, white, crystallized powder which is obtained from the leaves of the coca plant grown in the wild in South America. Cocaine acts as an anaesthetic because it interrupts bleeding. Abuse or misuse of cocaine leads to critical physical and psychological problems. It is a highly addictive drug. Once a person starts using it, it would be difficult to know when to stop it. There are three ways of using cocaine. In the first type the white powder is sniffed through the nose and the cocaine is readily absorbed into the bloodstream through the nasal mucous membranes, then it stimulates brain and the nerves system. The other type is taking cocaine through injection and automatically blends with blood. In the third type the cocaine is smoked like cigarette and it immediately reaches to our mind through the lung cells. For a short period it produces feeling high. When an addicted user stops taking it, s/he becomes depressed and to get relief of the depression the intake increases. This leads to high levels of addiction and dependency.

6. Heroin[6]

Heroin is a highly addictive drug derived from morphine, which is obtained from the opium poppy. It is a "downer" or depressant that affects the brain's pleasure systems and interferes with the brain's ability to perceive pain. It is a white to dark brown powder or tar-like substance. Heroin can be injected, smoked or snorted. The short-term effects of heroin abuse appear soon after a single dose and disappear in a few hours. After an injection of heroin, the user reports feeling a surge of euphoria accompanied by a warm flushing of the skin, a dry mouth, and heavy extremities. Following this initial euphoria, the user enters an alternately wakeful and drowsy

state. Mental functioning becomes clouded due to the depression of the central nervous system. Other effects included slowed and slurred speech, slow gait, constricted pupils, droopy eyelids, impaired night vision, vomiting, constipation. Long-term effects of heroin appear after repeated use for some period of time. Chronic users may develop collapsed veins, infection of the heart lining and valves, abscesses, cellulites, and liver disease. Pulmonary complications, including various types of pneumonia, may result from the poor health condition of the abuser, as well as from heroin's depressing effects on respiration. In addition to the effects of the drug itself, street heroin may have additives that do not really dissolve and result in clogging the blood vessels that lead to the lungs, liver, kidneys, or brain. This can cause infection or even death of small patches of cells in vital organs. With regular heroin use, tolerance develops. This means the abuser must use more heroin to achieve the same intensity or effect. As higher doses are used over time, physical dependence and addiction develop. With physical dependence, the body has adapted to the presence of the drug and withdrawal symptoms may occur if use is reduced or stopped. Withdrawal, which in regular abusers may occur as early as a few hours after the last administration, produces drug craving, restlessness, muscle and bone pain, insomnia, diarrhea and vomiting, cold flashes with goose bumps, kicking movements and other symptoms. Major withdrawal symptoms peak between 48 and 72 hours after the last does and subside after about a week. Sudden withdrawal by heavily dependent users who are in poor health can be fatal. Heroin users are facing a high risk of HIV infection if they share needles.

In 2004, 13.8 million people world wide died from drug consumption.

[6]*Adapted from http://www.drugfree.org/drug-guide/heroin*

Chapter 6: Harmful Traditional Practices

6.1 Female Genital Mutilation (FGM)

Mainly women and girls are affected by harmful traditional practices which are common practice in many countries. Such practices include female genital cutting or circumcision, marriage of very young girls with much older men, early marriage, inheritance marriage and marriage by abduction. What kind of problems do these practices create for our sisters and mothers? How do we judge them in terms of human rights? Do we have to accept things as they are? In the next activity we learn about harmful traditional practices based on these questions.

Exercise 16: Female Genital Mutilation (FGM) and its Consequences

Objective: To enable participants identify types and consequences of FGM
Method: Explore experiences and the persistent culture in their environment
Tools: Story or role play
Time: 40 minutes

Facilitator's tasks:

1. Introduce FGM (see basic information)
2. Read the story below or ask a participant to read the story.
3. Alternatively, you can also assign and four participants to prepare a role play based on the story.
3. Ask participants what they know about FGM from their reading and information obtained.
4. List their answers on a flip chart under the headings "Causes" and "Consequences".
5. Raise questions for discussion and correct answers of the participants

Story

An 18 years old mutilated girl heard that her parents were about to mutilate her 10 year old young sister. She argued to convince her parents not to mutilate her younger sister providing various reasons, but her parents did not accept her points and decided to mutilate the girl secretly. The elder sister, discovering the day of mutilation, begged her friends to save her sister explaining the type and consequences of the act. Her four friends decided to stop the mutilation of the girl and along with other friends they went to the house in the evening and surrounded/encircled it before the girl was mutilated. There they informed the people not to mutilate the girl substantiating their argument with scientific evidences. On the other hand the parents tried to explain its benefit mentioning that it would make her more disciplined no difficulty in getting a husband, etc. Finally the girls informed the parents that if they went for the mutilation, they would report it to the Police and get penalized; the parents became afraid of the consequences and stopped the mutilation.

based on the basic information given below.

- How many types of mutilation do you know about?
- What reasons are given to conduct FGM?
- What are the main consequences of FGM?
- What can peers do to prevent FGM?

6. Summary – close the discussion explaining the types and consequences of FGM. *(See basic information below).*

Exercise 17: Early Marriage and its consequences

Objective: Enable participants to challenge early marriage and know the consequences

Method: Contemplate and analyze related problems occurred on a girl and her friends

Tools: Rose's letter, explanatory questions, discussion

Time: 35 minutes

Facilitator's tasks:

1. Introduce the exercise
2. Request the participants to sit relaxed and close their eyes.
3. Ask a volunteer to read Rose's letter (see the letter below).
4. After the reading of the letter facilitator asks the following questions for discussion/explanation:
   - What problems did Rose face? Why?
   - What are the consequences of early marriage? Why?
   - Why did the obstetric fistula happen?
5. To conclude the lesson the exercise would be summarized as follows:
   - The body is capable to host a pregnancy after having reached the age of 18 years
   - Legally, the minimum age for marriage is 18 years.
   - Early marriage violates the human right to physical wellbeing.
   - Early marriage entails rape and infection of the not-fully developed vagina
   - As the genitals are not fully developed, during labour they may not be able to let the fetus out.
   - As her hips/pelvis bones are not strong enough, it would be difficult for her to bear the labour pain. They baby may not fit through the pelvis with all related consequences.
   - She may not be mature enough to shoulder the responsibility of leading a family and bringing up children.
6. Practice –Ask what participants could do to challenge early marriage.
   - Should we keep quiet doing nothing?
   - What efforts could you exert to rescue a girl who gets married in her early ages in your community?

ROSE'S LETTER

A letter to her father from a fistula project

Dad:

. . . Although it is disgusting I have to tell you. It can be a lesson for you not to put my sisters in a life full of suffering like mine. This is what they explained to me: Getting married at young age causes a lot of problems. I got pregnant while I was physically too young and my pelvis was of small size. My labour took days, and when I could not give birth, my baby died inside me. The deceased fetus, when its head shrinks, gets out but pierces your body. I lost both my baby and my healthy body. Even if rarely the fetus is born alive, due to lengthy labour it will definitely come out tearing holes into the tissue. What results is what they call a fistula, an abnormal duct or passageway in the body. For some, it happens between the rectum and the vagina. Those affected by such type of fistula, like Diana, excrete through their vagina. Some of them have undergone surgery and have recovered, while others still need further medical treatment. The other type is a hole between the bladder and the vagina. This is exactly my problem, and that of Aisha. As they told me since Aisha's case was minor, she underwent surgery and was released. Dad, Sarah who has arrived recently has been repaired and would go back soon. In my case, and some others, the bladder is totally damaged and cannot be repaired; thus they help us to urinate through an artificially fitted plastic bag. We move around with the plastic bag. Those of us who do not have access to medical services in our communities have been allowed to stay in their village for closer medical follow-up. We are involved in different activities like embroidery, weaving, and gardening. The village has an atmosphere of a countryside place. Because we spend most of our time doing things and playing, we do not think of our plastic bags, the pain and the suffering and the babies we have lost. It is really a village of happiness. In the future you may come and visit me.

Your daughter
Rose

Basic Information

Female Genital Mutilation (FGM)

Female genital mutilation (FGM), also known as female genital cutting or female circumcision, is defined by the World Health Organization (WHO) as "all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons." FGM is typically carried out on girls from a few days old to puberty. It may take place in a hospital, but is usually performed, without anaesthesia, by a traditional circumciser using a knife, razor, or scissors. According to the WHO, it is practiced in 28 countries in western, eastern, and north-eastern Africa, in parts of the Middle East, and within some immigrant communities in Europe, North America, and Australasia. The WHO estimates that 100–140 million women and girls around the world have experienced the procedure, including 92 million in Africa. The practice is carried out by some communities who believe it reduces a woman's libido. The WHO has offered four classifications of FGM. The main three are Type I, removal of

the clitoral hood, almost invariably accompanied by removal of the clitoris itself (clitoridectomy); Type II, removal of the clitoris and inner labia; and Type III (infibulation), removal of all or part of the inner and outer labia, and usually the clitoris, and the fusion of the wound, leaving a small hole for the passage of urine and menstrual blood—the fused wound is opened for intercourse and childbirth. Around 85 percent of women who undergo FGM experience Types I and II, and 15 percent Type III, though Type III is the most common procedure in several countries, including Sudan, Somalia, and Djibouti. Several miscellaneous acts are categorized as Type IV. These range from a symbolic pricking or piercing of the clitoris or labia, to cauterization of the clitoris, cutting into the vagina to widen it (gishiri cutting), and introducing corrosive substances to tighten it. Opposition to FGM focuses on human rights violations, lack of informed consent, and health risks, which include fatal hemorrhaging, epidermoid cysts, recurrent urinary and vaginal infections, chronic pain, and obstetrical complications[7].

Reasons given for practicing FGM

FGM is not something practiced all over the world. It is unknown in developed countries in Europe and America, and in most Asian countries, where for health/hygienic reasons, male circumcisions are conducted more frequently. In Africa, however, FGM is a widely spread tradition and practiced in 28 different countries including Ethiopia, Kenya, Tanzania and Uganda. Various cultural and traditional reasons for practicing FGM are given, it is basically is a gender related problem and has no relation to and no meaning for biological sex and human reproduction. As we discussed previously, gender is man-made (a social construct) and can be changed (See Module 5). FGM is a human rights violation.

The following arguments are among those brought forward by people favouring FGM:

- It is a very old tradition
- Uncircumcised women will face difficulties in finding a husband, men do not marry uncircumcised women
- Women who are not mutilated are believed to have an ongoing strong desire for sex
- A woman must be mutilated to satisfy the sexual needs of the male To preserve the virginity of a woman until she is married
- It is believed that a girl who is not mutilated will break household items

[7] http://en.wikipedia.org/wiki/Female_genital_mutilation

BUT:

- There is no rational, logical or scientific basis for FGM
- Negative health consequences include lack of sexual pleasure, psychological effects, heavy bleeding, problems in childbirth, urinary infections, trauma
  It is not advocated in Christianity or Islam, quite the contrary.
- It is prohibited in most countries and has legal consequences.
  It is against human rights.
- The pain and suffering of children undergoing FGM has a lasting legacy on health and relationship with parents.
- An important part of the body is taken away or damaged, feel less of a woman.
- Leads to problems with sexual relationships, sexuality and in particular women's relationship with her husband.
- It does nothing to stop pre-marital sex [8].

6.2 Early/Arranged Marriage

Early marriage refers to the marriage of girls during childhood or before the right physical maturity. (Normally below 18 years in most countries) There are a lot of ethnic groups that conduct the marriage of their children at early stage i.e. 10 to 14 years. This usually entails rape and infection on their not fully matured vagina and uterus. They are also vulnerable to early pregnancy and as the girls' hips/pelvis and uteri are not fully developed, they could not bear the pain during labour/delivery. Some of them may die or suffer from obstetric fistula (see the basic information below). The reasons given for practicing early marriage are similar to the reasons given for FGM. The primary and main reason is to preserve the virginity of a girl until she is married. To establish marriage relations with respected/well-to-do family parents exchange oral promises to give each other their children in marriage right after the birth of their children. This practice gradually becomes part of the culture and girls are obliged to get married at early age. As we discussed previously, the reproductive organs of a woman develop from early youth age until 18; thus before this time, a girl is not mature enough to bear and deliver a child. Early marriage entails rape; this again causes infections/wounds on the immature/not fully developed reproductive organs like genitals/vagina and uterus. As pelvis and uterus are not fully mature, labour is extremely painful and often obstructed. Some die and others suffer birth injuries including obstetric fistula.

[8] *Tackling Female Genital Mutilation (FGM) Special Initiative PEER RESEARCH. http://esmeefairbairn.org.uk/news-and-learning/publications/tackling-fgm-special-initiative-peer-research*

6.3 Marriage by Abduction

Marriage by abduction is one of the practices of forced marriage. It is common practice in most parts of Ethiopia, but very common in Southern Ethiopia and the Oromia Region. Various reasons are given for practicing marriage by abduction: When the man has financial difficulty to give dowry; inability to prepare wedding feast; when the abductor is not the choice of the girls' parents; and to beat another rival. Once the girl is abducted and raped she may be considered as unclean and unwanted by others, due to this both the girl and her parents are obliged to accept the kidnapping and approve it with marriage. In our previous discussion, we have seen that marriage by abduction is a gender violent practice that ensures the superiority of men. It should be underlined that it is a practice against the human rights and personality of women. Its consequences include all the discussed health impacts of childhood/early marriage and unwanted/early pregnancy, and gender based violence. According to the Ethiopian Criminal Code Article 558/1 marriage by abduction/kidnapping can be sentenced with up to three years of imprisonment.

6.4 Marriage of Unequal Ages

Like marriage by abduction, other forms of forced marriage are also practiced. Marriage of unequal ages takes place to establish relations with rich families or seeking for virginity. Girls are obliged or forced to marry an old man. This can be her first marriage for the girl but for the man it can be one of many.

6.5 Inheritance marriage

In some areas if the husband dies, the widow is obliged to marry her brother-in-law or relatives of her late husband. This seems to keep the property of her husband within his family. In some other cultures, as the man marries by giving dowry, if his wife dies, he is allowed to marry his sister-in-law without her consent.

Annex - Tools and master copies for Module 4

List of learning tools

- SRH Facilitators' Training Manual
- Flip Chart, Flip Chart Paper Or Large Sheets Of Paper
- Markers In Different Colours
- Chalk To Write On The Floor Or A Black Board
- Note Paper
- Cello Tape
- Cards Or Slips Of Paper, Scrap Paper To Cut Notes

Module 5

Gender and Gender- Based Violence

DSW

Table of Contents

Introduction

This Module has two Chapters. Throughout the module, the trainee facilitator, using participatory learning methods and tools, makes participants practice and understand the concepts of gender (Chapter 1) and gender-based violence (Chapter 2).

Gender norms and roles are in the focus of Chapter 1. They affect the lives of boys and girls, men and women. They determine what is expected of a man and a woman in their society, they shape their responsibilities and behavior in all aspects of their living, including their reproductive and sexual life. Gender thus has a big influence on sexual health. Many societies uphold gender norms that disadvantage women, or even boys.

Gender roles are learned and thus changeable. In fact, gender norms are changing all over the world and the differences between what men and women are supposed to do or not, decrease. Young people are often at the forefront of change by openly challenging outdated gender norms.

Achieving gender equality is one of the UN Millennium Development Goals since sustainable development can only be reached if all members of society, men and women, have the same opportunities and chances in life.

Chapter two addresses Gender based violence (GBV). GBV is any harmful act that is perpetrated against a person's will, and that is based on socially ascribed differences between males and females. It includes sexual violence, emotional violence, physical violence and harmful practices such as female genital mutilation.

Gender-based violence is always a human rights violation. Ensuring that people know that they have the right to live free of violence is thus central to fighting gender-based violence. In order to combat GBV the underlying gender norms and attitudes that make gender based violence accepted must be addressed. Ultimately, GBV is about relationships, partnerships and how we treat each other, so both men and women need to join hands to eliminate gender-based violence.

The facilitation of this module with all its exercises is expected to take about 7 hours.

Learning objectives

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

- Reflect upon gender roles, norms and attributes and discuss their impact
- Discuss and reflect upon existing imbalances and repercussions for you people's lives
- Describe gender-based violence, its characteristics and consequences
- Describe ways to prevent gender-based violence and take action against it

Chapter 1: Gender

1.1 Sex and Gender[1]

Warm-up:	Being Male or Female
Objective:	To become conscious for gender differences
Method:	Group discussion
Tools:	none
Time:	15 minutes

Facilitator's tasks:

1. Ask participants to stand up and to demonstrate a stance or a posture which depicts how men and women are perceived in their society. (If the group members are all the same sex, ask all participants to depict male postures, then ask all participants to depict female postures.)
2. Ask each participant to describe what his/her stance or posture shows. Ask them to consider what the stance or posture reflects about society's perceptions of men and women.
3. Thank participants for their contribution and introduce the module's topic – gender – referring to the warm-up exercise. Also explain that throughout this training session/ Module, participants may be encouraged to share memories and experiences related to gender issues, and that these memories and experiences may at times be difficult to discuss. Emphasize the importance of listening to others in a supportive way, without judgement, and of keeping all experiences shared in the group confidential. There is no obligation for anyone to share personal experiences or history with the group if they do not feel comfortable doing so.

[1] *Training manual VAW module (status as at 01.03.2010(2)), United Nations Economic and Social Commission for Western Asia (UN-ESCWA), 2010, retrieved from the world wide web on 28th March 2013: http://css.escwa.org.lb/sd/1269/4.pdf*

Exercise 1: Understanding the differences between gender and sex

Objective: Participants discuss and understand the differences between gender and sex and are able to recognise gender stereotypes.

Method: Group discussion

Tools: Cards, markers, flip chart/board

Time: 25 minutes

Facilitator's tasks:

1. Introduce the topic.
2. Draw three columns on the paper. Label the first column 'woman' and leave the other two blank. Ask participants to identify all characteristics (biological and non-biological) that are associated with women. Allow comments including stereotypes prevalent in the participants' communities. Write down their suggestions in the 'woman' column.
3. Next, label the third column 'man' and ask participants to again make a list of all characteristics (biological and non-biological) that are associated with men. These may include stereotypes prevalent in the participants' communities. Write down their suggestions in the 'man' column.
4. Ensure that participants also provide examples related to reproductive health. Ensure that both columns include positive and negative words or phrases, for example:

Girls and young women

- Are biologically more susceptible to stis and hiv
- Are at greater risk of morbidity and mortality
- Have natural skills to raise children
- Have the ability to cook
- Are beautiful
- Cannot play soccer
- Are unable to negotiate condom use effectively
- Have vaginas
- Are bad drivers
- Can breastfeed
- Can get pregnant and give birth to babies
- Menstruate
- Are shy
- Are emotional

Boys and young men:

- Are under peer pressure to be sexually active
- Are dominant
- Cannot cook
- Do not feel comfortable using reproductive health services
- Don't cry
- Avoid responsibility

- Have penises
- Experience wet dreams
- Are strong
- Can grow beards
- Produce sperm

5. Now reverse the headings of the first and third columns by writing 'man' above the first column and 'woman' above the third column. Working down the list, ask the participants whether men can exhibit the characteristics attributed to women and vice versa. (Make sure you have examples at hand if for example all participants agree that men can't cook) Place those attributes that are never interchangeable into the middle column, and label this column 'sex'.
6. Expect participants to debate the meanings of some words; one of the goals of this exercise is to demonstrate that people assign different meanings to most characteristics that are gender-based.
7. Summarize the new knowledge and emphasize that sex has to do with biological and genetic matters and is not interchangeable, whereas gender refers to socially constructed roles, responsibilities, and expectations of males and females in a given culture or society. These roles, responsibilities and expectations are learned from family, friends, communities, opinion leaders, religious institutions, schools, the workplace, advertising, and media (also refer to definitions of sex and gender in the background information). They are also influenced by custom, law, class, ethnicity and individual or institutional bias. The definitions of what it means to be female or male are learned, vary among cultures and change over time.
8. Point out that many people confuse sex with gender or vice versa. The word 'gender' is also often used inappropriately instead of 'sex' (for example, when people are asked their gender instead of their sex on application forms).

Basic information

Definition of sex

1) It stands for the act of sexual intercourse;
2) It refers to the biological and physical difference between males and females. Sex is not changeable and is determined by nature before birth. . Furthermore, sex is universal and the differences are worldwide the same. An individual's sex is a biological characteristic of being a man or a woman.. Sex identifies a person as male or female: type of genital organs (penis, testicles, vagina, and womb); type of predominant hormones circulating in the body (estrogens, testosterone); ability to produce sperm or ova (eggs); ability to give birth and breastfeed children.

Some examples of sex characteristics:

- Women menstruate while men do not
- Men have testicles while women do not
- Women have developed breasts that are usually capable of lactating, while men have not
- Men generally have more massive bones than women

Definition of gender

Gender refers to the socially constructed roles, responsibilities and expectations that a given society considers appropriate for men and women. The concept of gender also includes the expectation about the character, attitudes and likely behaviours of women and men *(feminine and masculine).*

In comparison to sex, gender is a social construct, which is learned and thus changeable. Accordingly, gender roles, attributes and responsibilities can differ from countries and areas (e.g. urban or rural setting), according to social factors like religion, history, culture and tradition.

Some examples of gender characteristics:

- In most of the world, women do more housework than men
- In the United States (and many other countries), women earn significantly less money than men for similar work
- In many countries it is considered more important for boys to go to school than for girls
- In Vietnam, many more men than women smoke, as female smoking has not traditionally been considered appropriate
- In Saudi Arabia men are allowed to drive cars while women are not
- In many countries women and girls are expected to be passive and submissive while men and boys are expected to be active and in a way aggressive.

The difference between sex and gender

	Sex	Gender
What?	Sex refers to the biological characteristics of women and men (penis, vagina, breasts, testes, ovaries, etc.)	Gender refers to the roles, responsibilities and behaviours attributed and associated with women and men
Who defines it?	Sex (male or female) is universally the same	Gender is socially and culturally constructed
When?	Sex is defined pre-birth	Gender identity is learned starting at birth
Can it be changed?	Naturally sex cannot be changed	Gender norms and values vary within and between cultures, they change over time[2]

[2]*Adopted from: Adolescent and Reproductive Health: A Training Manual for Program Managers, Catalyst Consortium, 2004*

1.2 Existing gender roles and attributes

Exercise 2:	Identify existing gender roles and attributes and discuss their impact
Objective:	Participants understand and reflect upon gender-based roles and at tributes and their impact
Method:	Brainstorming
Tools:	Flip chart
Time:	30 minutes

Facilitator's tasks:

1. Divide the group into boys and girls. Provide each of them with a flip chart titled "Roles, responsibilities, behaviours, expectations" (see example below).
2. Ask the female participants to write down in the first column the prevailing norms attributed to men and boys in their society and the male participants write down prevailing norms attributed to women and girls in their society.
3. Exchange the flip charts.
4. Let the groups discuss the roles that the others have attributed to them and how they feel about them. Next to each point, groups should indicate whether they perceive these as positive or negative and what impact these norms have on our identity, personal development, and life choices. Do make sure participants understand that gender norms have a complex impact and that they are not always black and white but there are always different sides to gender norms and that these can be quite contrary.
5. In a third column the groups should write down, how they feel that in future gender relationships and norms should look like.
6. In a next step, have the two groups present and explain their results.
7. Discuss the two presentations in a big group discussion.

Basic Information

Gender norms and values affect the lives of boys and girls, men and women. They determine what is expected of a man and a woman in their society, they shape their responsibilities and behaviour in all aspects of their living. Looking at different societies, these roles and responsibilities are not the same for women and men, they are unequal. Woman are allowed to execute different types of jobs than men, they behave differently in public, have different roles in their family. In the same way, gender norms also shape our reproductive and sexual knowledge, behaviour and life. They decide whether in a society it is accepted for a girl to say 'no' to a man's sexual advances. They decide whether it is ok for a boy to have more than one partner at the same time. Whether or not you have the control over your own sexual life, or whether someone else decides for you, can make a huge difference to your risk in getting infected with HIV or involuntary pregnant. Gender thus has a big influence on our sexual health.

Still today many societies have prevailing gender norms that disadvantage women. Girls do not receive the same education as their brothers; they often have more household chores and less leisure time; many cannot freely decide who and when they want to marry, to leave the house, to go to school, or what to wear. Yet also boys can suffer from gender norms. They are often asked to be brave and assertive; they are under pressure to have money and prepare to become providers; and they are often badly looked at if they express emotions or cry.

Examples:

<table>
<tr><th colspan="4">Men's/Boy's roles, responsibilities, behaviour, expectations</th></tr>
<tr><td>Current</td><td>Positive</td><td>Negative</td><td>Future changes</td></tr>
<tr><td rowspan="2">Men should earn the money for the family</td><td>Men:
feel powerful
feel needed</td><td>Men:
feel pressured
are afraid to commit to a relationship
can feel low self esteem if cannot comply</td><td rowspan="2">Men and women share the responsibility</td></tr>
<tr><td>Women:
feel protected</td><td>Women:
have no say in the family as they hold no resources
are dependent on men</td></tr>
<tr><td rowspan="2">Men have to show they are potent through having sex early</td><td rowspan="2"></td><td>Men:
feel pressured to engage in sexual behaviour
risk their own and others health</td><td rowspan="2">Men and women should be able t decide when to engage in sexual behaviour</td></tr>
<tr><td>Women:
are being sexually harassed</td></tr>
</table>

Women's/Girl's roles, responsibilities, behaviour, expectations			
Current	Positive	Negative	Future changes
Woman should do all household chores		Women feel less valued cannot go to school or get a job can be very exhausting	Men and women share the responsibility
		Men If woman falls ill, men will not know how to cook for their children	
Woman are not allowed to say no to sexual advances		Women feel scared physical and psychological pain risk unwanted pregnancy	Woman should have the control over their own sexual health

1.3 Changing unequal gender relations

Exercise 3: Develop an action plan to change gender norms and values

Objective: Participants define actions that have to be taken in order to achieve gender equality.

Method: Brainstorming

Tools: Flip chart

Time: 30 minutes

Facilitators' tasks:

1. Using the results from the previous exercise (Exercise 2), ask participants to go back to the tables on the flip charts and to rank the results according to their importance and choose the three most important issues for each group.
2. Ask participants to reflect what would happen if the identified future situations was to be achieved? What are the consequences? How does it change their life and that of the community? Could there be also negative consequences such as that men feel that women take away their power? Ensure that participants understand that changing gender norms and values is not always easy and sometimes involves conflict.
3. In a next step ask participants to discuss what can be done to achieve gender equality in the community and change these identified gender norms and values.
4. Fill out an Action Plan stating what should be achieved, how this can be achieved, who is needed as partners, and identify concrete actions.

Examples

	Action Plan for Change			
What do we want to achieve?	Consequences?	How?	With whom?	Action
Men and women share the responsibility for earning income of the family	When everyone can develop and apply her or his talent everyone benefits Increased income for the family Men have more time to be fathers Women feel self empowered Role model for others	Making parents understand that boys and girls have equal rights to go to school and follow a career Supporting each other in our relationships Accepting that men and women have the same rights	Peers Parents Community leaders	As individuals speak to your parent about your ideas Support your girlfriend/boyfriend in their choices As a group organize a meeting with community leaders to discuss your ideas
Women should have the control over their own sexual health	They can prevent unwanted pregnancy Increased confidence	Women and men need to know their rights Violations against these rights should not be accepted Perpetrators need to be punished	Community Law system	Speak up when you witness sexual assault or are a victim Report violations to a lawyer or support organisation Educate others about their rights Identify role models, leaders and convince them to speak on your behave

Basic information

Gender roles are learned. They are not innate or "natural." In fact, almost everything that males can do, females can also do. And almost everything that females can do, males can also do. This also implies that gender roles are not fixed, but flexible and everyone can contribute to changing them. In fact gender norms are changing all over the world, becoming more flexible and the differences between what men and woman are supposed to do or not, are getting smaller and often it is young people like are at the forefront of change through openly challenging outdated gender norms,

Reducing these differences and achieving gender equality, is also one of the United Nations Millennium Development Goals that many countries have committed to, because they have recognized that in order for development to be sustainable, it needs to be fair. This can only be reached if all members of society, men and women, have the same opportunities and chances in life.

Gender and gender equality in the international human rights context

It is essential to free oneself from the impositions of gender-stereotypes and respect them as human and natural rights.

Behaviour and attitudes that are based on gender equality

- Respect the human rights (see information below)
- Develop an attitude and strengthen practices and behaviour that ensure the equality of women and men;
- Develop an attitude and strengthen practices and behaviour that ensure the freedom, security and health of both women and men;

[3] *The International Planned Parenthood Federation (IPPF) has published the Charter on Sexual and Reproductive Rights in 1996. This IPPF charter demonstrates why sexual and reproductive rights are basic human rights. The right to sexual and reproductive health implies that people are able to enjoy a mutually satisfying and safe relationship, free from coercion or violence and without fear of infection or pregnancy, and that they are able to regulate their fertility without adverse or dangerous consequences. http://ippf.org/resources/publications/ippf-charter-sexual-and-reproductive-rights*
IPPF, Charter on Sexual and Reproductive Rights, 1996.

Criteria of equal and unequal gender relations

Any gender related relationship between male and female can be equal or unequal. We label it as equal and unequal using the following yardsticks:

- Human rights instruments enacted by the United National (UN) and the African Union (AU)
- Scientific instruments and evidences
- IPPF Charter on Sexual and Reproductive Rights[3]

Human Rights

Any human being, be it a man or a woman, has equal human rights. Human rights are common for both men and women and these rights are natural and should not be violated.

The following are basic human rights, including reproductive rights (compiled by IPPF, 1996) .

- The Right to Life
- The Right to Liberty and Security of the Person
- The Right to Equality, and to be Free from all Forms of Discrimination
- The Right to Privacy
- The Right to Freedom of Thought
- The Right to Information and Education
- The Right to Choose Whether or Not to Marry and to Found and Plan a Family
- The Right to Decide Whether or When to Have Children
- The Right to Health Care and Health Protection
- The Right to the Benefits of Scientific Progress
- The Right to Freedom of Assembly and Political Participation
- The Right to be Free from Torture and ill Treatment Kingdom

1.4 Summing up Chapter 1

Exercise 4:	Recapitulation and summary of Chapter 1
Objective:	Strengthen participants' understanding of characteristics or features attributed to sex or gender respectively and gender relations
Method:	Completion of summary sheet
Tools:	Gender summary sheet drawn on black board/ flip chart or attached to wall
Time:	30 minutes

Facilitator's tasks:

1. Show participants the Gender Summary Sheet.
2. Ask participants to either individually or jointly tick the appropriate box(es), which apply to the statement shown at the beginning of each line.
3. Compare and discuss answers
4. Summarise lessons learned from Chapter 1

	The Role of men or women	**Sex**	**Gender**	**Changeable man-made**	**Unchangeable natural**	**Right**	**Wrong**
1	Men are physically stronger than women						
2	Women get pregnant and men make them pregnant						
3	Children are named after their fathers, not mothers						
4	Whatever the case women are inferior to men						
5	Bringing up children is the duty of women, men are not obliged						
6	Men do not have menstruation period, women do						
7	Men have the right to ask for sex; it is taboo for women to express their desire						
8	Unwanted pregnancy is the concern for women						
9	Women should be shy and men should be courageous						
10	Women are created to satisfy men						
11	A woman cannot be a pilot						
12	Menstruation is a curse						
13	Only men can be the head of households; women cannot						
14	Women's enrolment in education is low						
15	No man resists the beauty of a beautiful lady and fresh harvest						
17	Women are created incomplete						
18	If a husband rapes his wife, it is his right.						
19	Men are not sexually assaulted.						
20	If a woman has not undergone female genital mutilation she becomes very destructive						
21	Expressing sexual desire is a taboo for women						
22	Men cannot control their sexual desire						
23	Mathematics, pure science and engineering are not suitable for women.						

Chapter 2: Gender-based Violence

2.1 Gender-based violence

Exercise 5: Identification of Gender-Based Violence in the community

Objective: Participants are able to identify the different forms of gender-based violence, the causes for gender-based violence including examples in their own community

Method: Group discussions

Tools: Case study

Time: 40 minutes

Facilitator's tasks:

1. Based on their knowledge about gender (Chapter 1), ask participants what they think gender-based violence is. What forms of violence do they know of?
2. Write definitions of gender-based violence and violence against women on the flip chart. Ensure participants understand that gender-based violence includes both women and men.
3. Write types of GBV (physical, sexual, psychological, economic, and socio-cultural violence) on the flip chart.
4. Read the experience of a girl below (Sara's story) to the participants:

Sara's story

Sara explains her experience as follows:'
'I go to school by foot. On my way to school, young men follow me and harass me. They bully me into talking to them and see them after school. I do not answer back. At times they kick or slap me. Sometimes, they threaten to stab me with a knife on the next day. Such harassment is not only experienced by me. I know of many girls whose hair is being pulled, arms twisted, or who are beaten and even raped. Due to this, I hate being a woman

5. Ask participants the following questions:
   What form of gender-based violence has Sara experienced?
   What are the consequences for Sara?
   What are the causes?
   Can you tell/describe similar situations?
6. Divide the group into five groups and ask each group to come up with 2 examples for each type of violence they know of in their community (group 1: physical violence, group 2: sexual violence etc.).
7. Ask the groups to finish their examples after 10 minutes and to present them to the plenary.
8. Write examples on the board/ flip charts and discuss results.
   What are the underlying causes?
   What gender norms and inequalities are these violations based on? What are the consequences for the victims?
   Have there been actions taken?
   How is the issue dealt with in the community?

Basic information

Definition: **Gender based violence (GBV)** is any harmful act that is perpetrated against a person's will, and that is based on socially ascribed differences between males and females. (Source: WHO, Agency Standing Committee, 2005). While the terms gender-based violence (GBV) and **Violence Against Women and girls (VAW)** are used inter-changeably, they have different meanings. Gender-based violence connotes violence perpetrated against women and men, girls and boys. Violence against women and girls refers to that committed only against women and girls.

GBV can take different forms

- **Physical violence:** forced labour, trafficking, beating, kicking, slapping or other physical harm.
- **Sexual violence:** any sexual behaviour without consent, such as rape (including marital rape), attempted rape, intimidating remarks, unwanted touching, receiving of unsolicited pornographic e-mails, being harassed etc.
- **Psychological or emotional violence:** intimidation or threatening of physical harm, restricted freedom of movement, verbal abuse, controlling, deny of care and love, embarrassments)
- **Economic violence:** lack of access to land rights, rights of inheritance and education, destruction of women's property, withholding money.
- **Socio-cultural violence:** social ostracism, discrimination, political marginalization, forced or early marriage, honour killings

Victims of violence suffer significant sexual and reproductive health consequences, including forced and unwanted pregnancies, unsafe abortions and resulting deaths, traumatic fistula and higher risks of sexually transmitted infections and HIV. It leaves deep psychological scars that can take years to overcome (UNFPA).

Based on country data available, up to 70 per cent of women experience physical or sexual violence from men in their lifetime including within their relationships, marriages and families. A World Health Organization[5] study of 24,000 women in ten countries found that the prevalence of physical and/or sexual violence by a partner varied from 15 percent in urban Japan to 71 percent in rural Ethiopia, with most areas being in the 30-60 percent range.
Among women aged between 15 and 44, acts of violence cause more death and disability than cancer, malaria, traffic accidents and war combined[6].

Gender based violence and violence against women has long been shrouded in a culture of silence. One of the reasons why women remain silent is that in many societies violence against women is accepted as a normal aspect of gender relations. Gender-based violence reflects and reinforces inequities and norms about masculinity, male control and dominance. Boys are often brought up to believe that males are superior to females and that men should dominate women.

[5]WHO, 2005, Summary report WHO multi-country study on women's health and domestic violence against women . [6] Campaign to Say No –UNITE: http://saynotoviolence.org/issue/facts-and-figures

While many girls are brought up to accept that men are entitled to be violent or that violence is an expression of a man's love. It is not uncommon that the victim is blamed rather than holding a man responsible for being violent[7].

Although there are many stereotypes about victims of gender-based violence, in reality it can happen to anyone. Victims of GBV can be wealthy or poor, educated or illiterate, and married, widowed or single.

Financial dependence, subordinate social status and a lack of legal rights and legal counselling services in many societies limit the ability of victims to protect themselves or leave abusive situations.

Gender based violence is always a Human Rights violation. Ensuring that people know that they have the right to live free of violence is thus central to fighting gender-based violence.
In order to combat gender-based violence we must address the underlying gender norms and attitudes that lead to gender-based violence and even make it accepted. Ultimately gender-based violence is about relationships, partnerships and how we treat each other, so both men and women need to join hands to eliminate gender-based violence.

TERMS AND DEFINITIONS related to Gender Based Violence
Physical violence: forced labour, trafficking, beating, kicking, slapping or other physical harm.

Sexual violence: any sexual behaviour without consent, such as rape (including marital rape), attempted rape, intimidating remarks, unwanted touching, receiving of unsolicited pornographic e-mails, being harassed etc.

Psychological or emotional violence: intimidation or threatening of physical harm, restricted freedom of movement, verbal abuse, controlling, deny of care and love, embarrassments)

Economic violence: lack of access to land rights, rights of inheritance and education, destruction of women's property, withholding money.

Socio-cultural violence: social ostracism, discrimination, political marginalization, forced or early marriage, honour killings

Early marriage is any form of marriage that takes place before a child is 18 years old. Most early marriages are arranged and based on the consent of parents

Female Genital Mutilation (FGM) (also referred to as Female genital cutting or female circumcision) is the cutting, or partial or total removal, of the external female genitalia for cultural, religious or other non-medical reasons. It is usually performed on girls between the ages of 4 and 10 and results in the cutting or removal of the tissues around the vagina that give women pleasurable sexual feelings

[7]*The Population Council, 2009, It's all one Curriculum, Guidelines and Activities for a Unified approach to Sexuality, Gender, HIV and Human Rights Education*

Forced marriage is as any marriage conducted without the full consent of both parties and where duress is a factor. Early marriages often include some element of force

Marital rape; spousal rape is non-consensual sexual assault in which the perpetrator is the victim's spouse

Rape is non-consensual sexual intercourse that is committed by physical force, threat of injury, or other duress. Rape can occur when the offender and victim have a pre-existing relationship (sometimes called "date rape"), or even when the offender is the victim's spouse

Sexual harassment is unsolicited verbal or physical behaviour of a sexual nature. Sexual harassment may include any sexually motivated behaviour considered offensive by the recipient.

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.

2.2 Consequences of gender based violence

Exercise 6:	Consequences of gender based violence
Objective:	Exemplify the different consequences of gender-based violence for males and females
Method:	Group discussions
Tools:	Case study
Time:	40 minutes

Facilitator's tasks:

1. Read out the story of Marcus and Jennifer (see box below) to the whole group of participants.
2. Divide participants into three groups and ask them to write down and the following:
   a. **Group 1:** Discuss consequences for Jennifer
   b. **Group 2:** Discuss consequences for Marcus
   c. **Group 3:** Discuss consequences for their families and the community
3. Ask the groups to present their results to the plenary after 15 minutes.
4. Explain that there are 5 categories of consequences (health, psychological, social, economic and legal consequences) and write the 5 categories on a flip chart. Ask participants which of the mentioned consequences were related to health, to psychological, to social, and to economic and legal.
5. Cross-check with the consequences in the table of Examples of consequences GBV (see basic information) and make corrections and adjustments.

A story of Marcus and Jennifer

Marcus and Jennifer went to a secondary school together. They became friends first when they went together for National Sports Competitions. They started meeting each other thereafter and discuss about their education, families and future. Very soon, Jennifer fell in love with Marcus. She was very fond of him and wanted to see him all the time. Marcus also liked Jennifer so much. Whenever they met, they were both very happy.

One evening after school, Jennifer told Marcus that she loved him. Marcus was very happy and told all his friends about it. Since then, whenever Marcus and Jennifer could meet, Marcus would touch her breasts and caress her body. This always made Jennifer uncomfortable because she did not feel ready for this kind of intimate contact, but because she loved him she could not tell him that. She always hid her feelings about it and tried to engage Marcus in their usual conversations.

One evening, as they were walking home from school, Marcus and Jennifer sat together for a discussion down the road near Jennifer's place. That evening, Marcus started touching Jennifer's breasts and asked her if they can have sex. Jennifer refused, said that she felt too young and not ready for sex yet and that she therefore also feels uncomfortable when he touches and caresses her. Marcus got very annoyed and forced himself onto her and raped her.

Jennifer was very scared and hurt. She went to report to her parents, who went to report to the LCs, school and police. Marcus was expelled from school. The next day he was arrested by police and later found to be HIV positive. He had got infected from Jennifer, who was born with HIV but didn't know about it. After two months, Jennifer was found to be pregnant and dropped out of school to give birth.

Marcus is now in prison for rape and defilement, and Jennifer is in the village. All her age mates and friends have shunned her and her parents blame her for not being careful.

Basic information

The consequences of gender based violence can last a lifetime. Violence has profound effects on the reproductive health and life cycle of women and girls. It can result in unwanted pregnancies, sexually transmitted infections, including HIV, fistula and unsafe abortion. It leaves deep psychological scars that can take years to overcome. According to UNFPA (2005), violence kills and disables as many women between the ages of 15 and 44 as cancer[9].

The impact of violence may also extend to future generations: Children who have witnessed abuse, or were victims themselves, often suffer lasting psychological damage.
Gender based violence has impacts far beyond the individual, but for the entire society, such as increased health care expenditures, demands on courts, police and schools and losses in educational achievement and productivity.

[9] *UNFPA, 2005, State of the World's Population Report 2005*

Example: Consequences of gender based violence

Health	Psycho-social and Economic and Legal
Acute Physical Fatal Consequences (Homicide, Suicide, Maternal Mortality, Infant mortality, AIDS related mortality) **Physical Consequences** (Injury, Shock, Disease, Infection) **Chronic Physical Consequences** (Disability, Somatic complaints, Chronic infections, Chronic pain, Gastrointestinal problems, Eating disorder, Sleeping disorder, Alcohol/drug abuse) **Reproductive Consequences** (Miscarriage, Unwanted Pregnancy, Unsafe abortion, STIs including HIV/AIDS, Menstrual disorder, Pregnancy complications, Gynaecological disorder, Sexual disorder)	**Emotional and Psychological Consequences** (Post traumatic stress, Depression, Anxiety and fear, Anger, Shame, Insecurity, Self-blame and Self-hate, Mental illness, Suicidal thoughts and behaviour) **Social and Economic Consequences** (Blaming the victim/survivor, Loss of role/functions in society like earning income or child care, Social stigma, Social rejection and isolation, Feminisation of poverty, Increased gender inequalities) **Legal Consequences** Perpetrators: Fines/imprisonment, Divorce (married couples)

2. 3 Identifying Sexual Violence

Exercise 7: Identifying situations of sexual violence including sensitive grey areas

Objective: Enable participants to recognise all types of sexual violence, including sensitive grey areas
Method: Group discussions
Tools: Example statements
Time: 20 minutes

Facilitator's tasks:

1. Explain to participants that sexual violence as one part of GBV is not always as clear-cut as rape with the threat of a knife. These situations are called the grey areas of sexual violence. They often include sexual harassment, or violating somebody's boundaries.
2. Ask two volunteers to come forward and read the story of Ashley and Jordan; one participant preferably a boy reading Jordan's part while a girl reads Ashley's part.
3. After the story discuss the story using the questions below;

Story *(adopted from http://www.vtnetwork.org/wp-content/uploads/Youth-Advocate-and-Educator-Activity-Manaual.pdf)*

Ashley:
Jordan and I had been going out for six months. Things were great between us until the night of Nicks party. His parents were out of town, and it was supposed to be the biggest party of the year. I borrowed this great mini skirt from my best friend to look good for Jordan.

Jordan:
Ashley and I had been going out for about six months. Ill never forget the night I met her. We got set up for this holiday dance at her school. I thought she would be a total loser because she didnt have a date, but she was far from that. Ashley isnt like any of the other girls Ive dated. I dont even mind when my friends tease me about spending so much time with her.

Ashley:
There were a ton of people at the party when my friends and I got there. Jordan and I started dancing right away. We were having a great time. In between songs, we talked to our friends and drank. After a couple hours, I began to feel sick and dizzy because of all that Id drunk. I could barely stand up, so I asked Jordan to take me upstairs. I thought I would feel better if I slept a while.

Jordan:
Last weekend, we made plans to meet at a party. She showed up in this incredible outfit. We drank some beer, which made her laugh at first, and then she started hanging all over me. When she said she wanted to go upstairs and lie down, what was I supposed to think? I mean, we had talked about sex before and she knew I really cared about her. I thought this was her way of telling me this was the night. Maybe she did grumble a little when I started to kiss her and take her clothes off. But I just figured she wanted me to slow down since it was our first time. We had sex, and I thought everything was OK when I took her home.

Ashley:
When we got upstairs, Jordan started kissing me on the neck and unbuttoning my shirt. I tried to tell him I just wanted to sleep for a while. The next thing I knew, Jordan was all over me. I didnt want to scream and make a fool of myself with all those other people around. I tried to tell him "No" and that I didnt want our first time to be like this. I guess I passed out because the next thing I remember is Jordan telling me he loved me and helping me get dressed. I never want to see him again. He seemed like the greatest guy. I thought he liked me as much as I liked him. What happened?

Questions for discussion

1. How do you think Ashley at the end of this scenario?
2. Ashley asks; what happened? what do you think happened? Was this rape? Ashley and Jordan have been dating for a while does that change things?
3. Why do you think Ashley can't remember part of the night? Does that mean alcohol is to blame?
4. Ashley said she tried to say NO…but then she passed out. Were there any other indicators that Ashley did not want to have sex? What were they? Did Jordan notice them?
5. Both Ashley and Jordan mentioned Ashley's clothing's on the night of the party …do you think that sometimes people make assumptions - sometimes unfair ones- based on the way someone is dressed? What do you think about that?

6. Do you think in some situations it can be difficult to understand the ways in which people say no? does that mean that what happened was not wrong?
7. How could the situation have ended better? Specifically, what should Jordan have done differently that night?

Sum up the exercise by emphasizing that there must always be mutual agreement and consent when any form of sexual behaviour is going on between two people. Fact is that many forms of sexual violence and sexual harassment are not recognized as such. A lot of young people disregard the fact that they are harassed or intimidated. They think it is normal and a lot of these acts or expressions are tolerated in many societies. Well, this is not normal and it is a basic right to be protected against all forms of sexual violence, including these grey areas. If that is not the case, it is sexual violence and can never be tolerated.

Basic Information

WHO defines sexual violence as '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.' Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats. It may also occur when the person aggressed is unable to give consent – for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation.

A wide range of sexually violent acts can take place in different circumstances and settings, for example:

- Rape within marriage or dating relationships;
- Rape by strangers;
- Systematic rape during armed conflict;
- Unwanted sexual advances or sexual harassment, including demanding sex in return for favours;
- Sexual abuse of mentally or physically disabled people;
- Sexual abuse of children;
- Forced marriage or cohabitation, including the marriage of children;
- Denial of the right to use contraception or to adopt other measures to protect against sexually transmitted diseases;
- Forced abortion;
- Violent acts against the sexual integrity of women, including female genital mutilation and obligatory inspections for virginity;
- Forced prostitution and trafficking of people for the purpose of sexual exploitation

Sexual violence can be directed against both men and women. Rates of sexual violence are difficult to establish because in many societies sexual violence remains an issue of deep shame for the victim and often their families.

Available data suggest that in some countries nearly one in four women may experience sexual violence by an intimate partner, and up to one-third of adolescent girls report their first sexual experience as being forced. The majority of sexual assault victims are young. Women in positions of abject dependence on male authorities are also particularly subject to unwanted sexual coercion. Often, men who coerce a spouse into a sexual act believe their actions are legitimate because they are married to the woman.

Studies conducted mostly in developed countries indicate that 5--10% of men report a history of childhood sexual abuse. In a few population-based studies conducted with adolescents in developing countries, the percentage of males reporting ever having been the victim of a sexual assault ranges from 3.6% in Namibia and 13.4% in the United Republic of Tanzania to 20% in Peru. Studies from both industrialized and developing countries also reveal that forced first intercourse is not rare. Most experts believe that official statistics vastly under-represent the number of male rape victims.

Whether sexual violence occurs in the context of an intimate partnership, within the larger family or community structure, or during times of conflict, it is a deeply violating and painful experience for the survivor. As well as causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences. Its impact on mental health can be as serious as its physical impact, and may be equally long lasting. Sexual violence can also profoundly affect the social wellbeing of victims; individuals may be stigmatized and ostracized by their families and others as a consequence[10].

2.4 Preventing Gender Based Violence and Taking Action

Exercise 8:	Preventing Gender-Based violence
Objective:	Enable participants to identify various strategies against gender-based violence.
Method:	Group discussion on gender-based violence and prevention
Tools:	Markers, flip charts
Time:	30 minutes

Facilitator's tasks:

1. Looking at the various levels of prevention strategies, divide participants into three groups and let them discuss and write down on a flip chart:

   Group 1: what they expect the government to do against GBV (laws etc),

   Group 2: what they feel that the community can do to fight GBV (support victims, speak out etc),

   Group 3: what the youth like themselves could do to prevent GBV
2. Ask the groups to present to the others and complement the list through discussion

[10] *http://whqlibdoc.who.int/publications/2002/9241545615_chap6_eng.pdf*

Exercise 9:	Taking action against gender-based violence
Objective:	To enable participants to come up with their own action against gender-based violence (Violence against women) and present their ideas to the community.
Method:	Group work and presentation
Tools:	Paper, pens (if needed)
Time:	60 minutes

Facilitator's tasks:

1. Divide the group into two.
2. Based on the previous exercise, ask one group to prepare an official statement that reflects the position of the youth on gender based violence, that includes a position what they expect their government to do, what they feel the community should do and that includes their own resolutions on what they as youth will do to end gender based violence.
3. Ask the other group to develop a short play that shows how gender based violence affects the community, and how this can be overcome. An idea would be to show two different couples, one living in a violent and unequal relationship, and one that lives in an equal relationship where both have the same rights etc.
4. Bring both groups together and refine both statement and play through discussion
5. In a next step the youth could ask for an open forum at a community event to show the play and read their statement. (This would have to be done in consent with community leaders etc.)

Basic information

Much can be done to reduce the incidence of gender-based violence. And over the past years various international conventions on respect of women's rights and the elimination of the gender stigmatization and discrimination, including gender-based violence, have been enacted. These international conventions have also been included in the constitutions and laws of countries that subscribe to these conventions, including Ethiopia, Kenya, Tanzania and Uganda. Countries have further developed their own laws, policies and programmes to fight gender-based violence in their countries. It is crucial that everyone knows and understands these rights, especially their right to live free of violence, including sexual coercion.

Men, women, and young people are working locally, nationally, and internationally to reduce interpersonal violence, including all forms of gender-based violence. Such activities include: legal reforms, community watch groups, education campaigns, and efforts to change norms.

We have learned through this manual that gender-based violence is influenced by prevailing gender norms. Achieving gender equality is thus the basis for sustainably fighting gender-based violence. Young men who believe in gender equality are less likely to be violent toward their female partners. Similarly, young women who believe in gender equality are less likely to be

involved with male partners who are violent. Achieving gender equality needs involvement of all decision makers in the community such as community or religious leaders, the elders and local authorities[11].

Gender based violence is about relationships between men and women and how we treat each other. In order to end gender-based violence we thus need both men and women to work hand in hand.

Our individual decisions will make the difference. If we strengthen our own commitment to communicating with friends, family members, and sex partners about problems related to gender-based violence, including sexual coercion, we can make a difference.

Young people can help to promote gender equality and social equality by:

- Learning about their human rights and telling others about them
- Knowing the country-specific laws and regulations on gender-based violence and sharing
- them with others
- Committing to zero tolerance against gender-based violence
- Taking self-responsibility and build non-violent relationships
- Taking care not to use degrading language or tell demeaning jokes about others
- Ending the culture of silence and speaking out against discrimination and gender-based violence
- Reaching out to a person who is being marginalized - this can help a person significantly
- Helping to ensure that everyone is treated fairly in the community;
- Joining organizations that support the fight against gender-based violence

Exercise 10: To whom can I refer in case of GBV?

Objective: To enable participants to know where to go to in case of experienced or witnessed GBV

Method: Group work

Time: 20 minutes

Facilitator's tasks:

1. Ask participants to form groups to build groups according to the area they are coming from.
2. Ask the groups to answer the following questions in 15 minutes:
   - Who could be the first contact person for someone who experienced sexual GBV?
   - Which health centre could provide medical care after someone has experienced sexual gbv?
   - Which organizations in your area are addressing sexual GBV?
   - What is the role of a peer educator if someone has experienced sexual GBV?
3. Ask the groups to present their answers, compare and discuss other ideas in the plenary.
4. Emphasize that the peer educators' task is to refer a victim/survivor of sexual GBV appropriately. Each youth club should identify 1 trustable person in the community the

[11] *The Population Council, 2009, It's all one Curriculum, Guidelines and Activities for a Unified approach to Sexuality, Gender, HIV and Human Rights Education*

victim/survivor could talk to, a health centre that provides care for sexual GBV victims/survivors and an organization in the area which is addressing sexual GBV.

Where to report GBV cases?

Suggestions for discussion

- Police
- Probation officers
- Local leaders/elders
- Trusted person (friend, family)

Annex - Tools and master copies for Module 5

List of learning tools

- SRH facilitators' training manual
- Flip chart, flip chart paper or large sheets of paper
- Markers in different colours
- Chalk to write on the floor or a black board
- Note paper
- Cello tape
- Cards or slips of paper, scrap paper to cut notes

Module 6

Sexually Transmitted Infections Including HIV & AIDS

DSW

Table of Contents

Introduction

Infections which are transmitted by sexual intercourse are known as Sexually Transmitted Infections (STI's). The spread of STI's is increasing at a very high rate. Common and widely known STI's include, for example, Gonorrhoea, Syphilis, Chlamydiae, genital herpes and genital warts.

Chapter 1 of this Module 6 seeks to provide detailed information on STI's, how they are transmitted and how they can be prevented. Chapter 2 deals with HIV and AIDS, an infection/disease which is frequently transmitted by sexual intercourse but which, due to the high mortality rate associated with it and the fact that there is still no cure for AIDS, plays a special role when talking about STI's including HIV/AIDS.

This Module 6 is designed for one-day training, but in an intensive training situation, six hours and forty minutes are recommended. If the participatory learning process is started with this Module, the facilitator is advised to prepare and start the sessions following the guidelines in Module 1. (See Module 1, Section 2 for more details)

The facilitation of this module with all its exercises is expected to take about 6 hours.

Learning objectives

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

- Differentiate between myths and facts on STI's
- Identify risky behaviour for STI infection
- Know about different STI, including HIV and how they are transmitted
- Understand and be sensitive on social challenges related to HIV and AIDS
- Understand the importance of life skills in dealing with the challenge of HIV
- Apply knowledge on how to prevent HIV infections

Chapter 1: Sexually Transmitted Infections (STI's)

Exercise 1:	Developing knowledge about STI's
Objective:	Identifying STI's and their ways of transmission, prevention and treatment
Method:	Group discussion, STI cards (prepare cards with a) STI's and b) related symptoms)
Tools:	Cards, markers, pens
Time:	45 minutes

Facilitator's tasks:

1. Introduce this exercise.
2. Form groups of two participants and give to each pair a card with an STI or a symptom written on it.
3. Ask one of the pairs to read out what is written on their card (either STI or symptom).
4. Ask participants to find the matching card. The activity continues until all cards are matched.
5. Ask for more explanation about the particular STI; correct wrong statements based on facts. (See basic information).

Suggested questions for discussion:

- What causes the infection?
- How is the infection transmitted?
- If infected, where do you go for treatment? Is it curable?
- If infected, is it advisable to tell your partner about it? Why yes? Or why not?

7. Allow 3 minutes for each card. Do not discuss prevention methods during this exercise.
8. Ask the participants if they have any questions or need further explanation. Answer the questions and provide the explanation.
9. Explain that STI's are spreading because of unsafe sex practices. Point out that a person may contract several types of STI's at a time. Indicate that STI's must be taken seriously as they may lead to severe health conditions including infertility or even death if left untreated.

Exercise 2: Myths and misinformation about STI's

Objective: To allow participants to differentiate between myths/misinformation and facts

Method: Group discussion, brainstorming

Tools: Flip charts, markers, pens, papers, cards

Time: 20 minutes

Facilitator's tasks:

1. Group participants in pairs and ask them what they know about STI's.
2. Let each group write down what they have heard about STI's and identify the ones they have heard about.
3. When the time is over, ask one representative from each group to come up front and share the results of the group with the other participants.
4. Meanwhile, write down and collect the STI's identified by each group on the flip chart without any comments.
5. Compare the list on the flip chart with the STI's listed in the basic information and revise what participants have identified in their discussions.
6. Correct myths and misinformation on STI's by presenting facts.
7. Asks participants for causes of STI's.
8. Mention that STI's are caused by microorganisms that are frequently transmitted through sexual intercourse.

Common myths about STI's:

1. Some people do not take protective measures believing that their lucky star is there to protect them.
2. Many believe that having sexual intercourse only once will not lead to an infection.
3. There is a belief that STI's are curable by having sex.
4. STI's are a curse of god and should not be talked about.

Risky behaviour that exposes young people to STI's

Exercise 3:	Help young people to recognize risky behaviours
Objective:	Identifying risky behaviours that expose a person to STI's
Method:	Sharing experiences
Tools:	Pens, markers, cards
Time:	40 minutes

Facilitators' tasks:

1. Briefly review the previous exercise and introduce this one.
2. Divide participants into groups of 5 or 6.
3. Ask the groups to discuss risky behaviours that might lead to STI infection and identify 3 risky behaviours.
4. Ask a representative from each group to present the 3 risky behaviours identified.
5. Collect the ideas on the board or the flip chart without comments.
6. After all groups have presented, cluster redundant ideas and post the flip charts for reference and future discussions.
7. Then rank risky behaviours as follows and discuss based on the following categories:

High risk **Low risk** **No risk** **Don't know**

Guiding questions:

What problems could this behaviour bring about? Which kind of behaviour would be less risky or even involve no risk at all?

Point out that life skills play an important role for responsible behaviour:

Risky behaviours that expose to STI's are less likely in people who have critical thinking skills and decision making skills. (Refer to Module 2 on Life Skills)

Risky thinking and practices

1. Underestimating the problems caused by STI's.
2. Ignoring the risk of contracting an STI's being driven by sexual urges.
3. Believing that having sex only once cannot cause any harm.
4. Having unprotected sex with multiple sex partners.
5. Having unprotected sex with commercial sex workers.
6. Not using condoms.
7. Hiding the fact that one has contracted an STI and being too shy to consult a doctor.
8. Not seeking medical treatment for any other reason.

Basic information

Sexually Transmitted Infections are infections transmitted by intimate body contact and/or sexual intercourse with an infected person. Sexual intercourse, non-penetrative genital contact, anal and oral sex can all transmit an infection. An infection may eventually cause a disease, which is why STI's are also often referred to as Sexually Transmitted Diseases (STD's). For example, one can get an HIV (the virus) that eventually leads to AIDS (the disease).

People (especially women) may sometimes have an STI without noticing any symptoms for a long time. Therefore, if you recognize any symptoms that might indicate an STI (please see below), inform your partner that you have an STI and seek medical assistance. Most STI's can be cured if managed early and correctly. Spontaneous healing of STI's is very unusual, so you will have to see a doctor and follow his/her instructions in any case. Do not have unprotected sex if you have an STI, since co-infection is likely, i.e. you are more likely to contract other STI's if you have one already.

Most STI's may not cause serious health problems if detected and treated early. However, if you don't go for treatment, it is a) possible that your condition gets worse and b) likely that you will contribute to the further spread of the STI in your community. The best way of protecting yourself against STI's is to use a condom whenever you have sex, are faithful to one partner or abstain from sexual intercourse.

1.0 Symptoms that indicate a Sexually Transmitted Infection

Please note that some infections may develop symptoms only at a later stage:

- Sores, blisters, warts, rashes, irritation or itching near the genitals or anus
- Pain on passing urine, or needing to pass urine more often
- Pain on intercourse
- Pelvic or lower abdominal pain
- Sores, bumps or blisters near sex organs or mouth.
- Burning and pain when urinating or defecating.
- Fevers, chills and aches-like flue.
- Swelling in the area around the sex organs.
- Yellow discharge from vagina/penis with unusual smell

Examples of effects of STI's if not treated

- Infertility
- Mental disturbance
- Transmitted to the baby during pregnancy and birth (for example: blindness in babies, skin problems, abortion, miscarriage, stillborn, deformities in babies)
- Death (e.g. from Aids)
- Increased risk of HIV infection

Examples of complications as a result of STI's if not treated

- PID – Pelvic Inflammatory Disease
- Complications during pregnancy

1.1 What to do in case of STI's

- Seek treatment as soon as possible from the nearest doctor/hospital/health facility
- Inform your sexual partner(s) in order for them to seek treatment as soon as possible
- Complete treatment as prescribed
- Seek counselling and HIV testing

Note: *It is very important to seek medical assistance in order to determine whether you are infected by an STI or not. STI's must be treated by medical personnel, not by traditional healers.*

1.2 How to prevent STI's and HIV infection

- Abstinence
- Consistent and correct use of condoms
- Avoid blood contact
- Never share needles or equipment for drugs, tattoos or body piercing
- Avoid risky behaviour (alcohol, substance and drug abuse and bad company)
- Get to know your HIV status in a health facility; and if you are found to be HIV positive, seek treatment and if found to be negative, maintain the status

1.3 Common STI's, causes, symptoms and treatment

There are around 25 STI's in total. Having one infection can make it easier to catch another, more serious, one. Some of them include the following:

1.3.1 Candidiasis

Candidiasis, often called yeast infection or thrush, is a type of infectious disease. It is a fungal infection (mycosis). The disease is caused by any of the Candida species of yeast. Candida albicans is the most common species. Candida yeasts are common in most people. The yeast is usually controlled in the body. When the yeast grows without control, an infection happens. A weakened, unhealthy, or young immune system may allow candidiasis to develop. Candidiasis is a very common cause of vaginal irritation, or vaginitis. It can also occur on the penis or scrotum[1]. In women, signs and symptoms of a vaginal yeast infection are a white discharge that is thick and often described as having a cottage cheese appearance. The infection typically causes itching and irritates the vagina and surrounding outer tissues. On occasion there may be pain with sexual intercourse or burning with urination[2].

Treatment: Yeast infections are usually treated with medicine that you put into your vagina. This medicine may be a cream that you insert in your vagina with a special applicator, or it may be a suppository that you put into your vagina and allow to dissolve on its own. Medicine in a cream form can also be put on your vulva to help relieve itching. Be sure to see your doctor the first time you have symptoms of a yeast infection. It's very important to make sure you have a yeast infection and not another more serious infection. The symptoms of a yeast infection are also the symptoms of other infections, such as some sexually transmitted infections (STI's). Treating yourself for a yeast infection when you actually have another type of infection may make the problem much worse[3].

1.3.2 Chlamydiae

Chlamydiae are the most common STI, especially for sexually active young adolescents. Sometimes they come with only minor symptoms, or none at all, which makes them more difficult to detect. Girls may have lower abdominal pain/belly pain, bleeding after intercourse or between periods, vaginal discharge or cystitis-type symptoms. Men may have a discharge, pain on passing urine or painful testicles. It can be treated with antibiotics. If Chlamydia is not treated, the infection may spread causing inflammations in the womb and sterility.

Treatment: Chlamydia can be treated with antibiotics. It is important that your sexual partner is treated as well to avoid mutual re-infection.

1.3.3 Genital warts

Genital warts look like fleshy growths of skin and are found on or around the genitals and anus. Warts are caused by the human papilloma virus (HPV) and are very easily spread during sex. They are easy to see if they appear on the outside of the body, but difficult to detect if they are inside a woman's vagina or on her cervix. They can itch and may bleed, or cause discomfort on intercourse.

[1]Wikipedia
[2]www.emedicinehealth.com/candidiasis_yeast_infection/page3_em.htm. [3]Adapted from: http://family-doctor.org/familydoctor/en/diseases-conditions/yeast-infections/treatment.html

Treatment: Warts are removed by painting on a chemical solution, or by using a freezing technique, usually with liquid nitrogen. Repeat treatments may be necessary. Warts sometimes come back because HPV remains in the body. HPV causes cervical cancer. Cervical cancer is the second most common cancer in women worldwide. New, highly efficacious vaccines against the strains of the human papillomavirus (HPV) responsible for 70% of cervical cancer cases have recently come on the market. (...) There are, however, challenges to successfully reaching the primary target population. [4]HPV is frequently spread by men who have multiple sex partners among their female partners, whereas for men no fatal consequences of an HPV infection are known.

1.3.4 Gonorrhoea

Gonorrhoea is a bacterial STI passed easily between people, often called the drip. It causes a yellow discharge and pain on urination. Women may have a discharge, but both men and women may have no symptoms at all. The disease may therefore be passed on without the carrier's knowledge. Women may notice a yellow/greenish vaginal discharge, pain on passing urine, lower abdominal pain or, more rarely, bleeding between periods or heavier periods. Up to 50% of women may have no symptoms. Men tend to have a yellow/greenish urethral discharge and pain on passing urine. Symptoms occur in three to five days after the infection. In men the rectum and throat can also be affected, depending on sexual activity. Gonorrhoea can be treated with antibiotics only under care of medical personnel.

If the infection is not detected and treated, then it will spread and may cause sterility. Children born to infected mothers can become infected during delivery.

Treatment: Antibiotics prescribed/ approved by a medical professional, so seek medical assistance.

1.3.5 Genital herpes

Genital herpes is a viral infection. Herpes lives in the nerve root endings and, once infected, a person is infected for life. The fist attack after infection is often the most painful. Small blisters occur around the site of infection – the mouth or the genitals - about 2 to 20 days after infection. The blisters may be accompanied by a high fever, genital aches and pains, and swollen glands. The blisters burst after about two to four days and eventually heal. The first (primary) episode usually causes painful ulcers in the genital area. There may also be pain on passing urine and a discharge - vaginal in women, urethral in men. There are often generalized symptoms such as fever, headaches, tiredness and enlarged lymph nodes (glands) in the groin. Some people experience repeated episodes of genital herpes infection but these do not tend to be as severe as the first. This happens because the virus lies dormant in local nerves until reactivated by factors such as stress or menstruation. Treatment with antiviral drugs (such as acyclovir) reduces the severity and duration of symptoms in both primary and recurrent genital herpes infection. Infection with primary genital herpes around the time of delivery can cause serious illness in babies.

[4]*HPV Vaccine Adoption in Developing Countries: Cost and Financing Issues. International AIDS Vaccine Initiative/ Program for Appropriate Technology in Health (PATH).*

Treatment: Although there is no cure for herpes medical personnel can advice you accordingly on how to manage the symptoms and post-related complications - so seek medical assistance.

1.3.6 Non-specific Urethritis

Non-specific urethritis (NSU) is an inflammation of the urethra in men, leading to discharge and pain on passing urine. Causes include:

- Sexually transmitted infections (e.g. Gonorrhoea, syphilis)
- Reaction to vaginal infections of a partner
- Injury to the urethra
- Urine or bladder infection - quite unusual in men

Treatment: NSU is treated with antibiotics if caused by infection under care of medical personnel – seek medical assistance.

1.3.7 Syphilis

Syphilis is a bacterial STI that had been declining. However, in recent years it has become much more common again. It is essential to treat syphilis because of the major health problems, including nerve and brain damage, that it can cause. Pregnant women are routinely tested for syphilis because of the high risk that babies of mothers with untreated syphilis could be stillborn, or born with syphilis. The first sign of syphilis is a raised lump usually found near the genitals or anus, which then forms a painless ulcer. This phase of the illness can last for around six weeks and may be followed by a general feeling of being unwell with symptoms such as fever, headache, and sore throat, rash and raised lymph nodes (glands). Wart-like growths may be seen in the genital and anal areas. These features gradually clear up, but untreated syphilis infection remains in the body and can cause serious complications years later.

Treatment: Early syphilis can be cured with antibiotics after consulting medical personnel. Seek medical assistance.

1.3.8 Pubic Lice

Pubic lice live in hair in the pubic area and can also sometimes live in body hair, eyebrows and eyelashes. They lay eggs (nits) that stick to the hairs. Itching is a common symptom.

Treatment: With lotions that are usually available in pharmacies or prescribed by your doctor, which may have to be re-applied after 3-7 days.

1.3.9 HIV and AIDS

The Human Immunodeficiency Virus (HIV) attacks the human immune system and results in AIDS, the Acquired Immunodeficiency Syndrome (AIDS), which is invariably fatal.
The HI-virus is transmitted by sexual contact, through contaminated blood products, by sharing infected needles for injection among e.g. drug users and through Mother-to-Child Transmission. Deaths from AIDS have fallen dramatically since the mid 1990's. Although there is no cure for HIV, new treatments can prolong life and prevent transmission from mothers to babies. However, HIV infections continue to rise.

Treatment: There is no known cure for AIDS even though there are drugs (ARV) that can help people to live longer and protect them from opportunistic infections, hence improving the quality of life.

More information on HIV & AIDS is provided in Chapter 2 of this Module.

1.3.10 Hepatitis B

This viral STI is spread in a similar way to HIV, but is generally more infectious. You can get Hepatitis B through direct contact with the blood or body fluid of an infected person. As with HIV, you can become infected by having sex or sharing needles with a person infected with Hepatitis B and a baby can get the virus from the mother during birth. Hepatitis B is not spread through food or water or by casual contact. Symptoms of Hepatitis include feeling generally tired and unwell with fevers, aching joints, rashes and jaundice. Some people can be infected without having any symptoms and make a full recovery. Others can be very ill but still recover completely. However, long term infection is also possible. This can lead to progressive liver damage. People who are at higher risk of catching Hepatitis B, such as men who have sex with men, or people who come into contact with human blood at work, can be immunized against the infection.

Treatment: There is no cure for Hepatitis B; this is why prevention is so important. A highly effective vaccine is available. Seek medical assistance.

For more information, please visit BUPA fact sheet on Hepatitis using the link below:

http://www.bupa.co.uk/individuals/health-information/directory/s/sexually-transmitted-diseases
http://www.bupa.co.uk/individuals/health-information/directory/h/Hepatitis -b

Chapter 2: HIV & AIDS

HIV and AIDS cannot be transmitted

A. By having coffee/tee together
B. By sneezing
C. By playing with HIV positive kids
D. By food
E. By faeces
F. By shaking hands
G. By dry kissing

Exercise 4:	STI's and HIV & AIDS quiz
Objective:	Help participants to test their knowledge about STI's/STDs and HIV & AIDS
Method:	4 groups answering a quiz
Tools:	Quiz (see Annex)
Time:	30 minutes

Facilitator's tasks:

1. Divide the participants into four groups.
2. Distribute the quiz (see Annex) to each group.
3. Ask each group to complete the quiz.
4. Once all groups have completed their quiz, read the questions aloud and let each group say their answers.
5. Discuss and correct wrong answers.
6. At the end of the quiz, ask participants to form a circle and go round asking what lessons they have learned about HIV & AIDS from the quiz.

Basic information

2.0 What is HIV?

HIV stands for Human Immune Deficiency Virus. HIV is the virus responsible for AIDS. AIDS is the most advanced stage of a HIV infection. If you get infected with HIV, your body will try to fight the infection. It will make "antibodies" –special molecules to fight HIV. For HIV to trigger an infection, the virus has to enter the body and attach itself to host cells. HIV attacks a particular set of cells called the CD4 positive T-cells. These are white blood cells. They co-ordinate the body's overall immune system which is responsible for attacking foreign bodies and fighting off infections. Within an infected person then commences a battle between the virus and the immune system. There is an initial burst of activity during which many cells are infected, but the immune system still has the power to fight back by producing a high number of antibodies. This is unseen and unfelt by the individual and the person's status cannot be detected using standard test kits. This is called the 'Window Period'. This period can last from three to six months and during this time the infected person is extremely contagious. At the end of this period, the infected person usually becomes very ill (colds, coughs, fever, sneezing) and still it

will not resemble a prominent HIV marker. The 'Window Period' is followed by the 'Incubation Period'. During this phase, the HIV and the CD4 cells that it is attacking are being produced and destroyed as rapidly as possible by each other. Up to 5% of the body's CD4 cells (2,000 million cells) may be destroyed each day by the billions of HIV particles (Barnett, T. and Whiteside, A., 1999). Eventually the immune cells get depleted, more quickly than they can be replaced, and the body's immune system is significantly weakened. As the CD4 cell count falls, opportunistic infections are caught. The person is said to have AIDS. These infections will increase in length, severity and regularity until they become too much for the body to handle and the person dies.

2.1 What is AIDS?

AIDS stands for **Acquired Immune Deficiency Syndrome.** It is an advanced stage of HIV infection. AIDS is now considered a major worldwide epidemic. By killing or damaging cells of the body's immune system HIV progressively destroys the body's natural ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by viruses or bacteria that usually do not make healthy people sick. No one dies from AIDS itself, but from diseases which result from AIDS. AIDS has no cure and everyone infected with HIV will eventually develop AIDS. Once the person is infected, the virus can remain in the body for many years without any sign that something is wrong. This phase can last for as little as a few months, or as long as ten years. During this phase, an infected person appears healthy and may not even know he or she has the virus, but the disease can be transmitted to others. Once AIDS actually develops, the infected person begins to get sick often because the body is less able to fight off diseases. The most common symptoms are fever, diarrhoea that will not go away, severe weight loss, persistent cough, and tiredness, loss of appetite and skin diseases. The most common diseases developed by people with AIDS are tuberculosis, cancer, meningitis, pneumonia and in women, gynaecological infections.

Signs and symptoms of HIV & AIDS

Only a professional can confirm whether a person has HIV& AIDS and only they can accurately inform the person of his/her status. A person is said to be HIV "positive" (or simply referred to as "positive") when the blood tests show a presence of HIV antibodies. A person is said to be HIV "negative" (or just "negative") when there is no evidence of the HIV antibodies. During the initial stages of HIV especially the "Window Period", an HIV positive person may begin by having flu like symptoms only. This could be followed by a period of witnessing or feeling no signs or symptoms at all. However, as HIV continues to attack the body's immune system, the following signs/ symptoms take effect or are felt:

- Fever
- Fatigue
- Diarrheal
- Skin rashes and lesions
- Night sweats
- Loss of appetite
- Gynaecological infections

- Swollen lymph glands
- Significant weight loss
- Memory loss
- Depression
- Movement problems and shortness of breath
- White spots in the mouth/tongue
- Vaginal discharge (yeast infection)
- Easy bruising and bruises that last and remain painful for a long time; these sometimes result in subcutaneous (under the skin) infections
- Weakness and numbness (especially in the hands and feet)
- Sinus infections (head feels congested and pressured)
- Trouble with certain body organs (lungs, liver, kidneys, intestines and heart)
- Lip dystrophy: though not a direct sign of HIV & AIDS, it is a side effect of the medication combinations used during HIV care. Though medication is gradually enabling persons living with HIV to live longer, it comes with side effects constituting fat redistribution syndrome or lip dystrophy. Persons infected with HIV are more prone to suffer from various opportunistic infections such as: Tuberculosis, Pneumonia, Malaria, Meningitis, and Candidacies.
- They are also at much greater risk of certain types of cancer, including:
- Invasive cervical cancer in women
- Kaposi's sarcoma
- Lymphoma

As mentioned previously, the culmination of all these diseases eventually results into full blown AIDS: the syndrome. Each individual person infected with HIV has a distinct set of signs and symptoms respective to his/her body's system.

It is important to note the following points:

- Some of the above mentioned signs/symptoms can develop as late as 10 years or more after the infection, and yet some studies have revealed signs/symptoms can appear in some people as early as 5 hours after the person has been infected with HIV.
- Even if a person may look and feel healthy, all HIV positive people (even those on combination therapy) should realize they are able to infect others with HIV.
- If a person engages in risky sexual practices (does not use condoms, has multiple partners, etc.), is an intravenous drug user, or works in a situation where he/she is exposed to body fluids, he/she is at increased risk of HIV infection and may decide to get HIV tests done regularly.
- If a person is HIV positive, he/she should note that there are various treatments and support/care services available and the sooner he/she registers or starts with one of them the better his/her chances will be for living a much longer and positive life (see later notes for this).
- In addition, communities should be encouraged to avoid rituals that involve cutting the skin or make sure that the instruments are sterilized.

How does one avoid infection?

Infection of HIV can be avoided by following the given advice:

- Never engage in sexual intercourse without using a condom.
- If you do decide to have sex without a condom (to get pregnant, for example) always ensure that you and your partner both go for an HIV test first.
- Remain faithful to one sexual partner.
- Do not share needles or other sharp instruments.
- Avoid harmful practices such as FGM.

Ways of Transmission

Exercise 5:	Identify ways of HIV transmission
Objective:	Enable participants to identify and understand ways of HIV transmission
Method:	Group work, brain storming
Tools:	Card playing amongst all the participants
Time:	35 minutes

Facilitator's tasks:

1. Distribute cards or papers on which the different modes of HIV transmission are written. *(See table below)*
2. Put four cards on the floor in front of the participants which are labelled "High Risk", "Low Risk", "No Risk", "Not Sure".
3. Each participant will read out his/her card to the other participants.
4. Then, ask this same person to sort the card under one of the four categories of risk levels on the floor.
5. Ask the participant to explain his/her reason for placing the card under this or that category. This might lead to further discussion.
6. Those cards placed under "Not Sure" will be further discussed to correctly place them under the right risk level.

Cards to prepare:

HIGH RISK	LOW RISK	NO RISK	NOT SURE
Sharing sexual toys	Having sex using a condom	Kissing on the cheek, caressing dry areas of the body	Tears, breath, saliva (unless they have blood in them)
Unprotected sexual intercourse	Ear piercing	Hand shaking	
Sharing injection needles	Body cutting	Sharing household utensils	
Breast feeding by an HIV positive mother	Female/male Circumcision	Hugging HIV patient and sleeping in one bed	
Inherited marriage	Blood donation	Share swimming pool, shower	
Having sex with commercial sex workers (prostitutes)	Sharing a comb	Mosquito or insect bite	
Using another person's tooth brush		Pets like cats, dogs, or birds…	
Having sex with a person who has an STI		Medical examination	
Sharing syringes		Going in the same bus or taxi	
Practicing unprotected sex		Sitting together at school	
Contact with wounds/body fluids		Seating next to each other, learning in the same class, playing together, opening doors, using public phones, sharing bath rooms	
Sharing sharp materials		Sneezing	
Having more than one sexual partner		Taking care of People Living with HIV	

Explain the main purpose of this exercise and indicate the ways of HIV transmission (in order of the risk):

- Sexual intercourse with infected persons;
- Mother to child; during pregnancy and breastfeeding
- Through blood and blood products;
- Sharing of needles or other sharp instruments, such as with intravenous drug users;
- The presence of other STI's increases vulnerability for HIV infections.

Because the HIV virus cannot survive long outside the body, it cannot be transmitted through the following ways:

- Through toilet seats used by an HIV positive person
- Through using the kitchen utensils (plate, glass) that a patient had previously used.
- Body contact, e.g. hugging, hand shaking, sleeping or swimming together.
- HIV is not transmitted by breathing

1. Practice

Underline that the HI-virus is spreading at a very high speed. Ask the participants what they can do to protect themselves and the younger generation. Read out the following story and ask the following questions.
Story

Story

Three young friends left their country to go look for a job elsewhere. They however reached a desert area where farming was forbidden. The desert was populated by lions, tigers, and hyenas. To make matters worse, HIV had invaded the place in the form of snake like creatures.

These youngsters were very worried as they did not find any way out. Suddenly, from a distance, they saw three cars stationed one away from the other. The word 'Condom' was written on one of the cars, it reads 'Abstinence' on the second and 'Faithfulness' was also written all over the third car. What would you do if you were in their place?

- What would happen to you if you do not get to those cars?
- Which car do you wish to choose in order to save your life?
- What would be the problem of going up to the place where the cars are stationed?
- Do you need help?
- Will it be possible to go from one car to the other?
- Will it be possible to allow another person in a similar difficult situation, in the car you are in?

Help the participants think critically, use their decision making skills and communication skills. Ask provocative questions that lead to more reflection rather than telling them what to do and which car to choose.

Basic information/handout

2.2 Ways of transmission

HIV is entirely preventable and avoidable. Unlike flu, cold or a cough it cannot be transmitted so easily. It can only be transmitted through sharing or mixing infected or contaminated body fluids. For a person to be infected the virus has to enter the body in sufficient quantities and it must pass through an entry point in the skin and/or mucous membranes in the bloodstream.
The main modes of transmission in order of the risk are: sexual intercourse with infected persons; mother to child; blood and blood products; and sharing of needles or other sharp instruments, such as with intravenous drug use.

2.2.1 Sexual transmission

Sexual transmission is the most common way in which HIV can be transmitted. The virus is usually passed from one infected person to another through sexual intercourse. About 80–85% of the people in Africa who have HIV were infected through sexual transmission. The virus is present in the semen or vaginal fluids of an infected person and he/she can easily pass it to his/her sexual partner during intercourse. It only takes one act of sexual intercourse with an infected person to contract HIV.

To help protect themselves against the virus, young people should:

- Use latex (rubber) condoms every time they have sexual intercourse.
- Avoid sexual intercourse if they or their sexual partners have a sexually transmitted disease. If one person has an STI and another person has HIV, the chance of getting HIV is very high.
- Avoid having a sexual relationship with multiple partners; in fact the best way to avoid getting AIDS is to stay with one person who does not have the HIV virus and who does not have sexual relationships with other people.
- Avoid causing scrapes, cuts or scratches in the genital area when having sexual intercourse; women who have been circumcised are at increased risk of catching the virus, since sexual intercourse is more likely to cause bleeding and cuts.

2.2.2 Mother to child transmission (MTCT)

An estimated 15–30% of mothers with HIV infection will transmit the infection to their child during pregnancy and delivery, and 10–20% through breast milk (WHO 2005). HIV infected infants usually become seriously ill by the age of six months, and many die before their first birthday. The child can be infected with HIV prenatally – that is, during the pregnancy itself; at the time of delivery (the most common mode of transmission) when the risk of exposure to the infected mother's blood is the highest; or post-natally through breast-feeding (Barnett and Whiteside, 2002). Because there are medicines that can be given to woman which reduce the risk of transmission during pregnancy and to both the mother and child at the time of delivery, it is extremely important that pregnant woman know their HIV status. HIV can be present in the breast milk of an infected mother and can be transmitted to the baby through breastfeeding.

However, breast feeding is extremely beneficial to both mother and baby and even though using artificial breast milk or "formula" reduces the risk of MTCT, it comes with its own risks, which need to be carefully considered and discussed with a trained professional. One thing to keep in mind is that given the right nutritional, physical and emotional care, a baby born with HIV or who tests positive after birth has good chances of testing negative after 18–24 months.

2.2.3 Transmission through blood or blood products

Blood to blood contamination is the most effective way of passing on the virus as HIV is introduced to the bloodstream directly. Since the virus is present in the blood of an infected person, it is possible to catch it if infected blood enters another body.

This can happen through:

1. Blood transfusion when using unscreened and infected blood products.
2. The use of injections and needles that have not been sterilized.

For example, women sometimes need a blood transfusion during pregnancy and childbirth, if they are bleeding heavily or have a serious bout of anaemia. They are most vulnerable to catch HIV through transfusions if infected blood and medical equipment like needles are used. Blood banks and donors in some poor settings are notorious for using unscreened blood for transfusions and market sale. In many countries this has proved to be the initial factor causing HIV & AIDS. Practices such as Female Genital Mutilation (FGM) and scarification (tribal markings) also increase the risk of contracting HIV. This is because these harmful and very painful practices are often performed in unhygienic settings and involve sharing sharp instruments such as razors, blades and knives. If the same tool is used on more than one person, it is very easy to spread the infection. The best way to avoid transmission through blood is to:

- Make sure that needles and surgical instruments are always sterilized.
- Only use blood that has been tested for blood transfusions.
- Never share needles, knives, razors or other sharp instruments
- Health workers should wear gloves when there is the risk of being exposed to infected blood, for example during delivery.

2.2.4 Intravenous drug use

Injecting drug users – IDUs who share needles during drug abuse are at a greater risk of being infected with HIV. If the equipment is contaminated, the virus can directly enter the body.
Note: HIV is not transmitted in any of the following ways:

- By sitting on toilet seats
- Sharing drinking cups or utensils
- Touching or other casual physical contact with an infected person (such as hugging or shaking hands)
- Mosquito bites.

2.3 AIDS-related health problems

Symptoms of opportunistic infections common in people with AIDS include

- Coughing and shortness of breath
- Seizures and lack of coordination
- Difficult or painful swallowing
- Mental symptoms such as confusion and forgetfulness
- Severe and persistent diarrhoea
- Fever
- Vision loss
- Nausea, abdominal cramps, and vomiting
- Weight loss and extreme fatigue
- Severe headaches
- Coma

Children with AIDS may get the same opportunistic infections as do adults with the disease. In addition, they also have severe forms of the bacterial infections all children may get, such as conjunctivitis (pink eye), ear infections, and tonsillitis. People with AIDS are particularly prone to developing various cancers, especially those caused by viruses such as Kaposi's sarcoma and cervical cancer, or cancers of the immune system known as lymphomas. These cancers are usually more aggressive and difficult to treat in people with AIDS. Signs of Kaposi's sarcoma in light-skinned people are round brown, reddish, or purple spots that develop in the skin or in the mouth. In dark-skinned people, the spots are more pigmented.

During the course of HIV infection, most people experience a gradual decline in the number of CD4+ T cells, although some may have abrupt and dramatic drops in their CD4+ T-cell counts. A person with CD4+ T cells above 200 may experience some of the early symptoms of HIV disease. Others may have no symptoms even though their CD4+ T-cell count is below 200.

Many people are so debilitated by the symptoms of AIDS that they cannot hold steady employment or do household chores. Other people with AIDS may experience phases of intense life-threatening illness followed by phases in which they function normally. A small number of people (fewer than 50) first infected with HIV 10 or more years ago have not developed symptoms of AIDS. Scientists are trying to determine what factors may account for their lack of progression to AIDS, such as particular characteristics of their immune systems or whether they were infected with a less aggressive strain of the virus, or if their genes may protect them from the effects of HIV. Scientists hope that understanding the body's natural method of control may lead to ideas for protective HIV vaccines and use of vaccines to prevent the disease from progressing[5].

[5] *http://www.healthieryou.com/hiv.html*

Social problems associated with AIDS

Exercise 6:	Realising the social problems of AIDS
Objective:	Help participants to understand social problems related to living with HIV & AIDS
Method:	Discussion
Tools:	Group discussion, Brain storming
Time:	25 minutes

Facilitators' tasks:

1. Recap the previous exercise and introduce this exercise.
2. Ask the participants to discuss the problems that AIDS causes for societies at all levels (families, communities, countries, the world's population at large). Ask each group to present their results.
3. Write down the social problems identified on a flip chart. Ask the group to brainstorm about solutions.
4. List the social effects of HIV & AIDS.(See the example below)
5. Note on a board a flip chart the ideas that come up during the brainstorming.
6. Ask the participants on how to remain healthy in such a way to be productive and supporting one's families and country. Point out ways to protect themselves: Going for VCT, blood testing, living with and being faithful to a partner who has a proven that he/she is not infected, not having sex without condoms or abstaining.

2.4 Social problems associated with AIDS

AIDS-related stigma and discrimination refers to prejudice, negative attitudes, abuse and maltreatment directed at people living with HIV & AIDS. The consequences of stigma and discrimination are wide-ranging: being shunned by family, peers and the wider community, poor treatment in healthcare and education settings, an erosion of rights, psychological damage, and a negative effect on the success of HIV testing and treatment. Research by the International Centre for Research on Women (ICRW) found the possible consequences of HIV-related stigma to be:

- Loss of income/livelihood
- Loss of marriage & childbearing options
- Poor care within the health sector
- Withdrawal of caregiving in the home
- Loss of hope & feelings of worthlessness
- Loss of reputation

Some of these consequences refer to 'internal stigma' or 'self-stigma'. Internal stigma refers to how people living with HIV regard themselves, as well as how they see public perception of people living with HIV. Stigmatising beliefs and actions may be imposed by people living with HIV themselves:

"I am afraid of giving my disease to my family members—especially my youngest brother who is so small. It would be so pitiful if he got the disease. I am aware that I have the disease so I do not touch him - I talk with him only. I don't hold him in my arms now." Woman in Vietnam.

Self-stigma and fear of a negative community reaction can hinder efforts to address the AIDS epidemic by perpetuating the wall of silence and shame surrounding the epidemic. Stigma also worsens problems faced by children orphaned by AIDS. AIDS orphans may encounter hostility from their extended families and community, and may be rejected, denied access to schooling and health care, and left to fend for themselves[6]. For societies, an increasing number of AIDS patients means, for example:

- Increased medical expenses.
- Lack of space in hospitals
- Decreasing population
- Shortage of educated/skilled man power
- When young farmers are affected by AIDS, income from agriculture will decline
- Industrial productivity will decrease
- When the head of a family dies of AIDS, housewives/ families are facing financial constraints and need assistance
- Children becoming AIDS orphans, needing assistance

[6] *www.avert.org*

Which role do life skills play in dealing with the challenge of HIV and AIDS?

Exercise 7: The importance of life skills in dealing with the challenges of HIV & AIDS

Objective: Sensitize participants
Method: Discussion, brainstorming
Tools: Flip charts, markers, Module 2
Time: 40 minutes

Facilitator's tasks:

1. Ask the participants to come up with life skills they can imagine to be helpful in dealing with the challenges of HIV & AIDS. Write the life skills on a large paper and post it on the wall.
2. Ask the participants to give examples for the challenges AIDS poses on all levels of society and write them on a large paper and post it on the wall.
3. Group participants in pairs.
4. Briefly introduce the life skills indicated by the participants based on Module 2 (Life Skills) add/subtract as necessary.
5. Ask participants to discuss which life skills can be used for which types of challenges. The answer can be a combination of different life skills used to handle one type of challenge.
6. Do this by reading out the challenges and asking participants to discuss about the life skill to be used, asking them to provide explanations as to why they chose this or that life skill for this or that type of challenge.
7. As a conclusion, emphasize the importance of life skills for preventing an HIV infection, having the guts to get tested for HIV, adopting responsible behaviours to stay healthy and dealing with HIV positive people in the community.

Application of life skills to overcome risky situations

1. **A peer who gets drunk and gives in to sex easily for peer pressure**
   - Needs to have the ability to overcome peer pressure and influence, and also
   - Needs more self confidence and critical thinking to assess what is good or bad for him to take the right decisions.

2. **One who gives in to temptations of having sex with a physically attractive person**
   - Need critical thinking to control oneself by evaluating the dangers involved
   - Need decision making ability to reject a sexual invitation or
   - Need decision making skills, at least refuse unsafe sex.

3. **Those who are shy of openly discussing condom use before having sex**
   - Need to get rid of fear and shyness by developing self confidence.

4. **Those who do not care much about people living with HIV and AIDS or who stigmatize victims**
   - Need knowledge to understand that proximity with HIV patients will not cause infection.
   - Need empathy and compassion to give help and love.

5. **Those who practice unprotected sex, exposing their partners to the HIV infection**
   - Need knowledge of their own and their partner's rights & obligations to a healthy life.
   - Need to develop social skills to care for the well being of another person.

6. **People who believe that Holy Water, Brown Teff, Herbs or different plants can cure AIDS**
   - Need critical thinking and correct, evidence-based information about HIV transmission.

7. **A partner who believes that because both people love each other, they do not incur any risk in engaging in sex**
   - Needs correct information on the risks involved in having sex.
   - Needs social skills to negotiate and agree on how to have a safe sex, by convincing the other person or refusing the unsafe sex.

8. **For those who fear to go for HIV testing through a blood test**
   - Need to have self confidence and be self decisive, so as to be able to choose what is really important for them to know.

2.5 The importance of Knowing your status

Exercise 8:	Taking an HIV blood test
Objective:	Enable participants to understand the importance of HIV blood tests
Method:	Using self awareness & self assessment skills, visualisation
Tools:	Questionnaire
Time:	40 minutes

Facilitator's tasks:

1. Revise briefly the previous exercise.
2. Ask the participants to sit relaxed.
3. Ask participants to assess situations that create vulnerabilities towards HIV infection by using their self assessment and self awareness skills (they do not necessarily have to give an answer). They can rather reflect on the following questions:
   - Have I done something that exposed me to HIV?
   - Have I ever had unprotected sex?
   - Have I ever had sex with many partners?
   - Did I ever have unprotected sex with a person assuming he/she would be free from AIDS?
   - Have I ever had sexual intercourse with a commercial sex worker?
   - Had I ever had STI's?
   - Did I ever use a needle that another person had used?

4. If the answer to any of the above questions is yes, you should be willing to take a blood test after getting counselling.
5. Ask what VCT and HCT means (voluntarily undergo HIV blood testing and counselling)
6. If the participants do not know, the facilitator will explain.
7. Ask detailed questions (use the information below to amend participants' replies)
   - Where are blood test and counselling services (VCT/HCT) provided?
   - What is the benefit of getting tested?
   - What happens if the virus is detected in the blood?
   - What if it is not detected while it is there for sure?

Explain:

The HIV window period: The window period is the period between the onset of HIV infection and the appearance of detectable antibodies to the virus. In the case of the most sensitive HIV antibody tests currently recommended, the window period is about three to four weeks. This period can, however, be longer. Any antibody-based blood tests (such as the ELISA, rapid tests and the Western Blot) conducted during this window period may give false negative results. Antibodies are produced from about three weeks after infection and usually become detectable by four to six weeks after infection. This four- to six-week period between infection and a positive test is called the window period.

Indicate places where VCT/HCT services can be found in your locality: Youth Centres, Health Facilities, hospitals, doctors, mobile clinics.

8. Underline that knowing one's HIV status is important to get a self awareness that can bring about important changes. Explain that an HIV positive person can take measures to avoid infecting others and live a long life if treated appropriately and pursuing a healthy life style. *(More information is provided below)*

2.6 Voluntary Counselling and Testing (VCT)/ HIV Counselling and Testing (HCT)

Information on where to go (or refer people) for VCT/HCT can be obtained from local health clinics, medical professionals, health workers and relevant NGOs. VCT/HCT services/centres offer the best means to find out one's status. This is whether one is HIV positive (positive) or HIV negative (negative).

There will be counselling before...

1. The counsellor will explain about the test and try to correct any wrong beliefs you may have about HIV testing.
2. You will discuss at what degree you have been exposed to HIV.
3. You may also discuss about the importance of knowing your status and the availability of prevention alternatives.

...and after the test:

1. The counsellor will focus on the importance of having undertaken the test whether the result is positive or negative.
2. If the test result is positive, i.e. there is an HIV infection, the counselling aims at helping the patient to accept that fact and understand that it is still possible to live a life even if with the virus.
3. The patient will be informed where to get further counselling, medical and social services.
4. If the test is negative, i.e. there is no HIV infection, the counselling will focus on maintaining this status by preventing an infection in the future.

VCT/HCT centres have helped:

- To reduce HIV transmission.
- HIV positive people learn to lead healthier and more positive lives.
- Be the focal points in initiating support/care groups.
- Employ more pro-active measures to deal with stigmatization/ostracisation.
- Act as a prime motivational and educational service to ensure that people who have been tested negative remain so.

Who will benefit from VCT/HCT information and referral?

- A person who is serious about behaviour change
- A person who is planning marriage, or venturing into a new relationship
- An individual or a couple considering pregnancy (or a woman who is already pregnant)
- A person with more than one sexual partner (now or in the past)
- A person whose partner has more than one sexual partner
- A person with an STI
- A person working and living away from his/her spouse and family
- A person who has had a blood transfusion
- A person who is constantly feeling unnaturally sick (with one or more of the signs or symptoms of HIV & AIDS)

Many people, especially young people, are afraid of going to visit a VCT/HCT centre primarily because they are thought of as 'scary' places to visit and because of the stigma associated with going to visit one; people may think you have a problem. This is a huge misconception as in fact they can go a long way in helping people live positively with HIV & AIDS; help people stay negative and offer care/support services for those infected and affected, for those who have been tested negative and those who have been tested positive.

VCT/HCT benefits for HIV negative persons:

- Clients learn how to stay negative.
- Couples can marry without having doubts.
- Couples can plan for future pregnancies without having doubts.
- Reduce anxiety over past risky behaviour
- Testing negative creates powerful motivation to be more aware about behavioural standards and remain uninfected.

VCT/HCT benefits for HIV positive persons:

- Counselling services offer help to clients on how to avoid passing the virus to anyone else.
- Clients learn to take better care of themselves to lead a longer, healthier life.
- Clients learn early about TB and STI treatment, prevention of mother to child transmission (PMTCT), family planning and social support.

ARVs/HIV & AIDS intervention - If I have HIV, how can AIDS be prevented?

ARVs - anti-retroviral drugs

ARVs can help further delay the time between becoming infected with HIV to the onset of full-blown AIDS. However, these medicines are still quite expensive and can be difficult to access. Some governments and NGOs are trying to make ARVs available for free, especially for pregnant women.

Intervention measures to seek prevention of HIV & AIDS can be best put in effect by altering sexual behaviour: these are commonly referred to as Knowledge, Attitude, Practices and

Behaviour (KAPB) interventions and/or the Behavioural Change and Communication (BCC) methods of tackling HIV & AIDS. People need to have the *Knowledge* first though:

This entails mechanisms to make one aware, concerned and better equipped with information on HIV & AIDS. This could be done using mass and group media and through interpersonal communication provided through government organizations, NGOs, training programmes, health and social workers, resource materials and the World Wide Web (www…) etc. From this, hopefully one will be able to change his/her *Attitude:*

Knowing all the relevant information, individuals should seriously begin to think about the need to protect themselves and their loved ones from AIDS. This is when motivation sets in and a decision is made to stick to one partner, buy condoms or get oneself tested. Moreover, it should promote receptiveness of peers to those infected and affected by HIV & AIDS. Finally altering one's Practices and Behaviour:

At this stage, condoms and other popular contraceptive methods need to be easily accessible and individuals need to feel capable of using them and negotiating safer sex. Mass and targeted campaigning and advocacy can help provide a supportive environment by showing role models and promoting a positive view of safer sexual behaviour. Peer role models are especially useful here. Support groups should be set up at this point for infected and affected peers and to bring about general positive change in community behaviour and response to HIV & AIDS.

Medical check ups
Going for a regular medical examination is the direct means of knowing your status. Regularity will also ensure that you are aware of the changes that may be taking place in your body and that you are informed about how to deal with these or how these may actually be signs and symptoms of HIV & AIDS.

Note: Getting tested during the 'Window Period' of infection (for those who have already contracted the virus) will not enable one to know their status as the virus is undetectable at this stage (see previous notes on what is HIV & AIDS). Therefore, a person who tests negative is asked to get a second test within 6 months just to be certain. Indirect, but unconfirmed means of detecting whether a person may be HIV positive could be determined as a result of constant and prolonged occurrence of any of the signs and symptoms of HIV & AIDS. A medical/health professional would be able to validate this.

2.7 Living positively - What do I do if I am HIV positive?

Once a person knows that he/she is HIV positive, they must understand the full nature of the disease and not get depressed. Depression will only embolden the virus to attack the body more aggressively.

An HIV positive person should employ the necessary steps to elongate the period of his life and delay the onset of full-blown AIDS. Moreover, he/she should make the best of his/her life by living positively and even more enthusiastically.

They can do this by:

1. Accessing the nearest VCT and HCT to get ongoing counselling and support to deal with HIV.
2. Get proper medical advice on the best treatment depending on the level of infection.
3. Take proper care of yourself through e.g. nutritional care, join support groups and always ensure that you are never idle; always keep your mind occupied.
4. Have many friends and family members around you.

How can you help somebody who is HIV positive or has AIDS?

1. Attitude and approach towards people living with HIV:

- Treat them like any other person.
- Do not discriminate/stigmatize them by either ignoring them completely or giving them too much attention.
- Involve them in your life and surrounding activities like you would any other person.
- Be patient and understanding: HIV positive people already have a lot to deal with, just by knowing they are positive. They are prone to getting upset, depressed, sensitive and moody; however you should be patient with them and actually help them through it.
- Ensure them that there is nothing wrong in being open about it and not to let others' opinions matter or affect them.
- Encourage them to go for regular counselling and medical checkups.
- Encourage them to develop a POSITIVE attitude (if they haven't done so already) and if they have, encourage them to always remain that way, as it is encouraging and motivational for others to see.

2. Caring for people with HIV:

- If you know someone with HIV, a friend, family member or a colleague, ensure that you keep a regular check on their weight and diet and advice/help them to undertake better nutritional standards (if they are not already doing so).
- Discuss issues with them: those that are affecting them directly or indirectly (i.e. be there for them whenever they may need you).
- Show them that there are people out there who really love and care for them: take an active interest in their lives.
- Encourage other friends and community members to go visit them and be supportive towards a person who may be HIV positive

3. Taking care of yourself: Advice for the person living with HIV and AIDS:

- Your body needs extra rest: sleep for at least 8 hours every night and rest whenever you feel tired.
- Try not to worry about things too much as this only aggravates the illness.
- Be positive and strong; being positive about your illness is so important in fighting the disease and helping you cope with living with it for a stronger and healthier

way of life. It would also help your fellow peers realize that one can live happily even if infected.

- HIV positive persons can serve as true humanitarian ambassadors in fighting the AIDS epidemic and ensuring that the spread is contained
- Do things you really enjoy.
- Exercise regularly.
- Find good care and support groups.
- Do not feel ashamed, intimidated or shy to ever ask for help or accept it when offered
- Stop smoking, drug abuse and taking alcohol
- Avoid taking unnecessary medicine, as these can have unwanted side effects.
- Only take medication prescribed by a qualified medical doctor.

Exercise 9:	Preventing HIV & AIDS and STI's
Objective:	To help participants decide to protect themselves from HIV & AIDS
Method:	Discussion
Tools:	Cards, flip charts
Time:	35 minutes

2.8 How to prevent HIV & AIDS

As seen previously, in addition to using condoms, young people's life skills play an important role in HIV & AIDS prevention, as they can help them to refrain from risky behaviours. By using skills such as self confidence, decisiveness, determination, and the ability to convince others, young people are able to actually use and apply the information we have provided to protect themselves from HIV and other STI's.

Facilitator's tasks:

1. Post positive statements such as "I have to be a healthy citizen" on the board. (See below). Summarize:
   - We have discussed our knowledge on HIV & AIDS
   - We have listed ways of transmission of HIV & AIDS
   - We have identified the behaviours that expose us to HIV & AIDS
   - We know how important it is to protect ourselves, as there is no cure for AIDS.
2. Write the following statements on the board/a flip chart and ask participants to discuss ways to stay healthy.

   To stay healthy…

   …We will use condoms

   …We will use life skills

   …We will not have unsafe sex

   …We will be faithful

   …We will not discourage virginity

   …We will cope with peer pressure

   …We will go for VCT.

   …We will control ourselves not to have sex in our teenage years

   …We will use a condom if we still do

   …We will not remain silent when there is sexual assault

   …We will take care of AIDS patients

   …We will not let ourselves be governed by alcohol and addictions
4. Ask participants if they can agree to the above points. Discuss as desired.
5. Ask participants to close their eyes, think of something nice, breathe deeply and slowly, and listen. Then read out the following:

   My family needs me.

   I can live now, my country needs me.

   I can live for a long time.

   I can be productive.

   I can make changes.

   Therefore, I have to be a healthy citizen.

Combination approach to HIV prevention

Exercise 10:	Using Combination approach to HIV prevention
Objective:	To help participants understand how to prevent all HIV transmissions in all population groups where the epidemic is driven by multiple behavioural, biomedical and structural drivers.
Method:	Discussion, group work
Tools:	Flip charts, Markers, Cards,
Time:	40 minutes

Facilitator's tasks:

1. Facilitator briefly introduce the concept of combination HIV prevention approach
2. Recap the previous exercise and introduce this exercise.
3. Divide the participants into three groups.
4. Write down the three interventions on a flip chart. Ask the group to brainstorm about them giving examples of activities they undertake under each.
5. Ask each group to present their results.
6. As a conclusion, emphasize the importance of combination approach for HIV prevention

Basic information/handout

Combination approach to HIV prevention

Definitions

"...rights-based, evidence-informed, and community-owned programmes that use a mix of biomedical, behavioural, and structural interventions, prioritized to meet the current HIV prevention needs of particular individuals and communities, so as to have the greatest sustained impact on reducing new infections."

Combination prevention is based on the idea that there is an optimal mix of interventions that will provide the greatest impact. Combination approaches are necessary because there is no single prevention intervention—or "magic bullet"—that fully protects against HIV. People require different prevention approaches over time as their risk changes. Moreover, within a given setting, HIV epidemics can occur simultaneously within different populations and among people in diverse social networks

Therefore, combination prevention approaches seek an optimal mix of mutually reinforcing
- Biomedical,
- Behavioural, and
- Structural interventions to meet the needs of different groups

1. Biomedical interventions: Biomedical HIV prevention strategies use medical and public health approaches to block infection, decrease infectiousness, and reduce susceptibility. These are directly influence the biological systems through which the virus infects a new host, such as blocking infection (e.g., male and female condoms), (e.g., voluntary medical male circumcision)

Key interventions include:

- **Antiretroviral therapy (ART)**, generally used to improve the health of the person being treated, can also serve as a preventive strategy by reducing viral load, which lowers the risk of transmitting HIV to a sex partner or needle-sharing partner
- **Blood Safety and Availability,** Inadequate and unsafe blood supply causes avoidable deaths and transmits infectious diseases, including HIV. Preventing transfusion of unsafe blood through improved screening of donors and testing processes, and increasing participation of voluntary, non-remunerated blood donors can significantly reduce the spread of HIV.
- **Contraception to Prevent Unintended Pregnancies among Women with HIV,** Providing contraception to women with HIV who wish to postpone or avoid pregnancy can prevent vertical transmission of HIV from mother to child.
- **Diagnosis and Treatment of Sexually Transmitted Infections,** Sexually transmitted infections (STIs) likely facilitate HIV transmission and acquisition. STI treatment efforts have been used as an HIV prevention approach with mixed

outcomes. This prevention strategy may be most effective in settings with a high burden of STIs and when targeted to most-at-risk populations and their sexual partners. However, randomized trials have found STI treatment to have little to no effect on HIV incidence

- **HIV Testing and Counseling as Prevention,** As a stand-alone intervention, HIV testing and counseling (HTC) contributes to prevention of HIV transmission by identifying and informing individuals, partners and couples, and families of their HIV status and counseling them to develop appropriate sexual, injection, or other risk-reduction measures. These measures differ according to the sero status of the individual or of couples, they may be sero concordant (both partners test either HIV-positive or HIV-negative) or sero discordant (one partner tests HIV-positive and the other tests HIV-negative)
- **Infant Feeding for Mothers Living with HIV,** HIV can be transmitted from a mother to her child during pregnancy or delivery. When a mother is HIV infected, her baby can also be infected through breastfeeding.
- **Injection Safety,** Addressing injection safety helps prevent the medical transmission of HIV and other blood borne pathogens to patients and health care workers
- **Microbicides,** Microbicides are products formulated for individuals to apply topically (vaginally or rectally) to reduce their risk of HIV and possibly other sexually transmitted infections.
- **Oral Pre-exposure Prophylaxis (PrEP) for HIV Prevention,** Pre-exposure prophylaxis (PrEP) aims to prevent acquisition of HIV through use of antiretroviral (ARV) agents before potential exposure to HIV. Several trials of daily oral PrEP have been completed and other trials of daily and intermittent use of oral PrEP and injectable agents are underway. The primary strategy being tested involves daily use of one (tenofovir [TDF]) or two (TDF/emtricitabine [FTC]) oral ARV drugs
- **Post-exposure Prophylaxis (PEP)**, Antiretroviral post-exposure prophylaxis (PEP)—short-term antiretroviral therapy initiated soon after known or suspected exposure to HIV—aims to prevent the establishment of HIV infection in an exposed person.
- **Prevention of Mother-to-Child Transmission of HIV (PMTCT)**, Prevention of mother-to-child transmission (PMTCT; also known as prevention of vertical transmission) refers to interventions to prevent transmission of HIV from a mother living with HIV to her infant during pregnancy, labor and delivery, or following childbirth during breastfeeding.
- **Voluntary Medical Male Circumcision,** Voluntary medical male circumcision (VMMC) is the surgical complete removal of the foreskin of the penis. While conducted for a number of reasons, evidence from recent clinical trials has shown that medical male circumcision can significantly reduce (but not eliminate) men's risk of acquiring HIV through heterosexual vaginal sex. The U.S. President's Emergency Plan for AIDS Relief (PEPFAR) supports VMMC performed by qualified and well-equipped professionals, and with the client's informed consent

2. Behavioral intervention: Behavioral interventions discourage risky behaviors and reinforce protective ones, typically by addressing knowledge, attitudes, skills, and beliefs. These include a range of sexual behavior change communication programs that use various communication channels (e.g., mass media, community-level, and interpersonal) to disseminate behavioral messages designed to encourage people to reduce behaviors that increase risk of HIV and increase protective behaviors (e.g., risks of having multiple partners and benefits of using a condom correctly and consistently). Behavior interventions also are aimed to increase the acceptability and demand for biomedical interventions.

Key interventions here include

- **Comprehensive Condom Use Programs,** Unprotected sex is the leading cause of HIV transmission, accounting for more than 80 percent of the total number of infections. Male and female condoms, when worn correctly, serve as an impermeable barrier to the sexual exchange of secretions that carry HIV and a number of other sexually transmitted infections (STIs), providing protection against transmission. Comprehensive condom programming remains an essential component of combination prevention programs
- **Comprehensive Sexuality Education,** Young people in many countries have unprotected sexual intercourse with one or more partners, potentially exposing themselves to HIV, other sexually transmitted infections (STIs), or unintentional pregnancy. Comprehensive sexuality education (CSE) programs work to delay initiation of sex, reduce the number of sexual partners, and increase the use of condoms and other forms of contraception. Some programs also seek to increase testing and treatment for HIV and other STIs. They can be implemented both in schools and in other community settings.
- - **Delayed Sexual Debut,** HIV programs generally define abstinence as not engaging in sexual intercourse, delaying sexual debut, or, for those who have already been sexually active, abstaining from sex (secondary abstinence). Abstinence-programs promote abstinence as the only effective method for preventing HIV. Many researchers and programmers advocate for abstinence-plus programs, which include sex education and information on abstinence, delay of sexual debut, condom use, and contraception
- **HIV Prevention for Hard-to-Reach Men Who Have Sex with Men,** Men who have sex with men (MSM) can be difficult to reach with HIV prevention messages and services, since many are secretive about their sexual activities. To be successful, programs must address behavioral risk reduction and reach MSM in ways that reflect the diversity of their sexual behavior and their varied social and political contexts
- **Mass Media and HIV Prevention,** Mass media interventions aim to prevent HIV by increasing knowledge, improving risk perception, changing sexual behaviors, and questioning potentially harmful social norms
- **Multiple and Concurrent Sexual Partnerships,** Many people are now aware that having multiple sexual partners increases their risk of contracting HIV. Fewer people are aware that having concurrent sexual partnerships, defined as having two or more partnerships that overlap in time, increases their risk of acquiring HIV; an individual is at increased risk of acquiring HIV if their sexual partner(s) connects them to a wider sexual network through which HIV can spread

- **Partner Reduction,** Partner reduction is a prevention strategy focused on decreasing overall number of partners in order to lessen the risk of becoming infected with or transmitting HIV
- **Peer Outreach and Education,** Peer outreach and education (POE) engage members of a specific group to influence other members to adopt healthy sexual behaviors and modify norms. Peer educators may be more effective at influencing hard-to-reach or disenfranchised individuals because they're seen as more credible or less judgmental than non-peers.
- **Prevention of Alcohol-related HIV Risk Behavior,** Alcohol use in virtually all cultures reduces both people's perception of risk and their inhibitions against engaging in risky behaviors. Alcohol use is associated with HIV risk factors, including inconsistent condom use and number and concurrency of sexual partners. Novel approaches show promise in bringing about behavior change, reducing, for example, the frequency of consuming alcohol prior to sex and of meeting sex partners at drinking venues.
- **Transactional and Age-disparate Sex in Hyperendemic Countries,** Transactional sex (TS) is the practice of exchanging sex for financial or lifestyle rewards. Distinct from formalized sex work, transactional sex is thought to be a fairly common form of sexual partnering in parts of sub-Saharan Africa.

3. Structural interventions : Structural approaches address social, economic, and cultural factors that contribute to HIV risk and vulnerability. Gender, poverty, and policy not only influence HIV risk but also help determine the success or failure of behavioral and biomedical HIV prevention interventions, address the critical social, legal, political, and environmental enablers that contribute to the spread of HIV. PEPFAR uses five categories to describe structural interventions: legal and policy reform, reducing stigma and discrimination against people living with HIV and marginalized groups, gender inequality and gender-based violence, economic empowerment and other multi-sectoral approaches, and education.

Key interventions here include

- **An Overview of Structural Approaches to HIV Prevention**, Structural approaches reduce an individual's vulnerability to HIV by creating the conditions in which people can adopt safer behaviors. For example, making micro-finance loans available to poor women can reduce their need to engage in transactional sex, which may reduce their vulnerability to HIV infection. Structural approaches include social, economic, and political interventions that can improve health outcomes by increasing the willingness and ability of individuals to practice prevention.
- **Interventions Addressing Policy Factors,** Due to the complexity of HIV prevention, both programmatic and policy-related interventions are necessary. Policies define the roles of various actors to achieve a set of objectives. Their implementation may involve cost assessments, development of supporting laws and regulations, dissemination of practical and technical guidelines and the planning of a programmatic response
- Workplace Interventions to Prevent HIV, Although the effects of HIV in the workplace differ by the size of the company/organization and the type of labor employed, for many companies and government employers HIV prevention efforts are essential to protecting an organization's productivity, profitability, economic growth, and efficiency

Annex - Tools and master copies for Module 6

List of learning tools

- SRH Facilitators' Training Manual
- Flip chart, flip chart paper or large sheets of paper
- Markers in different colours
- Chalk to write on the floor or a black board
- Note paper
- Cello tape
- Cards or slips of paper, scrap paper to cut notes

Sexually Transmitted Diseases: True and False Quiz

What do you think? Circle true (T) or false (F) next to each statement:

1. **HIV and AIDS is an STI ..... T/F**
2. **You can go to a pharmacist (or drug store) to get medicine to cure an STI without going to a doctor or nurse ..... T/F**
3. **Using a condom is the safest way for young people to protect themselves from STI's..... T/F**
4. **Boys and men always know if they have an STI because they have problems taking a leak (urinating)..... T/F**
5. **Girls or women who have STI infections may have problems getting pregnant ..... T/F**
6. **Men who are idlers often get STI's ..... T/F**
7. **Even if a girl or woman uses contraceptive pills, she can still get an STI ..... T/F**
8. **You can tell by looking at someone that they have HIV..... T/F**
9. **People often have an STI and not know about it and can spread it to others. ..... T/F**
10. **STI's, including HIV, is a very serious problem for young people in Africa.....T/F**
11. **Only men who have sex with men get HIV.....T/F**
12. **Men who have an STI can be cured by having sex with a virgin .....T/F**

True and False Quiz Answers

1. HIV & AIDS is an STI.
   Answer: TRUE – HIV & AIDS are sexually transmitted. It can also be transmitted from infected blood, shared needles, and from infected mother to child.
2. You can go to the pharmacist (or drug store) to get medicine to cure an STI without going to a doctor or nurse.
   Answer: FALSE – You must go to the doctor so he or she can find out if you have an STI, which one it is, and how it can be treated. Taking medicine from the chemist or friends is dangerous. It may not cure your STI, and your body may get too used to getting drugs. If that happens, some drugs will not work when they are needed.
3. Using a condom is the safest way for young people to protect themselves from STI's.
   Answer: FALSE – Using a latex condom is a good way to make sure you don't get an STI - but not having sex at all is the safest way.
4. Boys and men always know if they have a STI because they have problems taking a leak (urinating)).
   Answer: FALSE – Some STI's (like HIV & AIDS) don't have this symptom. Sometimes a boy or man can have an STI like gonorrhoea ("a dose" or "leak") and not have any symptoms.
5. Even if a girl or woman uses contraceptive pills, she can still get an STI.
   Answer: TRUE – The pill does not protect against STI's. Latex condoms are the only contraceptive method that can provide protection from STI's. Condoms are also good for preventing pregnancy.
6. Girls or women who have STI infections may have problems getting pregnant.
   Answer: TRUE – STI's can cause damage to the women's reproductive organs, making it difficult for her to have children
7. Men who are idlers often get STI's.
   Answer: false - It is not who you are, it is what you do. It is people who have sex without using latex condoms, especially if they have a number of partners, who often get STI's.
8. You can tell by looking at someone that they have HIV.
   Answer: FALSE
9. People often have an STI and do not know it and can spread it to others.
   Answer: TRUE
10. STI's, including HIV, are very serious problem of young people in Africa.
    Answer: TRUE – Every year, more and younger people get STI's.
11. Only men who have sex with men get HIV.
    Answer: FALSE – Anyone who doesn't practice safer sex can get HIV.
12. Men who have an STI can be cured by having sex with a virgin.
    Answer: - FALSE - In fact they are going to infect the virgin and stay infected.

Module 7
Family Planning and Contraceptive Methods

DSW

Table of Contents

Introduction

This module is on Family planning and contraceptive methods. It is divided into two chapters; chapter one focuses on Family planning and goes ahead to explain family planning and benefits of family planning to the children, family, men and women, and the large community. The chapter also gives information about accessibility of family planning and referral service in accessing family planning services.

Chapter two focuses on contraceptive methods and how to use them. The chapter also gives advantages and disadvantages of each contraceptive method. This chapter finally addresses male involvement.
The facilitation of this module with all its exercises is expected to take about 7 hours.

Learning objectives

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

- Understand the concept of family planning and benefits for the family and the community
- Describe usage, advantages and disadvantages of different contraceptive methods
- Discuss upon the most useful contraceptive methods in different situations

Chapter 1: Family Planning

1.1 Family Planning

Family planning is the voluntary use by a couple of different appropriate methods to anticipate and attain their desired number of children and the spacing and timing of their births. But it involves a lot more than using contraceptives:

The decision to have sex
Young adolescents and young people make a decision when to have sex. This decision lies entirely with the individual. The decision to have sex can also be looked at as being one aspect of family planning – no sex, no family. Young people have a right to decide when to have sex, however, the longer they delay having sex, the better is the position they find themselves in to make informed decisions and successfully plan their family.

The decision to have children
Many young adolescents and young people believe that it is a must to have children when living in a relationship. This is not true, because the decision to become pregnant and give birth is at the discretion of a couple, and both partners should be in agreement that they want children. Young adolescents and young people, especially boys, are not supposed to push for sex and pregnancy because girls as well have a decision to make; whether that is what they want or not.

Family size and frequency of child bearing
It is the sole responsibility of the couple to decide how many children they want to have and how big they want their family to be. It is not the responsibility or right of the man or the woman alone to decide how many children the family should have. Neither is it the right of the man alone to decide how often his wife will be pregnant. They have to decide together and it is the right of women to resist any forced pregnancies and child bearing.

The decision to use contraceptives
The use of contraceptive is a right of women as it is a right of men. Men should not only support their partners in matters related to contraception, they should in fact participate actively in family planning.

The benefits of family planning

To the CHILDREN
- Better health
- More food and other resources available
- Greater opportunity for emotional support from parents
- Better opportunity for education

To the whole FAMILY

- Freedom to decide when to have children
- Less emotional and financial strain
- Increased educational opportunities
- Increased economic opportunities
- More energy for household activities
- More energy for personal development and community activities

To WOMEN and MEN

- Better health
- Less physical/emotional strain
- Improved quality of life
- Increased educational opportunities
- Increased economic opportunities
- More energy for household activities
- More energy for personal development and community activities

To the COMMUNITY

- Reduced strain on environmental resources (land, food, water)
- Reduced strain on community resources (health care, education)
- Greater participation by individuals in community affairs

1.2 Accessibility of and referral for contraceptives

Accessibility

Contraceptives are widely available in most health facilities (including hospitals, health centres, clinics, pharmacies and drug shops) and from sexual and reproductive health or family planning organizations.

Even in non-medical enterprises, one can find contraceptives (e.g. condoms). Most government aided health facilities and sexual and reproductive health organizations provide contraceptives and information on their use free of charge.

Contraceptives can be bought in commercial enterprises such as private clinics, drug shops, pharmacies and shops (condoms). Where someone cannot afford contraceptives, it is possible to visit a government-supported health facility where contraceptives are available free of charge. The prices differ for different contraceptives. The condom and pill are the cheapest and tubal ligation and vasectomy are the most expensive ones, as they involve surgery.

Which particular contraceptive to use is a decision everyone will take individually. To choose which contraceptive works best for you, you need to know the advantages, disadvantages and proper use of the various available methods. You are therefore strongly advised to contact a qualified family planning service provider, a health care professional or counsellor before using any type of contraceptive.

Referral

When you are a Peer Educator or counselling young adolescents and young people on which contraceptives to use, remember to consider their individual situation.
It is important whether the individual is sexually active, has a permanent partner, is pregnant or not, and or whether he/she is HIV positive. For example, some contraceptives such as spermicides and diaphragm are not recommended for STI-infected persons, as they can increase the danger of re-infection, of contracting another or worsening an existing STI, and provide no protection for the partner.

This is why referral to qualified health care providers is important. Refer your clients to a health facility you know, and be sure to have evaluated and proved that this facility offers youth friendly services. Young adolescents and young people need youth-friendly services that provide for privacy, respect and equal treatment instead of being blamed.

After referral, follow up with both the individual and the health facility to establish whether your client actually received a satisfactory and youth-friendly service.

Chapter 2: Contraceptive Methods

Basic Information

A contraceptive is a drug or device used to prevent pregnancy. There are many contraceptive methods, but only the condom can prevent both prevent pregnancy and STI's. This Module 7 focuses on pregnancy prevention. For more detailed information on STI's, please refer to Module 6.

Most contraceptive methods are reversible; that means that a woman will be able to become pregnant again after she has stopped using the method. Some methods including male and female surgical sterilization are permanent, which means that the decision is final. A man who has undergone a vasectomy will never impregnate a woman, and a woman who has had a tubal ligation will never get pregnant.

This Module 7 introduces a range of contraceptive methods. Even though not all of the methods introduced may be recommended for young adolescents and young people or available where you are, it is important to know them and understand how they work.
Contraceptive methods are frequently referred to by the way they prevent pregnancy.
There are:

- Barrier methods
- Intrauterine methods
- Hormonal methods
- Surgical (permanent) methods
- Natural methods
- Emergency contraception
- Traditional methods

2.1 Barrier methods

2.1.1 Male Condoms

A male condom is a thin rubber sheath made of latex. It is placed on the erect penis before sexual intercourse to protect against unwanted pregnancy and STI's including HIV and AIDS. Condoms come with different features: they can be smooth, ribbed, studded, lubricated, flavoured, coloured etc. They should be used only once and then properly disposed off.

How it works
It works by preventing a man's semen from entering a woman's vagina, thus preventing the sperm and ovum from uniting and avoiding conception.

How to use a male condom

1. Always put on a condom on once the penis is erect and before any contact is made with your partner. Make sure to
   a. buy condoms from a reliable source and
   b. check if the condom is still okay by checking the expiry date and pressing the wrapper to check if it is sealed and also feel if pressure is still there.

2. Carefully open the package so as not to damage the condom. Don't use nails or teeth.
3. Penis should be erect (hard) before putting on the condom.
4. Squeeze the tip of the condom and put on the head of the penis (squeezing the tip allows for semen to collect and reduces the possibility of bursting).
5. While still holding the tip, unroll the condom down to the base of the penis. (Do not put on a condom after it has been unrolled, for it may tear in the process).
6. Then one is ready for intercourse.
7. After ejaculation (coming), hold the base (ring) of the condom and withdraw (pull out) the penis from your partner before the penis gets soft (holding the rim keeps the condom from slipping off).
8. Slide the condom off the penis without spilling the semen. (If possible one should use tissue paper, towel, or anything available when unrolling the condom).
9. If paper is available, wrap the condom in it and throw it in a pit latrine or bury it (condoms must only be used once).
10. Wash hands with soap and water.

Advantages:

- Condoms are 97% effective and they protect against most STI's if used correctly and consistently
- Condoms are the only contraceptives that can prevent STI's including HIV and AIDS and pregnancy at the same time
- Condoms are inexpensive and easy to get
- Condoms are lightweight and disposable
- Condoms do not require a prescription
- Condoms can help relieve premature ejaculation
- Condoms may help a man stay erect longer
- Condoms can be put on as part of sex play
- Condoms can be used with other methods

Disadvantages

Some men and women feel that the condom dulls sensation. Others become frustrated and lose some of their sexual excitement when they stop sexual engagement to put on a condom. Some men are self conscious about using condoms. They feel pressured about having to maintain an erection to keep the condom on. Others feel pressured to ejaculate. Many overcome these pressures and learn to enjoy using condoms by using them during sex play before intercourse.

Side effects

Condoms have no side effects except for people who are allergic to latex. Some women and men have such allergies. They may use plastic male or female condoms instead.

Effectiveness

A condom is extremely effective when used correctly. The effectiveness is increased when used with spermicides.

1.

Check the expiry or manufacturing date. Condoms should be used within 3 years of manufacturing date. Open package carefully.

Before any contact, place condom on tip of erect penis **with rolled side out.**

2.

Put on the condom before touching the vagina with the penis.

Squeeze the top of the condom and unroll the condom all the way to base of penis.

3.

If the condom does not unroll easily, use a new condom. It may be too old or backwards.

Lubricants can be used (water-based, not(!) oil-based) and should be used during anal intercourse.

4.

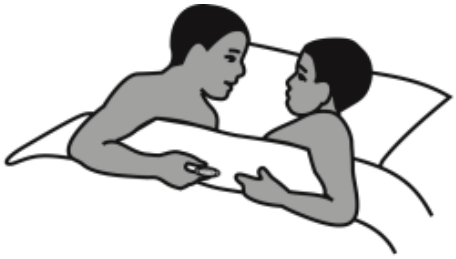
After ejaculation, hold rim of condom in place, and withdraw penis while it is still hard.

Be careful not to spill semen on vaginal or anal opening.

5.

Use only once
Throw away used condom safely.

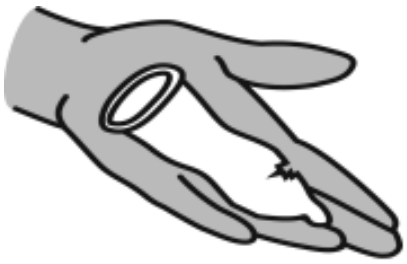
Remember to Use correctly EVERY TIME



For full protection, you need to use a condom EVERY TIME you have vaginal or anal sex. Use a condom every time to avoid infecting yourself or your partner. If you cannot use a condom every time, another method of family planning can prevent pregnancy but not infection.

Keep plenty on hand

Get more condoms before you run out.



Consider emergency contraception. (See page 33) Use an emergency contraceptive pill if condom breaks or slips. Condoms rarely break if properly used. If condoms break often, make sure they are not damaged or old. Review instructions for proper use. Also, try lubricated condoms, or use water or water-based lubricant on outside of the condom. Do not use a condom if the unopened package is torn or leaking, or the condom is dried out.

Water-based lubricants only

No oil-based lubricants!
Use only water-based lubricants, such as glycerine based, certain commercial lubricants, clean water, and saliva. Oils weaken condoms so condoms can break. Do not use oil-based materials such as cooking oil, baby oil, coconut oil, petroleum jelly, butter. Check whether the condom you are about to use is lubricated or not.

Sunlight and heat can make condoms weak and they can break.

Adapted from: Reproductive Choices for PLWHA, WHO, 2006, slide 22

More tips about condoms:

- Correct and consistent use of condoms protects you and your partner from STI's and pregnancy
- Using condoms is a responsible act that shows your concern for your own and your partners health
- Many married couples use condoms. They are not only for sex outside marriage
- Most people who use condoms do not have HIV and are healthy
- Proposing condom use does not mean a person is infected with HIV. It means that the person is responsible and caring. It does not imply mistrust
- Condoms are high quality and do not have holes
- Condoms do not contain or spread HIV
- Nearly everyone can use male condoms, regardless of penis size
- Using condoms may change the sensation of sex, but sex is still enjoyable. Some couple find sex even more enjoyable with condoms
- Male condoms do not make men sterile, impotent or weak and do not decrease their sex drive

Exercise 1: Step by step demonstration and practice on the correct use of a male condom

Objective: To enable each participant to use a condom correctly and safely
Method: Demonstration and exercises
Tools: Penis model, banana or bottles, cards with single steps from page 10, condoms
Time: 60 minutes

Facilitators' tasks:

1. Prepare in advance the step-by-step instruction on page 10. The sheets contain both illustrations and words describing the steps. Carefully photocopy the 5 steps of using a condom on cards or paper. (See annex for master copies).
2. Using a penis model and a condom, demonstrate how to properly remove a condom from the package and place it on the model, following the steps described below. Show the steps to follow when putting on a condom (about 5 minutes).
3. After the demonstration and a brief discussion, distribute penis models (you can also use bananas or bottles) and condoms, every the participant should put a condom on a model at least once.
4. Ask the participants to practice putting on and removing a condom using a penis model and a condom (10 minutes).
5. Summarize the main steps and ask for feedback from the participants. Can the exercise help master the use of a male condom? What are the problems?
6. Select five volunteers from the group of participants.
7. In random order, distribute the prepared "How to use a condom" cards to the volunteers.
8. Instruct volunteers to look at each other's cards and line up in correct order across the room (about 7 minutes).

9. Instruct the group to observe the problem solving skills used by members of the "card" group while completing the exercise.
10. After the participants with their cards are in the correct order, ask each volunteer to describe his/her card. Discuss any questions or comments participants may have (about 15 minutes).
11. Summarize the lessons learned and ask for feedback from the participants. What are the problems faced in performing the exercise? Can Peer Learning Groups use this exercise?

Myths and Misconceptions on condom use:

- Condoms break a lot and are not reliable
- Condoms fall off and get lost in the vagina
- Condoms are expensive
- There are defective condoms
- It is embarrassing to get condoms
- I do not have knowledge and skill in using a condom
- Condoms make peers more promiscuous
- I can't feel anything when I wear a condom; it diminishes pleasure
- None of my other friends use condoms
- It is embarrassing to be seen with a condom

Exercise 2: Identifying mental barriers in using condoms

Objective: Participants will be able to identify barriers in using condoms
Method: Large group discussions
Tools: Buzzing, brainstorming
Time: 25 minutes

Facilitator's tasks:

1. Ask participants to form buzz groups of 2 or 3 with their neighbours.
2. Ask them to briefly discuss and list 4 misconceptions, negative attitudes and behaviours towards the use of condoms (5–7 minutes).
3. Ask them to rank the barriers.
4. Ask one of the buzz group members to share the first two issues from the list with the whole group and brainstorm on them. (See example below)
5. Record the statements on a flip chart without comments.
6. Then screen and merge repeats and compare with the facts in the handout.
7. Rank the barriers in order of their potential to prevent a person from using a condom.
8. Summarize the important attitudinal and behavioural barriers against using condoms.
9. Ask for feedback from the participants. Has the exercise helped to identify some of the barriers?

Exercise 3: Life skills to overcome barriers to condom use

Objective: To enable participants to identify life skills to overcome barriers in using a condom
Method: Exercises
Tools: Flip chart, paper, pens, markers
Time: 35 minutes

Facilitators' tasks:

1. Ask participants to form four small groups. Use a group-dividing technique.
2. Assign to each group one of the four most prominent barriers identified and ranked earlier.
3. Ask the groups to identify and list the kind of life skills necessary to overcome the barriers to the use of a condom. Different life skills may apply to different behaviours. (See example below).
4. Allow 10 minutes for small group work.
5. When the time is up, let the groups come back.
6. Ask a presenter to brainstorm on the life skills identified.
7. Write on a flip chart the life skills mentioned (under the four barriers).
8. Summarize the main life skills learned for overcoming the barriers and ask for feedback. Was the exercise helpful?

Life skills in overcoming barriers in condom use

Myths or barriers	Life skills
• Condoms are not reliable or can be damaged easily	**Problem solving** Understand condom effectiveness Practice correct condom use, keep condoms away from heat and extreme coldness
• Condoms can get stuck inside the woman	**Critical thinking** Condoms which are placed properly on an erect penis cannot come off by themselves and stay inside your partner
• Condoms have viruses	**Critical Thinking** HIV cannot stay outside of human being or fluids of human beings for longer period of time
• There are defective condoms	**Problem Solving** Be able to identify defective condoms when you get them, know about condoms
• Buying a condom is embarrassing and it is a sign of promiscuity	**Self confidence** Be aware of yourself and have the confidence to get a condom. Having AIDS while you can protect yourself is more embarrassing than using a condom
• Condoms make people more promiscuous	**Self awareness and Self esteem** Using condoms and carrying them shows how protective you are
• Condoms decrease sexual pleasure/ satisfaction. • It is like eating candy with its wrapping/ banana with its peel.	**Effective communication** Sexual pleasure does not come only from sexual intercourse, there are other things you can do also. Most people do not experience a loss of feeling with a condom, but if you do you can use a lubricant with spermicide in combination with a condom (NEVER use petroleum jelly!). Condoms protect against STI's, HIV and avoid unwanted pregnancy

Male involvement in contraception and family planning

Men can physically participate in contraception and family planning by using condoms as detailed above, or having a vasectomy. However, this is not the only way men can participate in family planning interventions. In our society, ideas about manhood are deeply ingrained. From an early age, boys may be socialized into gender roles designed to keep men in power and in control. Many grow up to believe that dominant behaviour towards girls and women is part of being a man. Some men and boys tend to believe that anything to do with family planning is supposed to be done by women. This is not a good belief and there should be a change, so that men are allowed to participate fully in family planning by working with their partners all the way to plan their family and select and use appropriate family planning methods together.

Risk-taking and aggressive sexual behaviour on the part of young men are often applauded by peers and condoned by society. All these stereotypes result in harm to both women and men, and erode possibilities of establishing satisfying, mutually respectful relationships. Ideally, boys and young men can be encouraged to reflect upon and discuss issues surrounding masculinity, relationships and sexuality. This can contribute to the deconstruction of negative, high-risk and sometimes harmful attitudes.

Peer educators and facilitators should involve boys, male adolescents and youth in family planning, family life and life skills education to question current stereotypes about masculinity, male risk-taking behaviour (especially sexual behaviour) and to promote their understanding of and support for women's rights and gender equality.

Leaders in the community, parents, educators and youth should promote positive male role models that facilitate boys to become gender-sensitive adults and enable men to support, promote and respect women's sexual and reproductive health and reproductive rights, recognizing the inherent dignity of all human beings. Men should take responsibility for their own reproductive and sexual behaviour and health.

What Men Can Do to Support Women in Family Planning

1. Support women during the time of child-rearing, household work and income-generating activities. Male responsibilities should be emphasized with respect to child-rearing and housework.
2. Men should accord their wives (boys should accord girls) equal rights increase each other's knowledge, attitudes towards conditions necessary for achieving the harmonious partnership.
3. Men should play a key role in bringing about gender equality since, in our society, men exercise preponderant power in nearly every sphere of life, ranging from personal decisions regarding the size of families to the policy and program decisions taken at all levels of government.
4. Men should work towards improvement of communication between them and women on issues of sexuality and reproductive health, and the understanding of their joint responsibilities, so that men and women are equal partners in public and private life.
5. Male participation in family life should not be directed towards dominance but rather focused to shared responsibility and promoting active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; prenatal, maternal and child health; prevention of sexually transmitted diseases, including HIV and AIDS; prevention of unwanted and high-risk pregnancies; shared control and contribution to family income, children's education, health and nutrition; and recognition and promotion of the equal value of children of both sexes.
6. Male responsibilities in family life must be included in the education of children from the earliest ages. Special emphasis should be placed on the prevention of violence against women and children.
7. Equal opportunities between men and women in a relationship should be promoted at family level in matters of sexual relations and reproduction, including full respect for the physical integrity of the human body, decision to have sex, mutual respect and willingness to accept responsibility for the consequences of sexual behaviour.

Exercise 4: Male Participation in Family Planning Choices

Objective:	to help participants appreciate the involvement of males in family planning
Methods:	Question and answer, discussions
Tools:	Story of Tom and Dina
Time:	30 minutes

Facilitator's tasks:

1. Read or ask a participant to read the story below
2. Ask participants the following questions in relation to the story:
   - Why could you describe this family as successful?
   - What are the factors that lead to the success of this family?
   - Which family planning methods did Tom and Dina use?
   - What is your view on their decision to have only one child?
   - Have you learnt any lessons from Tom and Dina?
   - What are Tom's characters and attitudes that led to success of this family?
   - What are Dina's characters and attitudes that led to the success of this family?

The story of Tom and Dina

Dina and Tom met at a secondary school, when Tom transferred from the village school to join a city school in Kampala. They fell in love after having discussions together for some time. They used to meet every day and share meals as they discussed about their love. Many times, Tom demanded sex from Dina but she always told him that she was not ready. Tom could be disappointed but he waited for an opportunity when Dina would agree. He helped her when she was sick and encouraged her to do her exams whenever her motivation was low. When they finished senior four, Dina knew that it was time to start a family with Tom, since in her family all the girls were supposed to get husbands after senior four. They both passed well exams but Dina could not manage to go to A' level because her parents did not have any more money for fees. Tom went to A' level and finished with good grades to join the university. During this time, Dina operated a vegetable business in the neighbourhood.

Tom failed to get money for the university as well, and he started a chicken farm, using the money he borrowed from Dina. They remained friends and agreed to have sex only if they were sure of their relationship. Later they got married and got a daughter called Mimi. Since they both wanted to become responsible parents, they decided to remain with only one child. Dina was using injectables but later she refused to use them again. They visited a clinic which advised them to find suitable methods of family planning. Tom chose to use condoms to protect against unwanted pregnancies. Now their daughter is in P.7 and the family owns a supermarket near their home.

2.1.2 Female condoms

A female condom is a barrier method consisting of a thin rubber tube with flexible rings at each end; it is inserted into the vagina before sexual intercourse.

How it works

Prevents semen from entering the woman's body, protects the male partner from contact with vaginal fluids and therefore helps to prevent infection with STI'S/HIV.

How to use a female condom

The female condom can be inserted up to 8 hours before sexual intercourse. One of the rings is use to insert the device and hold it in place. The other ring stays outside of the vagina. The female condom must be removed immediately after intercourse and disposed of. Use only once!

A female condom looks like this:

Advantages of female condoms

- Protects against STI's and HIV and AIDS
- The female condom is lubricated to make it easier to use
- Can be put in any time before sex
- Protects against cervical cancer by avoiding infection with Human papillomaviruses

Disadvantages of female condoms

- They can be tricky to use at first; but practice makes perfect
- The inner ring is quite uncomfortable and can slide down if no properly fitted
- Like the male condoms, be careful when getting into contact with sharp objects (i.e. rings, nails etc) with the female condom
- It is possible for the man's penis to enter to the side of the female condom
- They can be quite expensive and not all Family Planning clinics have them
- It can slip out if not correctly inserted

Effectiveness

A female condom is extremely effective when correctly used.

Open package carefully
Make sure the condom is well-lubricated inside.
Use a new condom for each act of intercourse.
The female condom should be inserted before the penis touches the vagina.
It can be inserted up to 8 hours ahead of intercourse.

The condom is lubricated, but it may need extra lubricant inside so it is not moved out of place during sex.
More lubricant can be added either inside condom or on the penis.
Lubricant can be water-based or oil-based.

Choose a comfortable position—squat, raise one leg, sit, or lie down.

Squeeze the inner ring, at the closed end.

Gently insert the inner ring into the vagina.
Place the index finger inside the condom, and push the inner ring up as far as it will go.
Make sure the outer ring is outside the vagina and the condom is not twisted
Be sure that the penis enters inside the condom and stays inside it during intercourse.
When finished, carefully move away from your partner and take care not to spill semen on the vaginal opening.

To remove the female condom, twist the outer ring and gently pull.
Dispose of the condom safely.

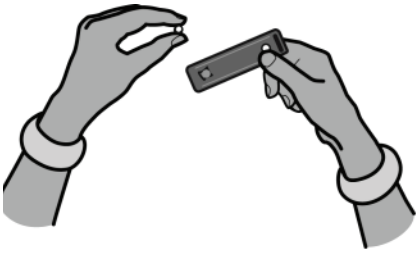
Remember to

Use correctly EVERY TIME

You need to use a condom EVERY TIME you have sex for full protection from pregnancy and infection. Use every time to prevent infecting yourself or your partner. You may also consider using another family planning method along with the condom.

Keep plenty on hand

Get more condoms before you run out.



Consider emergency contraception.
If the female condom does not stay in place or gets pushed inside the vagina, or if the penis was not inside the condom, emergency contraception can help prevent pregnancy.

All female condoms are lubricated. This may make the female condom slippery at first. You can use additional lubricant inside if needed. It can reduce noise during sex and makes sex smoother. Any kind of lubricant can be used with the female condom.

Adapted from: Reproductive Choices for PLWHA, WHO, 2006, slide 22

2.1.3 Diaphragm/Cervical cap

A Diaphragm/cervical cap is a shallow rubber cap that is placed inside the vagina before intercourse so that it covers the cervix.

How it works

Diaphragms/cervical caps prevent sperm from mixing with cervical mucus and entering the cervical canal thereby preventing the sperm from fertilizing the ovum. Spermicides provide added protection when used with diaphragm and are strongly recommended.

How to use a diaphragm/cervical cap

Diaphragm/cervical caps/cervical caps come in three types and a range of sizes. A trained health care provider will examine and determine the right size for you, and show you how to insert the diaphragm/cervical cap/cervical cap and check that it is in the correct position so that you can manage at home. It is advisable to use spermicides with the diaphragm/cervical cap/cervical cap to increase its effectiveness. The diaphragm/cervical cap must remain in place for at least six hours and not more than 24 hours after sexual intercourse. After use, it should be washed gently with soap and water, air dried and stored in a cool place.

Advantages

- The diaphragm/cervical caps/cervical caps are effective if properly used and every time you have intercourse
- There are no side effects unless you are allergic to rubber or to spermicides
- The diaphragm/cervical caps/cervical caps are immediately reversible form of contraception
- The diaphragm/cervical caps/cervical caps are low cost after the initial outlay. The diaphragm/cervical cap lasts several years with care
- The diaphragm/cervical cap can be inserted anytime and worn more or less all the time so its use does not interfere with sexual arousal.
- They are good if you need contraception only occasionally or for short periods now and then. Some women use a diaphragm/cervical cap or cervical cap during their fertile awareness (natural birth control) for contraception.
- They do offer some protection against those STI's that affect the cervix and upper reproductive tract (Cervical Wart, Virus, Gonorrhoea and Chlamydia).
- Many women wear a diaphragm/cervical cap if they have sex during menstruation to save soiling the sheets. It will hold an hour or two of average menstrual flow without leaking

Disadvantages

- Someone trained must fit them
- Some women don't like putting anything into their vagina
- Not every woman is anatomically suited to the available range of shapes and sizes
- Some women have difficulties with inserting the diaphragm/cervical cap themselves
- Occasionally the suction of the rim may lead to irritation of the vaginal lining
- Diaphragms in their plastic storage containers are too bulky for the average pocket or purse. This is not true for a cap.

Effectiveness

As with the cervical caps, diaphragms are between 92% and 96% effective at preventing pregnancy if used according to instruction.

2.1.4 Spermicides

These can be in the form of vaginal foaming tablets, cream or jelly and are inserted in the vagina before sexual intercourse to prevent pregnancy.

How it works

Makes the sperm unable to move to move towards the ova and blocks the path of sperm to the uterus. They also kill some sperm.

How to use spermicides

The spermicides are inserted into the vagina just before sexual intercourse. After each act of sexual intercourse, you need to insert more spermicide before the next act. One should not wash the vagina for at least 6 hours after sexual intercourse.

Advantages

Contraceptive foams, creams, jellies, film or suppositories can be used by just about any woman who wants to use them, but shouldn't be used many times a day. Some people may be sensitive to certain brands – they can try different ones.

Disadvantages

If not used exactly as directed, these products may not form a good barrier over the cervix. Some women complain of messiness or leakage. Spermicides may irritate the penis or vagina. Switching brands may solve this problem.

Side Effects

- Must be used before each sexual act and may interrupt sex if not inserted beforehand
- Causes more wetness of the vagina for several hours after intercourse
- Requires a woman to be willing to touch her vagina
- May cause skin irritation or annoyance to a woman or partner especially when used several times a day

Effectiveness

They are 79% effective if used alone and correctly. When combined with a condom, their effectiveness increases.

2.2 Intrauterine Methods

2.2.1 Intrauterine Devices (IUD)

The IUD is a unique method of birth control – it looks like a barrier method, but it is based on a chemical reaction. Intrauterine means "inside the uterus". An IUD is a plastic, T-shaped device about 3 cm long, generally coated with copper wire. Some IUDs also contain the hormone progestin. At the bottom of the IUD there are strings that hang inside the vagina, but cannot be seen outside. IUDs must be inserted into the uterus and removed by a trained person. They are not recommended for young women who have not yet had children, as there is a risk of infertility, and also for those with multiple or frequently changing sexual partners, as there is no protection against STI and HIV infections.

How it works

The essence of the copper wire changes the chemistry in the uterus, which makes it "unfriendly" to ova and destroys sperm before it can fertilize an ovum. An IUD does not protect against STI's.

- Copper T emits metallic ions, which kills sperm.
- Makes the sperm unable to swim and meet the ova

Advantages

IUDs are a popular form of reversible birth control. There is nothing to put in place before intercourse to protect against pregnancy. Some women say they feel free to be more spontaneous because they do not have to worry about becoming pregnant. Moreover, the ability to become pregnant returns quickly once the IUD is removed.

Side effects

Possible side effects that usually clear up after the first several weeks to months include

- Changes to menstrual flow (spotting between periods is common with IUD use)
- Menstrual cramps or backaches
- Inserting and/or removing an IUD can be very painful, especially if the women have never given birth.

Disadvantages

- Serious pain when put in and a few days afterwards, not recommended for adolescents.
- Must be inserted and removed by a health care professional.
- Longer and heavier periods in the first 3 months.
- Increased pain during periods.
- Can come out without the user noticing.

Effectiveness

It is very effective (97%) and protects for a long time, however, it is not recommended for young girls who have never given birth.

2.3 Hormonal methods

2.3.1 Oral contraceptives (the pill)

These are tablets containing artificial forms of hormones (chemicals) similar to those produced by the body to protect from getting pregnant. Different types of pills contain different levels of the hormones estrogen and progestin; there are also pills that contain only progestin. These hormones tell the ovaries not to let any ova cells ripen. The lining of the uterus becomes thinner and the entrance to the uterus is blocked by thick, jelly-like mucus, which makes it hard for sperm to reach the uterus. Birth control pills are taken every day and it is very important that the pills be taken at the same time every day, whether or not you have sexual intercourse. Pills should not be shared with anyone else.

If used properly and consistently, birth control pills can be 99.9% effective. If a woman forgets to take the pill for even a few days, it is possible for her to get pregnant. If a woman misses a pill for three or more days in a row, she should use a condom or other barrier method to protect against the risk of pregnancy. Most women do remember to take the pill on a daily basis. If a woman has problems remembering to take the pills, she should seek advice from a Family Planning Clinic about alternative contraceptive options.

How they work

- Suppressing the release of the ova (ovulation).
- Making the inner lining of the womb become thin so that implantation cannot take place.
- Making cervical mucus thick so that sperm cannot pass.

How to use the pill

The most common is the 21-day system whereby the woman takes a pill daily for 21 days then takes none (or iron containing pills) for 7 days. Women on contraceptives should see a gynaecologist at least once a year to be checked. Some women believe they should only use the pill for a year or two, and then stop. This is not necessary; the method can be used for many years provided the woman has regular check-ups.

Advantages

Taking the pill is simple, safe, and convenient. Many women who take the pill have fewer menstrual cramps and lighter periods. The pill does not interfere with having sex. Many women say it has improved their sex lives. They say it helps them feel more spontaneous. It also regulates the menstrual cycle, reduces menstrual flow, reduces acne, protects against certain cancers, and is totally reversible (once the woman using it is off the pill, her body resumes its normal cycle). When used correctly, the pill is very effective, making it the most reliable contraception available.

Other non-contraceptive benefits

It reduces the amount of blood lost and pain suffered during menstruation. Although this is a concern for some women, they can be reassured that it is not because the blood is staying inside the womb. The menstrual blood is reduced because the lining of the womb builds up less when a woman is taking the pill. When a woman stops taking the pill, she is usually able to get pregnant again quite soon.

Disadvantages

The pill doesn't protect against sexually transmitted infections and it may cause a few side effects such as irregular bleeding, breast tenderness, weight gain, headaches and nausea.
These side effects usually disappear after a few months, though. If you're on the pill and still suffer from side after a few months, see your doctor. As mentioned above, it does not protect you against sexually transmitted infections (STI's) or HIV and AIDS.

The most serious and rare side effect is that some women develop blood clots, especially if the woman;

1. Smokes cigarettes and is over the age of 35.
2. Has ever had any of the following conditions:
   - High blood pressure
   - Blood clots
   - Heart disease
3. The pill is not advisable in women who have or are suspected to have:
   - Swellings in the breast
   - Any unusual bleeding from the vagina

For healthy women who do not have one of these risk factors, taking the pill is less dangerous than having an unwanted pregnancy.

Effectiveness

If taken regularly and correctly, less than 1 woman per 100 will get pregnant. However, if you miss a pill or are sick or have severe diarrhoea, this could affect the performance of the pill and it is recommended that you use additional contraceptives (i.e. condoms) for the next 7 days.

The pill: beliefs, misconceptions and expectations

• The pill prevents pregnancy	• The pill makes you weak
• The pill is unreliable	• The pill is uncomfortable
• The pill causes deformed babies	• The pills collect in your stomach
• The pill causes sickness	• The pill prevents STI's

Exercise 5: Exploring experiences about the pill

Objective: At the end of the session, participants will have learned to identify beliefs and mis conception affecting the use of the pill

Method: Large group discussions

Tools: Buzzing

Time: 20 minutes

Facilitator's tasks:

1. Ask the participants to form buzz groups with their neighbours, mixing male and female participants.
2. Ask them to discuss their experience with the pill: their beliefs, fears, misconceptions and what they expect from the pill (5 minutes).
3. Ask each buzz group to take turns and share two of the fears or misconceptions identified.
4. Record on a flip chart, screen repeats and compares the beliefs with the facts in the training manual
5. Summarize the main misconceptions and ask for feedback from the participants. Did the

Exercise 6: Advantages and disadvantages of the pill

Objective: At the end of the session, participants will know the advantages and disadvantages of the pill

Method: Large group discussions

Tools: Buzzing

Time: 20 minutes

Facilitators' tasks:

1. Ask the participants to form a buzz group with their neighbours (you may change the seating order regularly) and discuss the advantages and disadvantages of the pill (5 minutes).
2. After 5 minutes, ask one member of each buzz group to share two of the identified advantages and two disadvantages of the pill.
3. Record the ideas on a flip chart under two columns: advantages and disadvantages.
4. Screen for repeats and compare with the facts from the handout.
5. Review the important lessons learned about advantages and disadvantages of the pill and ask for feedback from the participants. How useful was the exercise?

Advantages and disadvantages of the pill (an example)

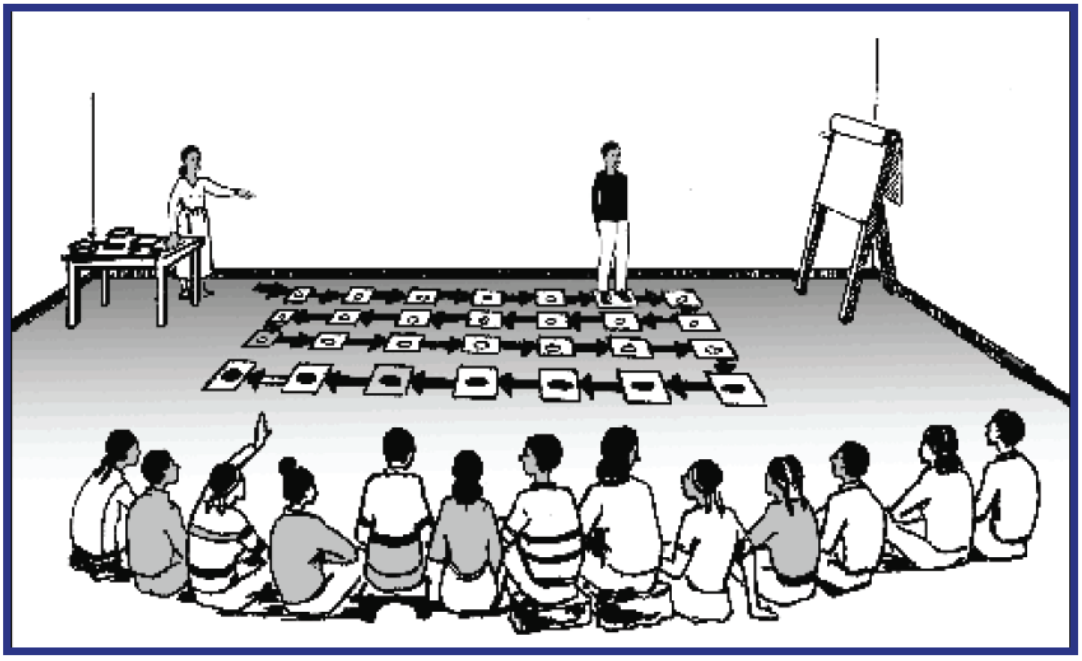
Advantages	Disadvantages
• Very effective in preventing pregnancy • Nothing to insert/take care of at the time of sex • Feels safer and more secure • When stopped, fertility returns quickly • Readily available • Less menstrual bleeding and pain, and more regular periods • Easy to stop if one wants to get pregnant	• Sometimes nausea, headaches, dizziness or sore breasts • Sometimes weight gain • Medical check-up is advisable • Does not protect one against STI's including HIV and AIDS. • Illness such as blood pressure and blood clots in a few women, especially older women who smoke • Must be taken daily

Exercise 7:	How to use the pill correctly
Objective:	Participants to learn how to correctly use the pill
Methods:	Large group discussions, buzzing, quiz, analysis questions, role-play and taking pills in relation to ovulation and menstrual cycle
Tools:	Packet of the pill, questions, role-play, 28 sheets of A4 paper with a flow chart and drawing of a menstrual cycle
Time:	1hr 20 minutes

Facilitator's tasks:

1. Give one pill packet (if possible) to each participant, or at least one per group.
2. Explain the steps of using the pill following the arrow on the package.
3. Ask participants to form a buzz group and discuss your input briefly. **Write the following questions on a flip chart or a large piece of paper (7 10 minutes).**
    1. Where will you get the pill?
    2. When do you take the pill?
    3. In what order will you take the pill?
    4. How will you remember to take a pill a day?
    5. What happens if you miss two days? Or three days?
4. Go round and conduct a quiz using the same questions.
5. Summarize the correct steps of using the pill and ask for feedback. Has the exercise clarified the correct use of the pill?
6. Stick the drawing of the menstrual cycle on the wall. (See Module 5, Section 2).
7. Draw arrows on each of the 28 sheets of A4 paper using a marker.
8. Put the arrow and the A4 size papers on the ground, like the pills (as seen in the picture below).
9. Each day represents each tablet to be taken every day. The average day for the menstrual cycle will be 28 days.
10. Ask a volunteer, male or female, to walk on the pills using the direction. Each step represents taking one pill.
11. Participants will ask the volunteer to stop when he/she steps on one arrow.
12. He/she will be asked to answer the following questions:
    - Where exactly is the stage of the menstrual cycle at this particular day?
    - What is the development of the ova at this day in the ovulation stage? (Use the drawing).
    - What exactly will the woman feel at this particular day?
    - What is the chance of the woman getting pregnant at this day? Is she safe? How safe?
    - What will happen if she forgets to take the pill on this particular day? How worrying it is for the chance of getting pregnant when she is on the last pills?
    - Why are these pills different? What are they for?
    - What will happen if a woman forgets to take it?
13. If the volunteer fails to answer the questions, please ask the trainees.
14. Ask as many volunteers as possible to walk on the papers representing pills.
15. Finalize the correct use of pills mentioned on the next page.
16. Ask for feedback from participants regarding this exercise. Has this exercise managed to equip you with the skill for correct usage of pills?

Picture illustrating how to use pills correctly



2.3.2 Injectables

Injectable contraceptives contain progesterone. An injection is given every two or three months, depending on the type, in the woman's arm or buttocks.

How they work

The hormones in injectables prevent pregnancy by causing changes in a woman's body similar to those caused by progesterone-only pills.

How to use

The woman gets an injection every two or three months, depending on the type of injectable.

Advantages

- You only have to think about it 4 times a year! You do not have to remember to take it every day
- Can be used by women who cannot take estrogens
- Can be used while breast-feeding
- Effective for 12 weeks
- Helps prevent cancer of the lining of the uterus
- No pill to take daily
- Nothing to put in place before vaginal intercourse
- It is reversible

Disadvantages

Injections not appropriate for women who are afraid of shots.

Effectiveness

Injectables are extremely effective (99.7%) in preventing pregnancy.

2.3.3 Implants

How it works

Implants prevent pregnancy by slowly releasing small amounts of progesterone into the body every day. They consist of small, thin plastic capsules containing progesterone. Implants contain a smaller dose of progesterone than the pill or injectables. It therefore works to prevent pregnancy the same way and has the same side effects as other program-only pills and injectable methods, especially the effects on menstruation. But these side effects are usually minimal. During the first months, bleeding may be irregular. There may be spotting in between periods, or the periods may be longer or more frequent. Usually menstrual periods will resume their normal pattern within 9–12 months. Once an implant is removed, fertility returns quickly.

How to use

The implant is placed under the skin of the upper arm through a small cut, during a minor operation with local anaesthesia. Implants must be inserted and removed by a trained health worker. Once implanted, the tubes cannot be seen easily, although they may be felt if the skin.

Advantages

- Can be used by women who cannot take estrogen
- Nothing to put in place before vaginal intercourse
- Can be used while breast-feeding
- Gives continuous long-lasting birth control without sterilization for seven years
- No birth control to take every day
- Ability to become pregnant returns quickly when use is stopped

Disadvantages

The most common side effect of implants is not serious. It is irregular bleeding which may include irregular intervals between periods. This includes:

- Longer or heavier menstrual flow
- Irregular bleeding or spotting between periods
- No menstrual bleeding for months at a time

Bleeding usually becomes more regular after the first two years. Moreover, it does not protect against sexually transmitted infections (STI's) or HIV and AIDS.

Effectiveness

The implant "Norplant" is highly effective, with a success rate of 99.9%. It remains effective for up to five years. Studies have shown that it is slightly less effective in women with more than 70 kilograms body weight.

2.3.4 Birth control patch (Contraceptive patch)

This is a thin 5 cm patch that is worn on the woman's buttocks, abdomen or upper arm. The patch releases estrogen and progestin through the skin into the bloodstream. Patches are worn for one week at a time for 3 consecutive weeks; the fourth week a patch is not worn and menstrual bleeding occurs. A patch is only available through a health professional, and is about 99% effective in preventing a pregnancy when used properly.

The patch can be worn while in water (swimming or bathing). Side effects may include breast tenderness, headache, nausea, upper respiratory infection, menstrual cramps and abdominal pain. There may also be skin irritation where the patch is worn.
Note: The patch does not prevent against STI's, and should always be used together with a (male) condom.

2.4 Permanent methods

These are sometimes also referred to as sterilization or surgical methods. They include vasectomy for males and tubal ligation for females. Once done, it is not reversible.

2.4.1 Tubal ligation (female sterilization)[1]

Tubal ligation is considered a major surgery requiring the patient to undergo general anaesthesia. It is advised that women should not undergo this surgery if they currently have or have a history of bladder cancer. After the anaesthesia takes effect, a surgeon will make a small incision at each side of, but just below the navel in order to gain access to each of the 2 fallopian tubes. With traditional tubal ligation, the surgeon severs the tubes, and then ties (ligates) them off thereby preventing the travel of eggs to the uterus. Tubal ligation is usually done in a hospital operating-room setting.

A tubal ligation is approximately 99% effective in the first year following the procedure. In the following years the effectiveness may be reduced slightly since the fallopian tubes can, in some cases, reform or reconnect which can cause unwanted pregnancy. Method failure is difficult to detect, except by subsequent pregnancy, unlike with vasectomy or IUD.

2.4.2 Vasectomy (male sterilization)

Vasectomy is a surgical procedure for male sterilization and/or permanent birth control. During the procedure, the vasa deferentia of a man are severed, and then tied/sealed in a manner such to prevent sperm from entering into the seminal stream (ejaculate). Vasectomies are usually performed in a physician's office or medical clinic. Due to the simplicity of the surgery, a vasectomy usually takes less than 30 minutes to complete. After a short recovery at the doctor's office (usually less than an hour), the patient is sent home to rest. Because the procedure is minimally invasive, many vasectomy patients find that they can resume their typical lifestyle routines within a week, and do so with minimal discomfort. Because the procedure is considered a permanent method of birth control. men are usually counselled/advised to consider how the long-term outcome of a vasectomy might affect them both emotionally and physically.

2.5 Natural methods

These include all methods that do not involve taking any drugs or using a device to prevent pregnancy. Most of these methods involve finding out when ovulation occurs during the menstrual cycle. The woman then needs to cooperate with her partner to avoid sexual relations during the days when she is likely to get pregnant. Since it can be difficult to tell the day of ovulation or the fertile phase when ovulation takes place, it is very unreliable and therefore not recommended here for adolescents. The natural methods include the following:

2.5.1 Abstinence

This is where one totally refrains from sexual intercourse. It is 100% effective at preventing pregnancy and has no side effects.

2.5.2 Lactational Amenorrhea Method (LAM) (prolonged breast-feeding)

LAM is a family planning method that uses breastfeeding to prevent pregnancy. It is most effective in a woman whose periods have not yet returned and when the baby is less than 6 months old breast-feeding exclusively (at least 10 times every day). The method's effectiveness is reduced when the baby starts eating other foods besides breast-milk and therefore breast-feeding is less frequent. It is not recommended for mothers with babies above 6 months.

2.5.3 Cervical Mucus Method

Here one has to observe the change in cervical mucus that takes place during ovulation. During ovulation the cloudy, tacky mucus becomes clear and slippery in the few days before ovulation. It also will stretch between the fingers. The woman has to put her fingers into her vagina to feel and look at this mucus so as to avoid sexual intercourse during this fertile period.

2.5.4 Basal Body Temperature

It requires a girl/woman taking her body temperature every morning before getting out of bed. The body temperature rises between 0.2oC and 0.4oC during ovulation. It remains at that level until her next period. Pregnancy may occur during two days before the temperature rise until six days after. This method requires plenty of discipline and knowledge of one's body.

2.6 Emergency Oral Contraceptives (EOC)

They are oral contraceptives taken within 72 hours after unprotected or forced sex to help avoid pregnancy. They prevent the release of the ova only and do not disrupt existing pregnancy. Emergency contraception can be given within 72 hours to women who have had unprotected sex, forced sex or their normal method of birth control cannot be relied upon. For example, the condom may have broken or she may have missed some contraceptive pills. There are two methods commonly used, either high dose hormonal pills (known commonly as the „morning-after-pill") are given or an IUD can be fitted. To ensure correct use of emergency contraceptives, young people should consult trained health workers. If sex was forced, the girl may need medical

[1] *Wikipedia*

care and also special counselling. The actual reliability is 95% at preventing unwanted pregnancy. This method is less effective than other family planning methods and should not be relied on routinely.

2.7 Traditional methods

Cultural traditional methods are contraceptive methods whose effectiveness has not been scientifically proven; hence adolescents are not encouraged to use and rely on them. In Africa, they include some of the following:

- Using charms, spells, e.g. tying a string or amulets around the waist
- Drinking herbs prepared from certain leaves, or roots
- Eating certain foods or taking the holy water
- Jumping with the legs spread out after sexual intercourse for the semen to come out of the vagina

Exercise 8: Exploring and deepening knowledge on contraceptive methods

Objective: To familiarize participants with contraceptives and family planning methods which are suitable for young people

Methods: Matching, analysis questions, large group work

Tools: Buzzing, cards, handout

Time: 45 minutes

Facilitators' tasks:

1. Prepare a set of cards with the different contraceptive methods and another set with the corresponding descriptions.
2. Have the group seated in a circle. Ask participants to form a buzz group of 2 or 3 with their neighbours.
3. Mix the two sets of cards and distribute them to each buzz group equally.
4. Ask every buzz group to read out what is on their card.
5. Ask for the one who has a matching card to read it out (method card or description card).
6. Show example by matching one correctly
7. Ask the buzz groups (and if necessary allow the buzz groups to discuss briefly),
   - What Is The Name Of The Method?
   - How Is It Used? And
   - How does it prevent conception, STI's and HIV and AIDS?
8. Write the important points on a flip chart.
9. Add important facts. Use the background information provided below.
10. Summarize the main methods learned and ask for feedback. Can participants use this exercise with Peer Learning Groups?

Note: Use the larger portion of your time for methods that are actually available to young people where you live, probably condoms, the pill, injectables, implants and abstinence.

Contraceptive Methods	Descriptions
Condom	Barrier method: rubber sheath
Spermicides	Chemical contraceptives: creams, jellies, foam, tablets, suppositories
Diaphragm	Shallow rubber cup with a rim
Diaphragm /cervical caps	Soft rubber cap covering only cervix
Contraceptive sponge	Round sponge with spermicides
The pill	The pill containing only progesterone
Norplant	Six plastic tubes with progesterone
IUD: Intrauterine devices	Plastic device inserted into the uterus
Male sterilization (Vasectomy)	Disconnecting the vasa deferentia
Female sterilization (Tubal Ligation)	Disconnecting the fallopian tubes
Natural methods	When ovulation occurs in menstrual cycle
Traditional methods	Using charms or spells, eating or drinking plants, etc.
Abstinence	Avoiding sexual intercourse

Exercise 9: Ranking contraceptive methods and analysis of advantages and disadvantages of selected contraceptive methods

Objective: To enable participants decide on appropriate contraceptive methods for themselves and identify the advantages and disadvantages of selected contraceptive methods

Method: Large and small group work

Tools: Buzzing, ranking brainstorming

Time: 45 minutes

Facilitator's tasks:

1. Collect the method cards from the first exercise and redistribute them to the buzz groups.
2. Ask the same buzz groups to rank the contraceptive methods in order of their suitability for young people in regards to: availability, safety, and easy use.
3. Write on the ground or on the top of a flip chart horizontally: "most useful", "less useful", "not useful at all", "don't know".
4. Ask the buzz groups to place the card where they think it belongs.
5. Ask them to tell why they have put it there.
6. Participants may suggest the following as most useful: condom, oral contraceptives, injectables, implants and abstinence.
7. Explain to participants that the above five are most appropriate for sexually active adolescents.
8. Summarize the main methods and ask for feedback from participants.

9. Has the ranking exercise enabled you to decide on appropriate methods?
10. Ask participants to form four small groups.
11. Write each of the four methods (condom, the pill, injectables/implant and abstinence) on a piece of paper and fold it.
12. Ask each small group to draw one from the four.
13. Ask the small groups to brainstorm on the advantages and disadvantages of the method they have drawn.
14. Tell them to place them under two columns (see example below) on a flip chart or a large piece of paper.
15. Allow 10 minutes for small group work.
16. Bring all groups together and ask presenters of each group to report as recorded on the flip chart
    (3 minutes).
17. Ask for comments. If necessary, make additional suggestions from information provided in the basic information.
18. Review the major advantages and disadvantages and ask for feedback. Have there been any difficulties in using this exercise to identify advantages and disadvantages?

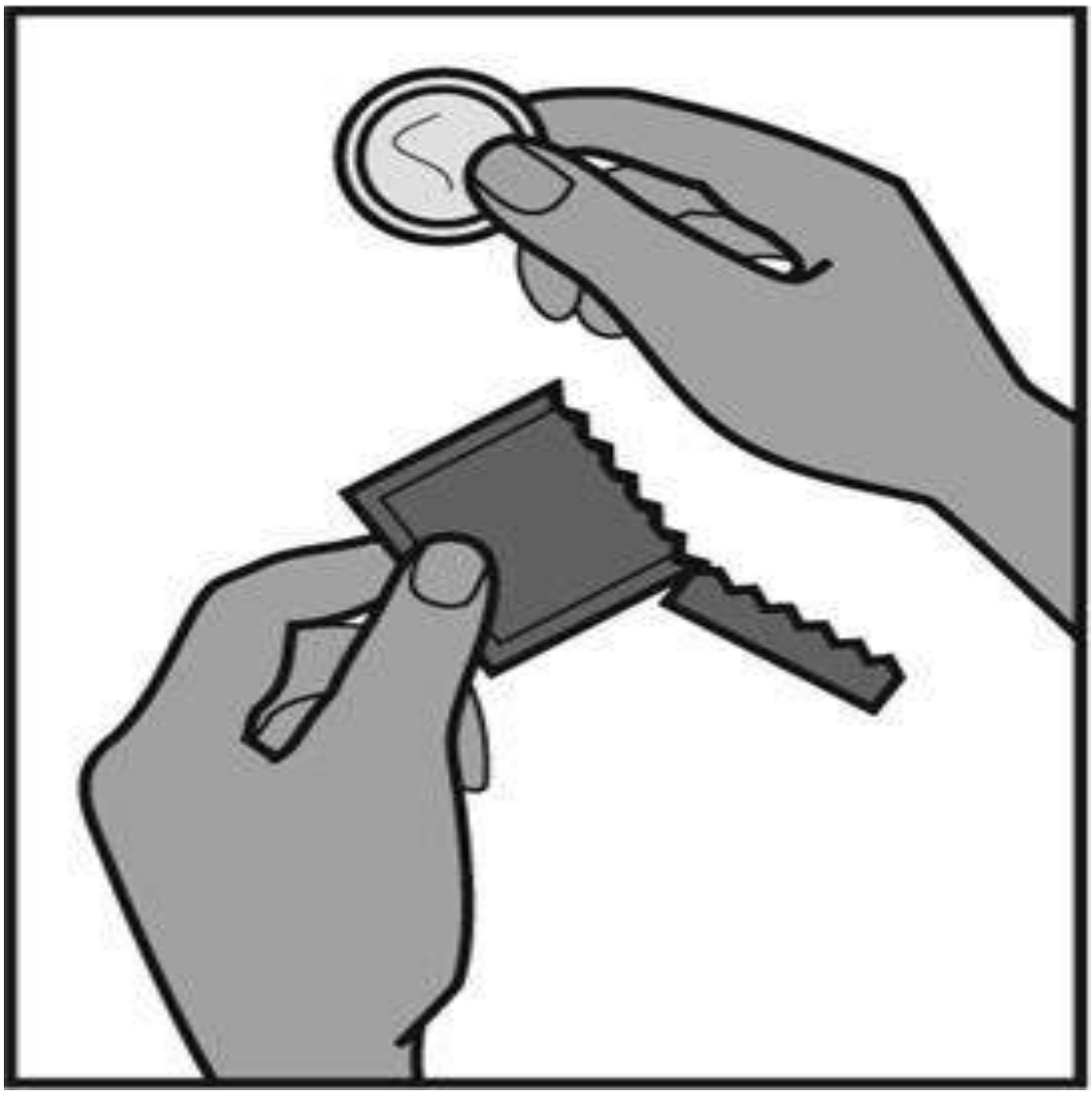
Advantages/disadvantages of selected methods (an example)

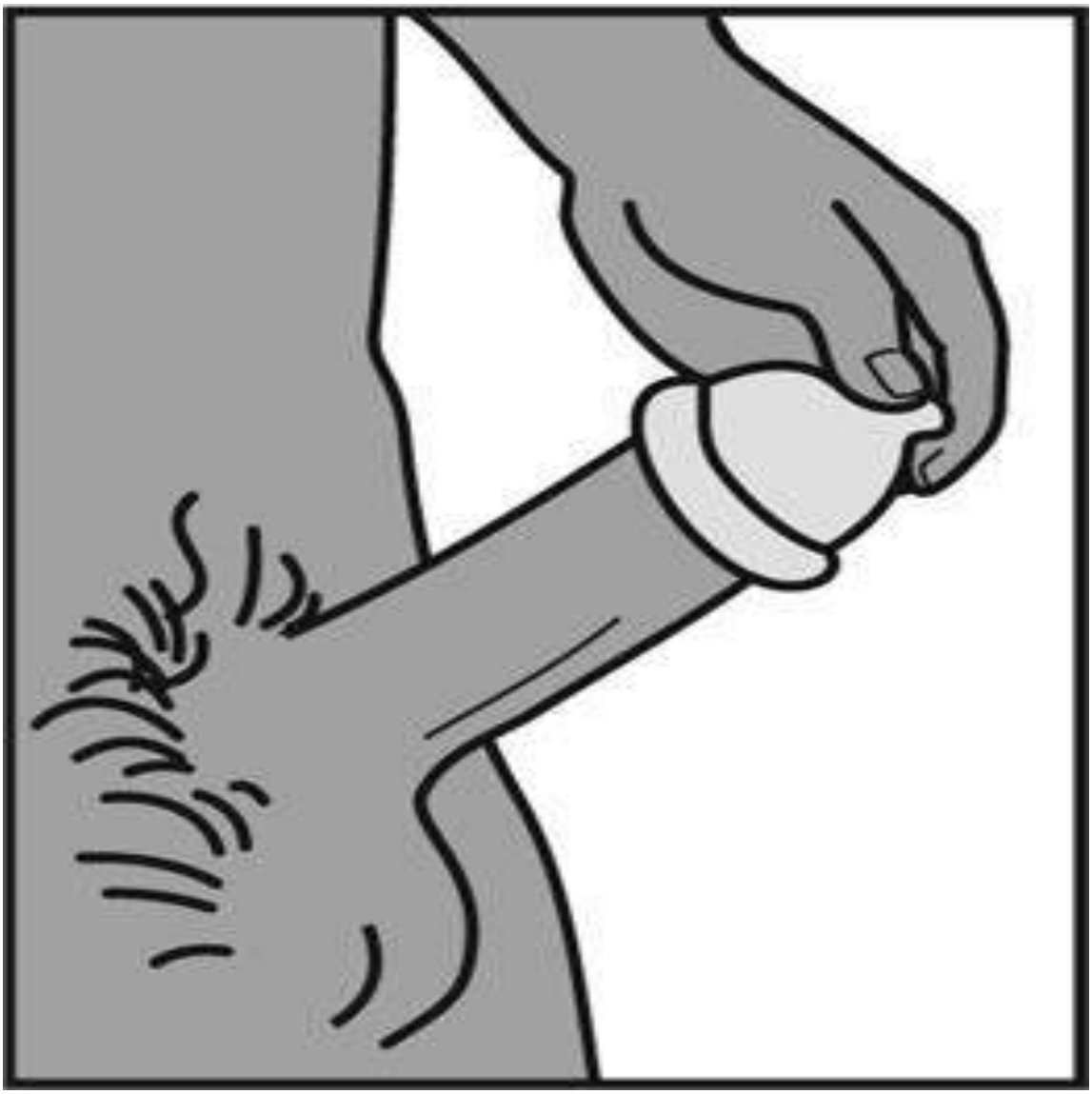
Condom	• Prevents STI's including HIV and AIDS • Prevents pregnancy • Doesn't necessitate going to the clinic • Success rate 97%	• Partner may refuse to wear condom • Takes partner longer time to "come" • The condom could break or slip off • Less lubrication during sex • Less enjoyment due to reduced sensation for the man
The pill	• Highly effective in prevention of pregnancy • Reduces blood lost during menstruation • Easy to get	• Must be swallowed every day at the same time • Can be missed/forgotten • Small temporary side effects • Doesn't prevent STI's
Injectables	• Easy to use • Long-acting (2–3 months) • Success rate of 99.7%	• Not easily available • Menstrual period irregular for some time • Fertility returns after 12–14 months • Don't prevent STI's
Norplant	• Highly effective • Success rate of 99.9% • Long-acting 5 years • Fertility returns quickly	• Must be inserted by a trained health worker • Bleeding irregular for a short time • More frequent periods or longer period
Abstinence	• Highly effective • No side effects	• Requires decision and discipline • May not persist

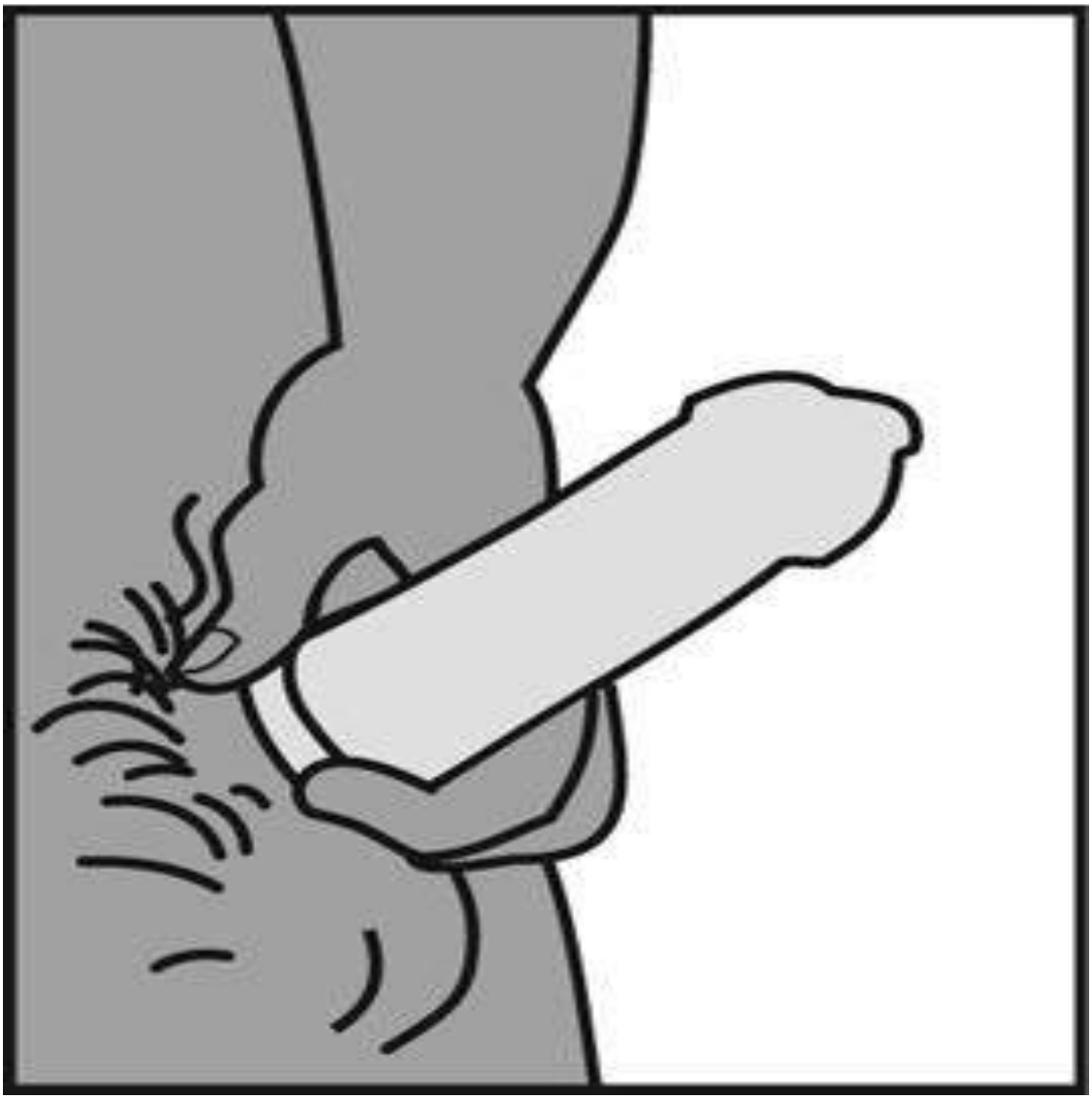
Annex Tools and master copies Module 7

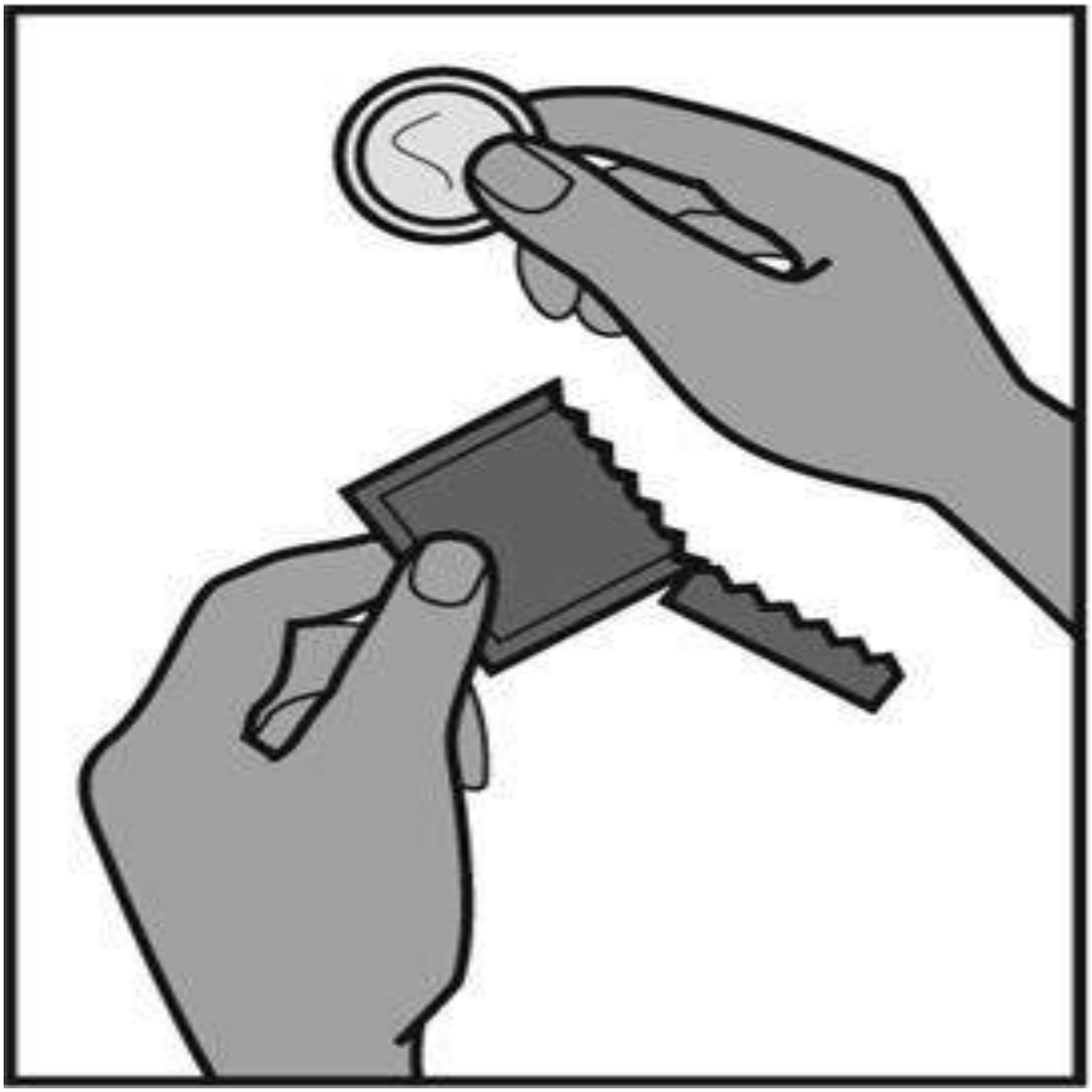
List of learning tools

- SRH facilitators' training manual
- Flip chart, flip chart paper or large sheets of paper
- Markers in different colours
- Chalk to write on the floor or a black board
- Note paper
- Glue stick, pins, cello tape
- Scissors
- Cartons to be cut into facilitation cards
- Cards or slips of paper, scrap paper to cut notes
- A variety of contraceptives for demonstration purposes
- Penis model, banana or bottles, condoms
- Any other demonstration or supporting tool that may be useful









Handout: Contraceptive Methods

Contraceptive Methods	Descriptions
Condom	Barrier method: rubber sheath
Spermicides	Chemical contraceptives: creams, jellies, foam, tablets, suppositories
Diaphragm	Shallow rubber cup with a rim
Diaphragm/Cervical and caps	Soft rubber cap covering only cervix
Contraceptive sponge	Round sponge with spermicides
The pill	The pill containing only progesterone
Norplant	Six plastic tubes with progesterone
IUD: Intrauterine devices	Plastic device inserted into the uterus
Male sterilization (Vasectomy)	Disconnecting the vasa deferentia
Female sterilization (Tubal Ligation)	Disconnecting the fallopian tubes
Natural methods	When ovulation occurs in menstrual cycle
Traditional methods	Using charms or spells, eating or drinking plants, etc.
Abstinence	Avoiding sexual intercourse

Tips about condoms:

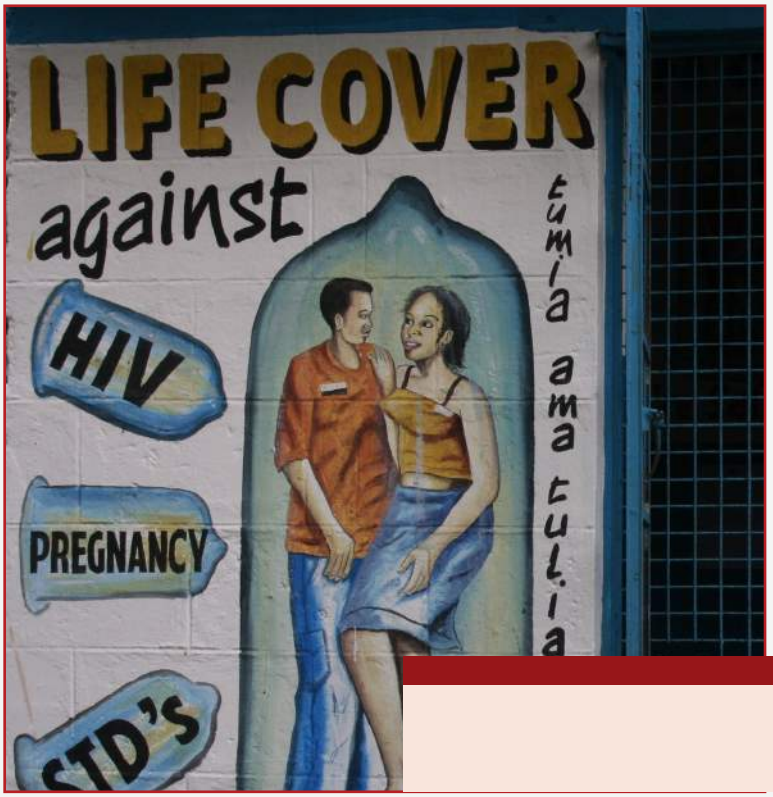
- Correct and consistent use of condoms protects you and your partner from STI's and pregnancy
- Using condoms is a responsible act that shows your concern for your own and your partners health
- Many married couples use condoms. They are not only for sex outside marriage
- Most people who use condoms do not have HIV and are healthy
- Proposing condom use does not mean a person is infected with HIV. It means that the person is responsible and caring. It does not imply mistrust
- Condoms are high quality and do not have holes
- Condoms do not contain or spread HIV
- Nearly everyone can use male condoms, regardless of penis size
- Using condoms may change the sensation of sex, but sex is still enjoyable. Some couple find sex even more enjoyable with condoms
- Male condoms do not make men sterile, impotent or weak and do not decrease their sex drive

Advantages and disadvantages of the pill (an example)

Advantages	Disadvantages
• Very effective in preventing pregnancy • Nothing to insert/take care of at the time of sex • Feels safer and more secure • When stopped, fertility returns quickly • Readily available • Less menstrual bleeding and pain, and more regular periods • Easy to stop if one wants to get pregnant	• Sometimes nausea, headaches, dizziness or sore breasts • Sometimes weight gain • Medical check-up is advisable • Does not protect one against STI's including HIV and AIDS. • Illness such as blood pressure and blood clots in a few women, especially older women who smoke • Must be taken daily

Handout: Life skills in overcoming barriers in condom use

Myths or barriers	Life skills
• Condoms are not reliable or can be damaged easily	**Problem solving** Understand condom effectiveness Practice correct condom use, keep condoms away from heat and extreme coldness
• Condoms can get stuck inside the woman	**Critical thinking** Condoms which are placed properly on an erect penis cannot come off by themselves and stay inside your partner
• Condoms have viruses	**Critical Thinking** HIV cannot stay outside of human being or fluids of human beings for longer period of time
• There are defective condoms	**Problem Solving** Be able to identify defective condoms when you get them, know about condoms
• Buying a condom is embarrassing and it is a sign of promiscuity	**Self confidence** Be aware of yourself and have the confidence to get a condom. Having AIDS while you can protect yourself is more embarrassing than using a condom
• Condoms make people more promiscuous	**Self awareness and Self esteem** Using condoms and carrying them shows how protective you are
• Condoms decrease sexual pleasure/ satisfaction. • It is like eating candy with its wrapping/ banana with its peel.	**Effective communication** Sexual pleasure does not come only from sexual intercourse, there are other things you can do also. Most people do not experience a loss of feeling with a condom, but if you do you can use a lubricant with spermicide in combination with a condom (NEVER usepetroleum jelly!). Condoms protect against STI's, HIV and avoid unwanted pregnancy



Module 8
Peer Counselling Service

DSW

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Introduction

This Module 8 seeks to draw a line between different peer-led approaches and provide knowledge and skills to support solution-oriented discussions (peer counselling) in regard to specific ASRH and related problems among peers.

The facilitation of this Module with all its exercises is expected to take 5 hours. If you start with this Module, please refer to Module 1 (Effective Facilitation) for additional instructions on how to facilitate this Module effectively and in a participatory way.

Learning objectives

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

- Understand peer counselling services
- Identify and explain effective peer counselling skills
- Create a conducive environment for peer counselling services
- Apply knowledge and skills on conducting peer counseling service

Chapter 1: Concepts of Peer Counselling

1.0 Concepts of peer counselling and its justification

Peer support occurs when people provide knowledge, experience, emotional, social or practical help to each other. It commonly refers to an initiative consisting of trained supporters, and can take a number of forms such as peer mentoring, listening, or counselling. "Peer" means that the relationship between counsellor and client is one of equality, e.g. both are of the same age or gender, from the same social setting, etc.

Peer-led approaches have been successful in sex education programmes for young people, who feel more comfortable talking about sexuality with their peers in a safe environment rather than turning to an adult with their problems, questions and concerns. It should, however, be stressed that the concept of 'peer counselling' sometimes confuses people. In some situations, so-called peer counselling (for example, young people answering a hotline) should be considered as 'young people providing appropriate information and referral to their peers'.

Although there is little experience of good practice and limited evidence of the effectiveness of young people acting as 'counsellors' for their peers (as opposed to 'peer information' programmes), this approach may be appropriate in reaching some groups of especially vulnerable young people. The method is often used in HIV testing and counselling and supporting young people living with HIV. Counselling services are usually provided by trained professionals.

In DSW's Youth-to-Youth (Y2Y) Initiative, peer counselling/education/information provided by trained peer counsellors/peer educators is an important element. Many youth clubs under the Y2Y Initiative provide peer education and information services, and when a peer education programme is delivered, it is not uncommon for a young person from the audience to share a personal problem with one of the peer educators and ask for advice .

This Module has been designed as a guideline for peer counselling in order to build club members' capacities to provide personal counselling within their professional scope, as may be requested by peers during programmes conducted under the Youth-to-Youth Initiative. In this context, peer counselling refers to a one to one private discussion. It helps to understand reproductive health, clearing doubts, getting rid of unfavourable behaviours and awareness on the different ways of keeping reproductive health intact and take the right decisions without any pressure.

Exercise 1: Snowball fight

Objective: Clarify the difference between peer education and peer counselling
Method: Group discussions and presentations or individual work
Tools: Pens, papers and flip chart
Time: 25 minutes

Facilitator's tasks:

1. Have the participants brainstorm for a working definition for peer counselling, ending with a definition that is close to this one: 'Youth peer counselling is a situation where a young person turns to a trained person of his or her own age for understanding, assurance, and assistance in coping with a personal problem.'
2. Give one sheet of paper per participant and pens.
3. Ask participants to write on a sheet of paper what they think are the differences between peer counselling and peer education.
4. When they are finished, ask participants to crumple their sheets into a paper ball, and throw the balls around for a few minutes to other participants (having a 'snowball' fight), so that everyone gets someone else's response. Have each person read the response they now hold, ask them to respond, and then ask the group react. Structure and summarize the discussion around the following issues:

Role of an ...educator'

- Knows the content
- Teaches for a specific amount of time, usually short-term
- Is goal-oriented
- Works to improve knowledge, attitudes, and skills to facilitate behaviour change
- Refers to other professionals as needed

Role of a ...counsellor'

- Is trained in counselling skills
- Conducts counselling as a potentially long-term process
- Works with a person's thoughts, feelings, and behaviour
- Has an open-ended relationship with the person being counselled
- Is relationship oriented
- Addresses motivation, denial, and resistance on a personal level

At the end of this training session, highlight the differences between the three peer-led approaches – peer information, peer education, and peer counselling:

Types of peer-led approaches :[1]

	Peer information	**Peer education**	**Peer counselling**
Objectives	Awareness Information Attitude change	Awareness Information Attitude change Skills building	Information Attitude change Prevention skills solving/coping skills
Coverage	High	Medium	Low
Intensity	Low	Medium/high	High
Confidentiality	None	Important	Essential
Focus	Community Large groups	Small groups	Individual
Training required	Brief	Structured workshops and refresher courses	Intense and long
Examples of activities	Distribution of material in public events (sports events, youth concerts), World AIDS Day	Repeated group events based on a curriculum	Counselling of young people living with AIDS Clinic-based youth counselling on reproductive health

Exercise 2: Understanding peer counselling services and its necessities

Objective: Inform and make participants aware of what peer counselling services are

Method: By comparing their experience in providing counselling services wiht basic information and evidence

Tools: Sharing experiences, role play

Time: 30 minutes

Facilitator's tasks:

1. Give a brief introduction on peer counselling service.
2. Invite 2 volunteers to simulate for 3 minutes a discussion related to unwanted pregnancy.
3. Invite participants to share their experiences from peer counselling with the person sitting next to them. Encourage them to discuss freely on what they think about counselling service.
4. Ask them to present what they have discussed.
5. The points raised by each pair will be written down on a flip chart without commenting them at this point. Group similar ideas/points.

[1]*Handout, projected on a screen or shown on the flip chart: Types of Peer-Led Approaches (B); Youth Peer Education Toolkit, Training of Trainers Manual, United Nations Population Fund and Youth Peer Education Network (Y-PEER), 2005.*

6. Explain what peer to peer counselling service is, based on the information provided herein.
7. Open the floor for discussion so that participants can see if/how much their preliminary ideas differ from the definition. Conclude stating that peer-led approaches are not about teaching or advising, but rather seeking to enable the peer to opt for a healthy sexual life and make the right choices and decisions on his/her own.
8. Ask participants to discuss the following topics:
   - Behaviour of the peer counselling provider
   - The skills needed by a peer counselling provider
   - The role of the peer counselling provider

Exercise 3: Kinds of problems for which young people may seek support from a peer

Objective:	Identify the problems for which young people may seek support from a peer
Method:	Group discussions and presentations
Tools:	Pens, papers and flip chart, markers
Time:	25 minutes

Facilitator's tasks:

Facilitator: Points out that when a peer education programme is delivered, it is not uncommon for a young person from the audience to share a personal problem with one of the peer educators and ask for advice. In such a case, it is crucial that:

- The peer educator is a sensitive listener and has the required referral skills.
- The team of peer educators is supervised by competent adults to whom they can turn for advice.
- Peer educators must realize that they may face sensitive and difficult issues, when they will need to be able to link to other services, counsellors, and trusted adults.

1. Ask participants to brainstorm about the kinds of problems for which young people seek support from a peer.
2. List their responses on the flip chart. You can add the following examples if they are not mentioned: unhappiness (depression), difficulties in relationships with friends or adults (parent, teacher), problems related to school, problems related to sexual behaviour, unwanted pregnancy, substance abuse, etc.
3. Lead a group discussion and reflection on following issues:
   - Do peer counsellors in your programme possess all the knowledge and skills required to give appropriate support in dealing with the problems listed above?
   - Did they get specific training to do so?
4. What obstacles might stop them from giving proper support?
5. What might the dangers be if peers give inappropriate support?

1.1 Skills needed by ASRH peer counselling providers

A peer counselling provider on adolescent sexual and reproductive health needs, for example, sufficient knowledge of reproductive organs, youth behaviour, norms, gender, alcohol and drug addictions, Sexually Transmitted Infections (STIs) including HIV and AIDS, contraceptive methods, life skills and skills on how to keep referral records. Hence he/she must have a well developed adequate communication skill so as to express his/her thoughts, ask proper questions, listen and make effective use of all available aids and counselling procedures.
(Refer to *basic information below)*

In addition, he/she must have well developed communication skills to be able to express his/her thoughts properly, ask appropriate questions, listen and effectively use available counselling methods and tools. *(See basic information below)*

Exercise 4:	Skills needed by peer counselling providers
Objective:	Enable the participants to understand the characteristics and roles of peer counselling service providers
Method:	Group work, brainstorming, discussion
Tools:	Flip chart, markers, pens
Time:	20 minutes

Facilitator's tasks:

1. Summarize what has been learnt so far and briefly introduce this exercise.
2. Divide the participants into 3 groups each of them having not more than 6 members
   - Group 1 – List behaviours of a competent peer counsellor
   - Group 2 – List knowledge that that a peer counsellor needs to have
   - Group 3 – List down the roles of the peer counsellor
3. Allow 7-10 minutes for this task and let each group present their ideas
4. List the ideas of the groups on flip chart papers under the headings 'Behaviour', 'Knowl edge' and 'Role'.
5. Discuss and compare with basic information.

Conclusion - Peer counselling service providers are expected to keep themselves updated and well informed reading relevant materials and consulting relevant sources of information. They are not expected to know everything. If they encounter an issue they feel they cannot deal with appropriately, they refer the individual to an appropriate service provider or postpone the question until they have gathered the needed information. In any case, whenever you are not sure that the information you are providing is absolutely correct, seek support from a competent source rather than providing inadequate guidance.

For application - If participants are interested in becoming counselling service providers, encourage them to participate in trainings and contact nearby health service providers and organizations that have competent counselling staff. Try to organize a field visit to a youth friendly health facility in the course of the training.

Creating a conducive environment for peer counselling

A conducive environment is very important for peer counselling. Since peer counselling is based on personal needs and issues, the client must feel comfortable with the setting, the time, the environment and the service provider. The appropriate tools also need to be available. This requires preparation.

Exercise 5:	Creating a conducive environment for peer counselling services
Objective:	To enable participants to create a conducive environment for a peer counselling session
Method:	Group work, competition
Tools:	Posters, models
Time:	20 minutes

Facilitator's tasks:

1. Summarise what participants have learned so far and introduce the exercise.
2. Read out to all participants the summarized information on how to create a conducive environment for peer to peer counselling (See basic information)
3. Group the participants into 3 groups
4. Ask each group to create a favourable environment for counselling services.
5. All participants will then visit these places, ask questions and evaluate.
6. At the end of the presentation, gather the participants and have an overall discussion on the outcomes of the activity. Rank the groups according to their accomplishment in creating a conducive environment.

Conclusion - Ask what participants have learnt from the exercise. Emphasize the importance of a conducive environment for a successful session and of adequate preparation. The facilitator will wind up this discussion by highlighting the 6 points on conducive environment and 10 areas on which preliminary preparation is required. (See the list of 6 points and the 10 requirements below).

6 key points to note under conducive environment.

Of course the discussion must be kept confidential in the first place.

Note:

1. A clean place, free of distractive noises, having sufficient and comfortable seats
2. Prepare a place that allows for confidential discussions
3. Prepare forms for registration and referrals
4. Samples for preventive methods
5. Have relevant reference materials such as posters, pictures and models
6. Flyers/brochures in accessible areas and show their existence and availability

Prepare yourself before every counselling session. Asking yourself the following questions may be helpful:

1. Am I mentally and emotionally ready to provide the counselling service?
2. Can I provide a conducive environment?
3. Will I be able to give my full attention to the client without being interrupted by others or distracted?
4. Is the place convenient for a private talk?
5. Is the place clean and free from disturbances?
6. Are there enough and comfortable seats?
7. Do I have enough registration and referral forms?
8. Am I well equipped with the necessary information material on e.g. contraceptive methods?
9. Do I have the illustrations, samples, models etc. I need for demonstration purposes?
10. Do I have enough flyers, brochures, magazines etc. reproductive health and other issues?

Chapter 2: Peer Counseling in Practice

When providing peer counselling services, following certain steps and procedures may be helpful. Guiding steps for a peer counselling session are as follows:

1. Create rapport/ contracting (make the individual confident to talk to you)
2. Assess needs and provide information
3. Explore alternatives
4. Discuss available options/choices
5. Discuss the choices and provide information
6. Take action (only if you really know you are providing adequate advice), or refer client as appropriate
7. Follow-up

Exercise 6: Peer counselling in practice

Objective:	Enhance participants' abilities and skills to provide peer counselling services
Method:	Role plays in pairs; random picking
Tools:	Space, seats, handout: The Ten (10) Commandments of Peer Counselling
Time:	70 minutes

Facilitator's tasks:

1. Write and post the 7 steps of providing peer counselling services on the wall and explain them to the participants.
2. Explain that peer to peer counselling cannot be conducted in groups. It is a one to one process, and therefore participants are required to practice individually.
3. Group participants in pairs and assign them the role of counselling service provider or client.
4. Write down various counselling topics on pieces of paper, roll them up and put them all in front of the participants for each participant to randomly pick a topic. The topics may include counselling on 'Contraceptive Methods', 'VCT (blood test) for people not exposed to HIV', 'VCT (blood test) for people exposed to HIV' or 'Unwanted Pregnancy'.
5. Let each pair prepare according to the 'The Ten (10) Commandments of Peer Counselling' and the steps mentioned above for 10 minutes.
6. Let each pair present their 'counselling session' for 5 - 7 minutes.
7. After each presentation, ask the following questions for discussion :
   - What did you try to show?
   - To what extent have you followed the recommendations in the handouts?
   - Where did you get it wrong?
   - What do the other participants think about the presentation?
   - Where do you think the provider needs help?
   - What were the strong points of the pair's presentation?
   - How did you feel as a client and what did you like about the service?
   - What were the weaknesses of the service?

Conclusion: Initiate a discussion about what was learnt from the exercise.

For application: Enquire about what skills the participants might lack at this point to provide peer counselling service. Ask them about how they can build their capacity. Point out that peer counselling providers need practice and training before they start providing services.

Basic Information[2]

2.0 Counselling

Counselling seeks to provide a client with information (generally in a face to face discussion) to enable him or her make informed decisions about an issue, and achieve a self-determined change of attitude, practice and behaviour that will benefit the client. This may include building preventive skills, problem solving or coping skills and self-esteem of the client and providing psychosocial support as necessary. Discussions between counselling service providers and clients in the field of adolescent sexual and reproductive health usually aim at helping young people to gain the information they need to make informed decisions to stay healthy or cope with a problem related to reproductive health (e.g. unwanted pregnancy or an HIV infection). Supported by the counselling service provider, the client is expected to freely take his or her own decisions on how to change his/her behaviour and which steps to take next, without any influence and/or impositions from the counsellor. Based on this, counselling service is not (only)

- About giving advice;
- About giving instructions;
- About teaching or simply giving information;
- About transferring knowledge or raising awareness.

A counsellor will not involve in directing regarding the measures to be taken, or advise on the type of contraceptive to be used or not used, or influence or encourage towards this or that behaviour, and will neither criticize the client for what he or she did, nor judge his or her decisions.

Counselling service means to discuss with the concerned person to let him or her know where he/she stands now, and all options that are available to him/her, so that he/she can reach at his/her own decision.

2.1 The purpose of peer counselling service in ASRH programmes

During puberty, when fast physical growth occurs along with the development of the reproductive organs and a variety of new and different feelings and desires that suddenly awaken, many young people have mixed feelings, often changing quickly between happiness and anxiety. What most of them have in common is the belief that there is no one who can understand them at home or at school. Accordingly, they start their sexual life based on their friends' experiences or advice. Young people become sexually active, but they often lack the information they need to protect themselves from unwanted consequences such as pregnancy

[2]*This basic information has been adapted from various references.*

and STI's/HIV. They have fears regarding e.g. Sexually Transmitted Infections (STIs), unwanted pregnancy, HIV and AIDS, and many worries and questions ranging from unshared feelings of love to a perceived too small size of their sex organ, their menstruation and many other issues including experiences of rape and sexual abuse. There is a huge and unmet need for correct and reliable sexual and reproductive health information among young people. Peer counselling can help to fill this gap, as it gives young people a chance to access the information and advice they need in a safe and youth-friendly environment.

2.2 Who provides peer counselling services?

Counselling services are often provided by trained professionals. However, in the field of adolescent sexual and reproductive health, peer counselling has proven a successful approach in providing information and referral services to young people. DSW's Youth-to-Youth (Y2Y) Initiative includes peer counselling/education/information provided by trained peer counsellors/educators as an important element.

2.3 Knowledge, role and skills of a peer counsellor

As mentioned above, a peer counselling provider in the field of adolescent sexual and reproductive health needs profound knowledge regarding reproductive health, prevalent behaviours and attitudes, existing social and legal norms, gender issues, alcohol and drug addiction, Sexually Transmitted Infections (STIs) including HIV and AIDS, contraceptive methods, life skills and how to keep referral records. A peer counsellor needs to stay informed and update his/her knowledge on an ongoing basis. Of course, he/she will not be expected to know everything, in fact it is absolutely recommended to refer clients to an appropriate service provider if the issue goes beyond the capacities of the peer counsellor.

Roles of a peer counsellor (examples)

1. Prepare for a conducive environment and sufficient, correct and reliable information
2. Maintains and safeguards proper (and confidential) records on each counselling session
3. Provides counselling within his/her professional scope
4. Refers to appropriate service providers for follow up if the issue goes beyond his/her capacities
5. Gives priority to the peer's needs and feelings
6. Helps the peer to engage in good decision making towards safe sex by helping him/her to evaluate his/her own feelings and opinions
7. Supports the change of wrong information and behaviours so as to avoid related problems
8. Provides correct and reliable information
9. Helps the young person to recognize and change risky behaviours

Skills and behaviours of a peer counsellor (examples)

- Knows and respects his/her duties - and limits
- Has effective communication skills
- Is willing to help other peers and is compassionate to them
- Believes that family planning and contraception is beneficial to families
- Respects others' opinion and does neither judge nor blame
- Respects the young people's right to make their own decisions
- Is trustworthy and respects confidentiality
- Asks the right questions to encourage the young people to express themselves
- 'Speaks the same language' as the young people.

2.4 Creating a conducive environment for peer counselling

The provision of counselling services requires comfortable seating arrangements. Since personal issues will be raised during the talk, the setting should allow for a personal discussion in a quiet place. For a young person to talk about his/her real worries and feelings, he/she should be received alone in such a way that the discussion will not be heard by others. When peer counselling services are provided outdoors, it should be done in an area that is protected from noise, interference and other peoples' ears. The client will feel more comfortable then. Of course the discussion must be kept confidential.

7. A clean place, free of distractive noises, having sufficient and comfortable seats
8. Prepare a place that allows for confidential discussions
9. Prepare forms for registration and referrals
10. Samples for preventive methods
11. Have relevant reference materials such as posters, pictures and models
12. Flyers/brochures in accessible areas and show their existence and availability

2.5 Preparation

Prepare yourself before every counselling session. Asking yourself the following questions may be helpful:

1. Am I mentally and emotionally ready to provide the counselling service?
2. Can I provide a conducive environment?
3. Will I be able to give my full attention to the client without being interrupted by others or distracted?
4. Is the place convenient for a private talk?
5. Is the place clean and free from disturbances?
6. Are there enough and comfortable seats?
7. Do I have enough registration and referral forms?

8. Am I well equipped with the necessary information material on e.g. contraceptive methods?
9. Do I have the illustrations, samples, models etc. I need for demonstration purposes?
10. Do I have enough flyers, brochures, magazines etc. reproductive health and other issues?

Steps in providing peer counselling services

Repeat:
1. Create rapport/ contracting (make the individual confident to talk to you)
2. Assess needs and provide information
3. Explore alternatives
4. Discuss available options/choices
5. Discuss the choices and provide information
6. Take action if you really know you are providing adequate advice, or refer client as appropriate

Peer counselling service providers have to be well trained and competent. He/she has to follow the steps in providing counselling services so that the client makes his/her own choice. A counselling service has its own ways and means of provision.

2.6 Guiding questions

Have I understood the reasons why the client wanted the service?
At the beginning, try to find out the reason why the client wanted to be counselled, a decision he she has taken for himself/herself. Then continue the discussion on the circumstances for his/her seeking counselling. This is necessary to understand his/her experiences, decisions and/or behaviour.

Have I informed the client about available alternatives and choices?
The role of the peer counselling service provider is to inform the client about all possibilities and choices. The counsellor will provide the client enough information, for instance by completing the knowledge he/she might have on HIV/AIDS or the use of contraceptives. This increases the likelihood of making the right choice, which will be left to the client.

Have I helped him/her to choose from available options?
Explore together whether the decision to be taken by the client is favourable in his/her personal situation and help him/her to think it over. In this process, let the client take a decision, because if he/she consciously and willingly chooses one thing, it is believed that he/she will be more likely to strive towards its implementation, because it was his/her own decision to do so. This will increase the effectiveness of the decision.

[3] *For sake of brevity, the masculine shall include the feminine in the following, e.g. the client can of course also be a female.*

2.7 Counselling - Step by Step

2.7.1 Example 1 - Contraceptive Methods[3]

Step 1 Introduction: Give special attention to the client. Respectfully stand up while welcoming the person into your office then invite him to take a seat and introduce yourself. Try to make the client feel comfortable. If it is a new client, fill in the registration form. Make your questions as short and easy as possible, and look at the client when you speak to him. Assure the client that whatever is said and talked about during this session will remain confidential.

Step 2: Ask the client what you can do for him
Ask "What can I do for you?" and let him explain why he came. Allow the client to freely express his problems and questions regarding the subject and listen until he has finished. If the case at hand represents a serious health issue beyond your professional scope, explain that you will be referring the person to a health centre and do so. If the client has come for issues related to contraceptive methods, ask him/her about what he knows about contraception.

Step 3: Undertaking discussions on contraceptive methods: If the client has wrong information regarding contraceptives, understand where the beliefs originate and provide correct and complete information. Explain to him/her the available different types of contraception and how to access them.

Step 4: Help the client to choose a contraceptive that is suitable for him: Ask what kind of contraceptive he would like to use. It is important here to help the client see if what he has chosen is appropriate for him and his situation. Give a brief explanation about the type of contraceptive he chose and identify both positive and negative aspects.

Step 5: Explain the use of the contraceptive: Once the client has chosen a contraceptive method, explain in detail how it is used and indicate the next steps to get it. To ensure that he has understood properly, ask him to repeat what you said. Warn him if there are contraindications or side effects, and refer him to an appropriate health service provider. Give him a flyer or brochure or similar info on contraceptives. Invite him to come again and say you will be happy to see him again. Fill in your record.

Step 6: Follow up: If the client comes back, inquire on whether he uses the contraceptive method he has chosen. Ask if he has had any difficulty in using the method. Ask him how he was using it to check whether it was correctly used. If the contraceptive method resulted in complications, refer him to the nearest health service provider. If the client wishes to try another contraceptive method, help him interrupt the one he has started with and begin a new one including the whole information process. Understand that sometimes it is appropriate to change contraceptive methods and find another, more suitable one (e.g. the pill is sometimes not well tolerated by certain patients and they might need another type of pill).

2.7.2 Example 2 - HIV

Step 1: Introduction: Give special attention to the client and welcome him respectfully by greeting him standing up from your seat. Invite him to take a seat. Introduce yourself. Talk about this and that to make your client feel at ease. If he/she is a new client, fill in the registration form. In doing so, keep your questions short and clear and look at the client when you talk to him. Ensure the client that the information will not be shared with anyone and kept strictly confidential.

Step 2: Help the client recognize behaviours that might make him vulnerable to HIV infection: Then ask why he has come and understand what he expects from the counselling. Allow him/her to express his/her opinion, view, fear and anxiety related to HIV and AIDS.

a) For persons who are likely not to have been exposed to an HIV infection: Focus on those parts of behaviour that did not expose him to the risk. Evaluate together the behaviour and identify strengths and weaknesses. Ask how the positive behaviour can be strengthened and help him to strengthen it. Give any HIV related information he may need. If the client wishes to undergo an HIV test, refer to appropriate health service providers.

b) For persons who are likely to have been exposed to an HIV infection: Do not focus on providing information on HIV and AIDS. Give a special focus on enabling the client to identify and evaluate the behaviour that exposed him to an HIV infection. It is useful to focus on points that the client believes or does not believe. It is important not to raise any questions that divert the attention elsewhere. Assess in depth the possibility of an infection. Help to find tangible solutions and enable him to make a decision to go for testing. Ask about measures he had previously taken to prevent HIV infection. Let him evaluate the strengths and weaknesses of the measures. If there are any misconceptions and beliefs, try to discuss them. Explain to the client that you will be referring him/her to an appropriate health service provider and do so.

Step 3: Counselling service on how to prevent HIV transmission through behavioural change
Focus on the measures to be taken to decrease the likelihood of infection. The measures must be convenient and acceptable to the client. If the client shows several behaviours that might expose him or his partner(s) to infection, it is important to focus on the major ones. The measures must be clear and feasible for him. If there are barriers that stand in the way to the implementation of these measures, discuss these. Ask the client about what kind of preventive measures he wishes to take and what knowledge he has on them. If the client expresses wrong beliefs, attempt to understand the origin of the beliefs. Try to correct or propose alternative explanations. Tell the client what other preventive measures are available and how to access them. It is important to let go of the rigid belief that the solution is just one. For instance, it should not be said 'only through condom' or 'only by being faithful' etc…Explain the preventive measure chosen by him to see the pros and cons.

Step 4: HIV Pre-test counselling service: If it seems that the client has been exposed, the counselling service should focus on making him decide to go for VCT (HIV blood test). Hence the counselling service should focus on evaluation, the risk involved in the client's behaviour and the importance of knowing one's status for the future. The test will only be acceptable if the concerned client himself becomes conscious of having been exposed and realizes the behaviour leading to that. Provide information regarding the test without focusing on technical information. Help him understand the importance of knowing the test result. The test result might provoke feelings of unease. Make him aware that knowing the status of being positive early will help a great deal by getting proper medical attention in good time, thereby reducing the likelihood of co-infections and the risk to pass on the HIV to his/her sexual partner(s). Help him to overcome the fear of knowing and accepting the truth. Guarantee that the information will be kept confidentially by you and the testing facility. Make the client aware that he will be tested only by consent. Ensure that he understands that a) undergoing the test or b) not undergoing the test is the only decision to take.

Step 5: Post Test Counselling Service

a) The HIV test shows a negative result (the person is not infected)
Ask him how he feels about the result. If he has been exposed to infection three months before, make him aware that an additional test needs to be made to be certain. Ask him to indicate the kind of behavioural changes to avoid future exposures. Support him to take a decision to use life skills, respect himself, watch himself, make decisions and solve problems. Do not provide information or advice to do this and that; but help him to make his own decisions. If the client has come for a follow up, ask if he is using contraceptives at the moment. Ask how he has been using them to make sure that the method has been applied correctly. If need be, refer the client to another health centre or professional.

b) HIV test shows a positive result (the person is infected)
To be able to help the client surmount the psychological trauma that follows the news, you need to be prepared ahead of time, and you need a special training. If this is not available: Help the client not to resort to self blaming and depression. Encourage him to still respect himself. Make him aware that he can still be living for a long time if he takes care of himself, follows a healthy lifestyle, moral and hygiene and an adapted balanced diet, and above all, has inner strength, so that the client does not consider the test result as the end of the world. Make sure that the client really understands what the virus entails. Make sure that he realizes that he still needs to protect himself from unsafe sex and STIs. Discuss together on how to protect his partner(s) from contracting the virus as well. For further medical follow up and psychological support, in any case you will refer the client to a competent healthcare institution. Get the client in touch with organizations that provide psychological, social and material support. Invite and encourage the client to come again for follow up.

Step 6: Follow up:

When the client comes for follow up, ask the relevant questions that relate to the problem identified during the peer counselling session; E.g: if the problem discussed was on STI prevention or family planning please ask; if the client was successful in abstaining from risky behaviour or if they were successful in using a condom? .you may ask whether they successfully used contraceptives? Ask how he uses it? Clarify on the correct use.

The main concept of counselling here is neither giving information nor advising but rather help the client make an informed decision. Look for handouts or flyers with the relevant information and give to the client.

Note:

1. If the client is actually HIV positive, ask how they are feeling, if the referral has worked for them, if they are on ARV, if they have any problems with their families or partners, if they need any other support, if they are protecting their partners from infection and the like, not only if they have changed the risky sexual behaviour and if they know now how to use contraceptives.

2. If the peer counsellor only provided information on contraceptives, prevention of STIs including HIV transmission, unwanted pregnancy and risky behaviour, let the discussion during the follow up focus on these areas. If other issues arise that are beyond the jurisdiction of the peer counsellor please refer to the appropriate health service provider.

2.8 The Ten (10) Commandments of Peer Counselling

Adopted from the Handbook for Peer Counsellors by Tom Durkin 2006

1. Be nonjudgmental. Your opinion could turn off your client. The idea is to create a safe environment where your client feels free to talk – about anything.

2. Be empathic. Let your client know you understand and you care. Be interested and supportive. Suppress your true feelings if you have to.

3. Listen! Listen! Listen! Active listening is the best and most essential counselling tool you have. Use restatements, paraphrases, and summarizations to let your clients know they've been heard.

4. Avoid questions. Bite your tongue before asking questions. Is this question really necessary? Do I need to know this? While questions have their place, interrogations put your client on the defensive and shut down real communication.

5. Deal with feelings first. Find the emotions behind the words. You can't deal with a client's problem (or even discover the real problem) until the emotions are cleared. This can be heavy. Hang in there.

6. Don't give advice. Get solutions, don't give them. Assist your clients in generating their own options and actions. It's okay to give information – just don't tell them what to do with it.

7. It's not your problem. Don't steal it. The purpose of peer counselling is to help clients learn to solve or cope with their own problems. Often clients just want to express their feelings in a safe environment. Let them.

8. Keep it confidential. Clients will tell you intensely personal things. Except as specified in your peer counselling contract, keep this information to yourself. Violating a confidence not only destroys your client's trust, it can ruin the entire peer counselling program.

9. Know your limits. Know when you must refer (life-threatening situations and child abuse/molestation) and when you should refer (severe psychological problems) clients to the appropriate, qualified professionals.

10. Be informed. People will be looking to you to know what's happening (including rumour control) and where to get help. Don't let them down.

Annex - Tools and master copies for Module 8

List of learning tools

- SRH facilitators' training manual
- Flip chart, or large sheets of paper
- Markers in different colours
- Chalk to write on the floor or a black board
- Note paper/note books
- Masking tapes
- Cards or slips of paper, scrap paper to cut notes
- Flyers, brochures
- Registration forms, referral forms
- Information on organizations/institutions in the area for referral
- Information on vct or hct providers in the area
- Contraceptives for demonstration purposes
- Penis model/banana/bottle

Types of Peer Led Approaches

	Peer information	Peer education	Peer counselling
Objectives	Awareness Information Attitude change	Awareness Information Attitude change Skills building	Information Attitude change Prevention skills solving/coping skills
Coverage	High	Medium	Low
Intensity	Low	Medium/high	High
Confidentiality	None	Important	Essential
Focus	Community Large groups	Small groups	Individual
Training required	Brief	Structured workshops and refresher courses	Intense and long
Examples of activities	Distribution of material in public events (sports events, youth concerts), World AIDS Day	Repeated group events based on a curriculum	Counseling of young people living with AIDS Clinic-based youth counseling on reproductive health

Types of Peer Led Approaches (B); Youth Peer Education Toolkit, Training of Trainers Manual, United Nations Population Fund and Youth Peer Education Network (Y-PEER), 2005

Glossary

Adolescence
The period during which an individual progresses from dependence on adults to responsible adulthood.

Adolescents/Very young adolescents/Youth/Young people
In regard to Adolescents and Youth – DSW is using the following definitions (based on WHO definitions)
Very young adolescent: 10-14
Adolescents: 10- 19 -
Youth: 15- 24
Young People: 10 - 24

Advocacy
A campaign, strategy or other activity aimed at building support for a cause or issue. Advocacy is directed towards creating a favourable environment, by trying to gain support and influence attitudes and behaviour, or change legislation.

AIDS
Acquired Immunodeficiency Syndrome advanced stage of infections caused by human immunodeficiency virus (HIV).

Antiretroviral (ARV) therapy
The course of medications or drugs used to treat people with acquired immune deficiency syndrome (AIDS), control and slow progression of HIV. Other terms are HAART (highly active antiretroviral therapy), anti-retroviral drugs, HIV treatment, HIV medications, HIV drug regimen and HIV drugs.

There are several ARV classes, which work against HIV in different ways. Patients may take a combination of several drugs at once.

Behaviour Change Communication (BCC)
Behaviour change communication is an interactive process aimed at changing individual and social behaviour, which uses targeted and specific messages, different communication approaches, and is linked to services for effective outcomes.

Capacity building
Capacity building equals the development of abilities and skills that enable people, organisations and systems to shape their present and future living conditions through their own efforts.

Change agent
A change agent is an individual or a group that takes responsibility for changing the existing pattern of behaviour of an individual or institution.

Community Mobilisation

Community mobilisation is a process of convincing and empowering community members, groups of people and relevant stakeholders to play an active role in community development at all levels. In the context of the Youth-to-Youth Initiative, community mobilisation entails identifying key stakeholders which have a direct and indirect impact on the sexual and reproductive health needs and rights of young people both positively and negatively as well as making them part and parcel of the efforts to create positive impacts and to increase support from the community. Community mobilisation combines awareness creation, dialogue, self-organisation and action.

Community services

Community services (community work) are activities and services that are provided by any kind of youth clubs for free with the aim to contribute to and strengthen social welfare (e.g. environment protection, tree planting, home-based care, garbage collection)

DSW (Deutsche Stiftung Weltbevoelkerung)

DSW is an international development and advocacy organisation that empowers young people and communities in low- and middle-income countries by addressing the issues of population dynamics and by improving health as a way to achieve sustainable development. With its headquarters in Hannover, Germany, DSW maintains four country offices in Ethiopia, Kenya, Tanzania and Uganda, as well as liaison offices in Berlin, Germany and Brussels, Belgium.

The aim of DSW is to prevent poverty before it occurs and the focus is on achieving universal access to sexual and reproductive health services and information, which is fundamental to improving health and effectively fighting poverty.
DSWs' motto is: Empowering people for a healthy future!
Further information can be found on the link: *www.dsw.org*

Dual protection

Avoiding both pregnancy and sexually transmitted infection

Economic empowerment

Economic empowerment describes the effort to promote economic opportunities for youth by sharing information, skills training, supporting income generation activities, as well as linking young people with financial service providers and local support networks. (Also see "Youth livelihood")

Emergency Obstetric Care

Includes intravenous antibiotics, oxytocics and sedatives; manual removal of the placenta; manual removal of retained products of conception; and assisted (vaginal) delivery.

Environmental activities

In the framework of the Y2Y Initiative, "environmental activities" refer to any activities conducted by Y2Y clubs or individual youth that particularly aim at improving the environment or at integrating environment-friendly and environmental protection with community work, income generating activities or education activities.

Family planning (FP)
The conscious effort of couples or individuals to plan for, and attain, their desired number of children and to regulate the spacing and timing of the births. Family planning is achieved through abstinence, contraception, male or female sterilization, or the treatment of infertility.

Female Genital Mutilation (FGM) / Female Genital Cutting
All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.

(Obstetric) Fistula
A rupture that results in an abnormal passage linking two areas such as the vagina, rectum, bladder or abdominal cavity. Obstetric fistulae are caused by difficult, prolonged, obstructed labour, unsafe abortion, traditional practices such as female genital mutilation, and various forms of sexual violence on women.

Gender
Refers to the biological, legal, economic, social and cultural attributes and opportunities associated with being male or female.

Gender-based violence (GBV)
All forms of violence targeted at an individual because of his or her gender, including, but not limited to, domestic violence, rape and sexual assault, community violence, and emotional or psychological abuse.

Gender equality
The measurable equal representation of women and men. Gender equality does not imply that women and men are the same, but that they have equal value and should be accorded equal treatment.

Gender mainstreaming
A new term that is similar to gender perspective or gender-sensitive focus. It is the reorganisation, improvement, development and evaluation of policy processes, so that a gender equality perspective is incorporated in all policies, at all levels and at all stages, by those normally involved in policy making.

Good practices
Good practices are reported examples and cases that reveal how a programme/intervention is making a difference in people's lives. More than a list of events or activities, it describes a positive change and shows how that change benefits the people of intervention area. Good practice documentation uses evidence to show the value of the program.

Health centre
Premises, owned by a local authority, providing health care for the local community and usually housing a group practice, nursing staff, a child-health clinic, X-ray facilities, etc. (Definition provided by DSW Ethiopia)

Health facility
Health facilities are places that provide health care. They include hospitals, clinics, outpatient care centres and specialised care centres.

HIV
Human Immunodeficiency Virus

Home-based Care (HBC)
HBC is care that is provided to an individual in his/her own environment (home) by family or community members and/or skilled individuals to meet not only the physical and health needs, but also the spiritual, material, and psychosocial needs [Source: Gaborne Declaration on Community Home Based Care, 2001]. In the context of the Youth-to-Youth Initiative, youth club members organise home-based care for peers, e.g. HIV-positive fellows, in their respective communities on their own initiative. In that case, HBC does not include medical services

Hormonal Contraceptives
Methods of birth control that use hormones (progestogen and oestrogen combined, or progestogen alone) to prevent pregnancy: pills, implants for subdermal use, injectables, intra-uterine devices (IUDs), vaginal rings and patches.

Human rights approach
Human rights are the minimum standards that people require to live in freedom and dignity. The human rights approach to programming is based on applying the principles of participation, empowerment, interdependence, equality, mutual respect and non-discrimination.

Informed choice
Voluntary decision by a client to use, or not use, a contraceptive method (or accept any sexual and reproductive health service) after receiving adequate information regarding the options, risks, advantages and disadvantages of all available methods, a goal of family planning counselling.

Income Generating Activities (IGAs)
Income generating activities refer to any kind of activity implemented by youth that aims at generating income. As part of the Youth-to-Youth Initiative, selected young people receive business skills, entrepreneurship, or vocational trainings and learn how to develop business plans, set up, and manage their own IGAs that support youth clubs to finance club activities and/or individuals to improve their economic situation. IGAs cover a wide range of activities, including traditional bee-keeping, poultry-rearing and basket weaving, renting services, but also theatre and internet cafés. Some types of IGAs like the provision of transport services, public showers, barber's shops or internet access benefit the entire community and contribute to the latter's improvement.

Information, Education and Communication (IEC) Materials

IEC materials comprise posters, brochures, information leaflets, newspapers, t-shirts, radio programmes as well as audio and video productions. The purpose of IEC materials is to communicate and promote health-related messages, information, and behaviour through many channels and thus to increase awareness and knowledge of different populations about various issues, products and behaviours.

Life skills

"Abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life" (WHO 1994); *"Life skills are the strategies, abilities, expertise or competencies that enable adolescents to develop positive attitudes and responsible sexual behaviours, leading towards a healthy lifestyle." (DSW, 2006).* Life skills empower young people to take positive action to protect themselves and promote health and positive social relationships. UNICEF, UNESCO and WHO list the ten core life skill strategies and techniques as: problem solving, critical thinking, effective communication skills, decision-making, creative thinking, interpersonal relationship skills, self awareness building skills, empathy, and coping with stress and emotions. (UNODC, 2003).

Livelihood

"Livelihood is defined as a means of living, and the capabilities, assets, and activities required for it. A livelihood encompasses income, as well as social institutions, gender relations, and property rights required to support and sustain a certain standard of living. It also includes access to and benefits derived from social and public services provided by the state, such as education, health services, and other infrastructure" (Masanjala, 2006, p. 1033).

A livelihood is everything people know, have, and do to make a living. The livelihoods approach builds on earlier poverty reduction models, including participatory and integra-ted rural development. Source:
http://www.fhi.org/en/youth/youthnet/publications/focus/infocus/youthlivelihoods.htm

Maternal and Child Health programmes

Health care aimed at improving the health of mothers and children, including ensuring safe motherhood, eliminating unsafe abortion, and helping women to plan and space their births.

Maternal death

The death of a woman while pregnant or within 42 days of birth or termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to, or aggravated by, the pregnancy or its management, but not from accidental or incidental cases.

Maternal mortality rate

The number of maternal deaths in a given period per 100.000 women aged 15-45 or 15-49 years. This rate reflects a woman's lifetime risk of death associated with reproduction. It is influenced by the risks of pregnancy and dying childbirth.

Menarche
The beginning of cycles of monthly bleeding. Occurs during puberty after girls start producing estrogen and progesterone

Menopause
The time in a woman's life when monthly bleeding stops permanently. Occurs when a woman's ovaries stop producing eggs (ova). A woman is considered menopausal after she has had no bleeding for 12 months.

Menstrual cycle
A repeating series of changes in the ovaries and endometrium that includes ovulation and monthly bleeding. Most women have cycles that each last between 24 and 35 days

Medical officer
A medical doctor serving in a public or private health centre

Mobile services
Mobile services entail the "on-the-spot" delivery of SRH and/or VCT/HCT services and/or provide respective information and training to youth and community members in urban, rural and far-to-reach areas with limited access to static services. DSW provides mobile services in different ways by the means of Youth Trucks (Uganda, Tanzania) and VCT Trucks (Kenya).

Monthly bleeding
Monthly flow of bloody fluid from the uterus through the vagina in adult women, which takes place between menarche and menopause.

Over-the-counter (OTC)
Refers to a drug that is available without a doctor's prescription

Outreach
The term "Outreach" generally describes the involvement of a youth club and/or DSW staff/ partners with or activity in the community and neglected groups of people. A number of different activities can be defined as outreaches. These include, inter alia, information and service events, edutainment shows, DSW Youth Truck activities, sport events, mobile health services, dialogue meetings, community services (e.g. environmental work), etc.

Peer education
Peer education is defined as the process by which well-trained and motivated individuals lead organised educational and skills-building activities with their peers to support and improve young people's health and well-being. It is a process of acquiring knowledge, skills and practices with members of the same age group, interests, sex, social background etc. Peer education takes place in both in formal and informal settings that are convenient both timely and location-wise to the involved peers with the aim to bring about change in knowledge, attitude, beliefs or behaviour.

Peer Educator

A peer educator is a youth club member that has attended a peer education training and who facilitates peer learning groups in youth clubs in order to educate, counsel, inform, and share quality knowledge on issues related to SRH of young people. A peer educator not only tells the peers about a responsible SRH behaviour and opportunities but also acts as a role model.

Peer educator training

During this training, participants attain not only quality knowledge on sexual and reproductive health and rights, but also obtain those skills that are needed to organise and facilitate peer learning groups and informal peer education.

Peer Counsellor/ Peer Counselling

A peer counsellor is an experienced youth club member (at least 18 years old) who is trained in improved counselling skills (higher level than peer educators) to provide youth with support, information and psychological backstopping as regards very sensitive SRH issues, HIV and testing, contraceptives (other than condoms), sexual abuse etc. In some countries, a peer counsellor is authorised to distribute oral contraceptives, such as pills. A peer counsellor helps peers to understand their options and to effectively assess the potential risks and benefits, so that his or her peer can make informed decisions.

Peer pressure

The efforts of a group of equals (e.g. same age group) to maintain conformity to the group's norms.

Population, health, and environment (PHE)

Cross-sectoral Population, Health and Environment (PHE) interventions integrate population aspects such
as family planning with health and environmental issues

Rapid test for HIV

A high-quality, simple HIV test that provides same-day results and requires little or not equipment. It was designed as a preliminary screening test, and is especially useful in smaller laboratories with a low volume of tests. A positive result should be confirmed by a repeat, or an ELISA (Enzyme-Linked Immunosorbent Assay).

Reproductive health (RH)

RH is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. RH therefore implied that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant. (ICPD, 1994, Programme of Action, Paragraph 7.2)

Reproductive Health Care
Constellation of methods, techniques and services that contribute to SRH and well-being by prevention and solving RH problems. The purpose of reproductive health care is the enhancement of life and personal relations, not merely counselling and care related to reproduction and sexually transmitted infections.

Reproductive Health Commodity security (RHCS)
A secure supply and choice of quality contraceptives, condoms and other essential reproductive health commodities to meet every person's needs, at the right time and in the right place.

Reproductive Health Supplies
The term "RH supplies" refers to any material or consumable needed to provide reproductive health (RH) services. This includes, but is not necessarily limited to contraceptives for family planning, drugs to treat sexually transmitted infections, and equipment such as that used for safe delivery. *(source: http://www.rhsupplies.org)*

Reproductive rights
Reproductive rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right al all to make decisions concerning reproduction free of discrimination, coercion and violence, (WHO).

Referral
A referral is a service where a client (youth) is being referred by a trained peer educator or counsellor from a youth club to a specific health service provider. A functioning referral system between clubs and health facilities of any kind requires referral contacts, a referral form that is filled out by clubs and health service providers and an active feedback mechanism.

Referral directory
A referral directory is a document that entails information and addresses of nearby health facilities that offer general and youth-friendly SRH services. Youth club members use referral directories to inform and refer youth on where to go with particular SRH problems for treatment in their respective area.

Safe Motherhood
Pregnancy and childbirth with a low risk of death or ill health. This necessitates access to contraception, safe delivery, emergency obstetric care, and to safe abortion services.

Sanitary pad
Absorbent napkin made of cotton or similar fibres that are worn against the vulva to absorb menstrual flow or post-abortion or post-partum discharge.

Sex, sexual intercourse
Sexual activity in which the penis is inserted into a body cavity, anal Sex involving the anus, oral Sex involving the mouth, vaginal Sex involving the vagina.

Sexual health
A state of physical, emotional, mental and social well-being in relation to sexuality; not merely the absence of disease, dysfunction or infirmity. It requires a positive approach to sexuality and safe, pleasurable sexual relationships, and that the sexual rights of all persons must be respected, protected and fulfilled.

Sexual rights
Sexual rights include the right to have control over and decide freely and responsibly on matters related their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence. Equal relationships between women and men in matters of sexual relations and reproduction, including full respect for the integrity of the person, require mutual respect, consent and shared responsibility for sexual behaviour and its consequences.

Sexuality
The sexual knowledge, beliefs, attitudes, values and behaviours of Individuals. It includes the anatomy, physiology and biochemistry of the sexual response system; identity, orientation, roles and personality; and thoughts, feelings and relationships. The expression of sexuality is influenced by ethical, spiritual, cultural and moral concerns.

Sexuality education
Education, designed to equip young people with the knowledge, skills, positive attitudes and values necessary to determine and enjoy their sexuality – physically and emotionally, individually and in relationships.

Sexually transmitted Infections (STIs)
STIs are infections that spread primarily through person-to-person sexual contact. There are more than 30 different sexually transmissible infections. STIs are partly also referred to as sexually transmitted diseases (STDs).

Sex worker
Sex workers are female, male or transgender adults or young people who receive money, shelter or goods in exchange for sexual services, either regularly or occasionally, and who may or may not consciously define those activities as income-generating.

Social marketing
The application of private sector marketing techniques to the sale of products that fulfil a social objective at a cost, such as condoms.

Stigma
Negative attitudes towards a group of people, on the basis of particular attributes such as theirs HIV status, gender, sexuality or behaviour, are created and sustained to legitimatise dominant groups in society. Often associated with marginalised people, stigma can affect people directly or by association.

Sperm
The male sex cell. Sperm are produced in the testes of an adult male, mixed with semen in the seminal vesicles, and released during ejaculation

SRH Services
Defined as the constellation of methods, techniques and services that contribute to reproductive health and well-being through preventing and solving reproductive health problems. *(IPPF, 2014, http://www.ippf.org/resources/media-press/glossary/s).*

Traditional Birth Attendant (TBA)
Local community women who provide safe delivery services in the community. They initially acquired their skills by delivering babies themselves or through apprenticeship. (WHO does not include them in the category of "skilled attendants" who are allowed to provide/manage deliveries).

Traditional Methods of Contraception
Non-supply methods, including periodic and post-partum abstinence, total abstinence if for contraceptive reasons, and withdrawal methods.

Unmet need for family planning
Estimates of women (including youth) who would like to prevent or delay pregnancy but are not using contraception, either because they lack knowledge about family planning or access to services, or because they face cultural, religious and family obstacles.

Voluntary Counselling and Testing (VCT)
A client-initiated form of HIV testing in which people are tested only with their informed, voluntary, and specific consent. Counselling is provided both before and after HIV testing, and confidentiality of results can be guaranteed. VCT is also referred to as HCT (HIV-Counselling and Testing).

Youth-to-Youth (Y2Y) Initiative
Developed in 1999 by DSW (Deutsche Stiftung Weltbevoelkerung), the Youth-to-Youth (Y2Y) Initiative offers an innovative and integrated response to the multi-faceted needs of young people between 10 to 24 years in developing countries. It empowers young people to improve their sexual and reproductive health (SRH) as well as their socio-economic situation.

The Y2Y Initiative empowers young people by:

- Enabling youth-led peer education

Selected youth club members participate in peer education, SRHR, life skills, club management and leadership trainings. The acquired knowledge and skills help them to successfully manage their clubs and to provide quality youth-friendly SRHR information and educational materials on issues such as contraception, family planning, HIV &Aids, gender, and maternal health in a confidential setting to their peers.

- Creating community support for youth

Youth clubs engage in community outreach activities designed to raise awareness, change attitudes and strengthen community life. These activities include youth-led edutainment (music, drama, dance) shows, environmental work and community services as well community dialogue and advocacy meetings targeting local decision-makers and community members.

- Strengthening youth-friendly and quality sexual and reproductive health services

In the clubs, trained peer educators, peer counsellors or health staff offer individual SRH-counselling services, HIV & Aids testing and counselling, contraceptives and family planning services or home-based care to their peers in a confidential setting. Moreover, referral services between youth clubs and health facilities are set up to ensure that young people with SRH-related problems are referred from clubs to health service providers for respective treatment. Health personnel receive training in order to ensure that these services are youth-friendly.

- Enhancing the social and economic development of young people

Trainings provided to young people on entrepreneurship, business, and resource mobilisation skills enable them to develop, set up and maintain income generating activities. Club members learn how to sustain youth club activities and how to secure small loans. Strong clubs and Youth Empowerment Centres often become youth-led community organisations and mobilise diverse resources. Regular exchange meetings among clubs enable young people to share their experiences, problems, and good practices with other members of the Y2Y network. http://www.youth-to-youth.org/

- Youth livelihood

Livelihood development programming refers to interventions that enhance the capacity of young people to engage in sustainable liveli¬hood activities such as: (1) employment in the formal and informal sector; (2) contributions (paid and unpaid) to household-based liveli-hood activities (in agriculture, fishing, or small scale manufacturing); and, (3) self-employment micro-enterprise activities in areas such as petty trading, the production of food or trade goods, and the delivery of informal services. There are two facets of livelihood programming: Readiness-oriented and Access-oriented programming. Readiness-oriented youth livelihood programs can include formal and nonformal basic educa¬tion, vocational and technical skills training, and programs that focus on employability and the development of key cross-cutting work and life skills. Access-oriented programming refers to interventions that improve young people's access to market-driven products services that can enhance their economic suc¬cess or that of their households. These can in¬clude access to microfinance products (savings, credit, micro-insurance), business development services, technical skills training, linkages with mentors or business skills coaches,

and sup-port in improving the value-added proposition of their livelihood activities (through improve¬ments to quality, cost, or market access).
Sources: http://www.equip123.net/docs/e3-LivelihoodsGuide.pdf (also see "Economic Empowerment")

Youth-led Peer Education

All activities that include SRHR, life skills, club leadership and management trainings, peer learning groups in clubs, distribution of IEC materials
Youth-led peer education refers to structured training sessions led by trained peer educators during which they systemically pass on SRHR, life skills, entrepreneurship or leadership as well as club management knowledge and skills. In the Y2Y context, peer educators organise peer learning groups of young people. Youth-led peer education may be conducted in form of a training over several days or regular meetings of the same peer learning groups over a longer period of time. Youth led peer education is normally supported by IEC materials and DSW's training manuals.

Youth-friendly

The characteristics of, for instance, policies, programmes, resources, services or activities that attract young people, meet their sexual and reproductive health needs, and are acceptable and accessible to a diversity of young people.

Youth Truck

The Youth Truck is a DSW-owned vehicle that is used by trained DSW staff to conduct community outreach activities, raise awareness and provide SRH information (and services) on-the-spot in remote and neglected areas.

Youth empowerment

Young people are empowered when they acknowledge that they have or can create choices in life, are aware of the implications of those choices, make an informed decision freely, take action based on that decision and accept responsibility for the consequences of those actions. Empowering young people means creating and supporting the enabling conditions under which young people can act on their own behalf, and on their own terms, rather than at the direction of others.
(http://www.thecommonwealth.org/Internal/152834/154159/youth_empowerment/)

Youth empowerment is an attitudinal, structural, and cultural process whereby young people gain the ability, authority, and agency to make decisions and implement change in their own lives and the lives of other people, including youth and adults. Youth empowerment is often addressed as a gateway to intergenerational equity, civic engagement and democracy building. (Source: Wikipedia)

Youth Empowerment Centre (YEC)

A Youth Empowerment Centre is a well-equipped, self-sustaining, multi-functional and youth-led centre that addresses the needs of youth in a holistic manner and plays a coordinating and supervisory role in respect of Model Clubs and Youth Clubs located in its area. It provides comprehensive SRHR information and services to members, visiting youth and the community. It actively increases SRHR knowledge, life skills, leadership and livelihood capacities of its members, attached Youth and Model Clubs as well as visiting youth through trainings, community services and mobilisation, leisure activities, and computer access. The Youth Empowerment Centre is integrated into existing local structures, networks with government authorities, health facilities and NGO partners, and strengthens youth participation in decision-making processes and leadership skills.

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