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Adopting a gender transformative approach in sexual and reproductive health and rights, and gender-based violence programmes

RUTGERS' TOOLKIT

Module 3
Gender transformative approach and youth-friendly services

Rutgers
For sexual and reproductive health and rights

Adopting a gender transformative approach in sexual and reproductive health and rights, and gender-based violence programmes

This toolkit has been designed as a resource and a guide to support the integration of a gender transformative approach (GTA) into sexual and reproductive health and rights (SRHR) programmes and organisations.

It consists of five modules and a guide to the theoretical background of the components covered. For each module there is an accompanying set of handouts.

Module 1: Six interrelated components and the socio-ecological model

Module 2: Gender transformative approach and comprehensive sexuality education

Module 3: Gender transformative approach and youth-friendly services

Module 4: Gender transformative approach and advocacy in the area of SRHR

Module 5: Gender transformative approach at the level of organisations and institutions

This module is a stand-alone module, which can be used without having applied the other modules, although we do recommend you start your workshop with a selection of the sessions from Module 1.

The toolkit on GTA can be also found on Rutgers' website: www.rutgers.international/GTA

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Contents

Abbreviations

CRC	Convention on the Rights of the Child
GBV	gender-based violence
GTA	gender transformative approach
HIV	human immunodeficiency virus
IPPF	International Planned Parenthood Federation
LGBTI	lesbian, gay, bisexual, transgender, intersex
NGO	non-governmental organisation
SDS	sexual double standard
SOGIESC	sexual orientations, gender identities and expressions and sex characteristics
SRH	sexual and reproductive health
SRHR	sexual and reproductive health and rights
STD	sexually transmitted disease
STI	sexually transmitted infection
ToR	terms of reference
ToT	training/trainer of trainers
UNFPA	United Nations Population Fund
WHO	World Health Organization
YFS	youth-friendly services

Introduction

> "I now listen to young people better and give them time to express themselves and understand challenges they are faced with … I had never heard of evolving capacity, norms, or gender diversity before the training; now I feel empowered. Also, I feel comfortable to talk about sex and sexuality with the young people, unlike before where you assumed they do not need the information and cover it up."
>
> **Zopher Obuto, health counsellor, Kenya**

Evidence shows that programmes and training that include a gender and power perspective are substantially more effective at achieving positive health outcomes, such as reducing rates of unintended pregnancy, unsafe abortion or sexually transmitted infections (STIs), than programmes which do not incorporate these elements.[1] While there have been interventions to improve healthcare, providers' capacities and skills in youth-friendly sexual and reproductive health (SRH) services, gender and power perspectives have often been left out of the picture.

By applying a gender transformative approach (GTA) to youth-friendly services (YFS) this module aims to generate increased awareness and critical thinking on gender and power imbalances. The module stimulates a process of transformation that starts at the individual level, influencing the knowledge, attitudes and skills of healthcare providers to become more gender equitable. This module recognises the challenges that healthcare workers might encounter in their work in making considered decisions. The aim of the module is to provide tools to support this process, that ultimately will benefit the SRH outcomes of young people that seek services.

This module is part of the Rutgers comprehensive toolkit for implementing the gender transformative approach in sexual and reproductive health and rights (SRHR) programmes.[2]

Rutgers' definition of the gender transformative approach

Rutgers' programmes focus on SRHR for all. During the implementation of our SRHR programmes, Rutgers and our partners have experienced a growing need to
1) integrate a bolder and clearer gender perspective and
2) pay more attention to masculinities and the role that men and boys could play in transforming unequal gender patterns.

Based on these experiences and building on the ever-growing insights from other experts in SRHR and gender, Rutgers formulated a definition of the GTA (see Box 1), which is based on various literature sources.[3,4,5]

All people are gendered. Men, boys and people with diverse gender identities and sexual orientations have often been left out of traditional gender mainstreaming – as well as gender and development approaches – even though they have vital roles to play in the process of achieving gender equality. What makes our GTA innovative is the interconnectedness between the six components shown in Figure 1.

1. Haberland, N. and Rogow, D. (2015).
2. https://www.rutgers.international/GTA
3. Gupta (2000).
4. Rolleri et. al. (2014).
5. USAID and IGWG (2011).

Box 1: The Rutgers gender transformative approach

For Rutgers, a gender transformative approach (GTA) actively strives to examine, question, and change rigid gender norms and imbalances of power. This is done in order to achieve SRHR objectives, as well as gender equality objectives at all levels of the socio-ecological model (see page 7).

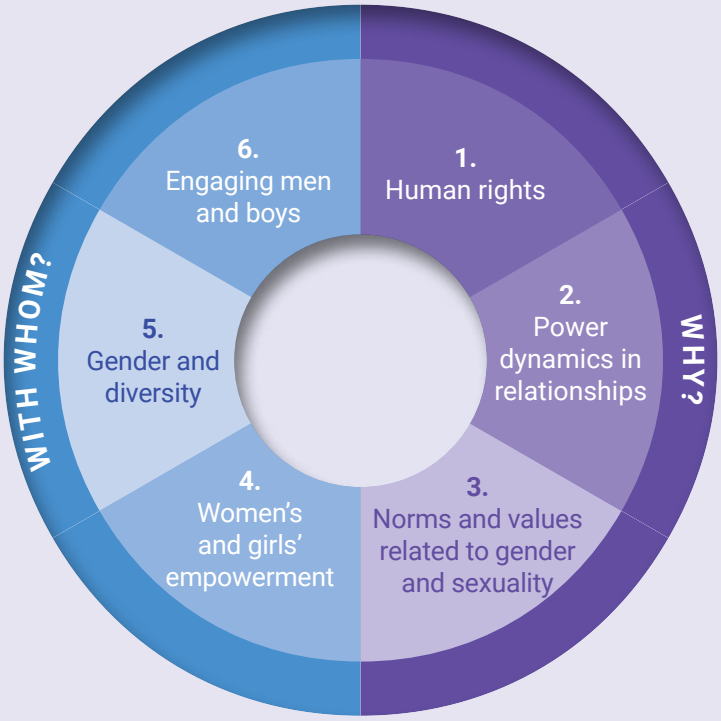
Programmes and policies may transform gender relations through:

- Encouraging critical awareness of gender roles and norms
- Questioning the costs of harmful, inequitable gender norms in relation to SRHR and making explicit the advantages of changing them
- Empowering women/girls and people with diverse gender identities or sexual orientations
- Engaging boys and men in SRHR and gender equality

By applying these four strategies, harmful, inequitable gender norms can change into positive, equitable and inclusive ones and lead to the improved SRH of all and the prevention of gender-based violence (GBV) and gender equality.

These six components are covered in Module 1 of the GTA toolkit and references to these components can be found throughout this Module 3.

Figure 1: The six interrelated principles of GTA

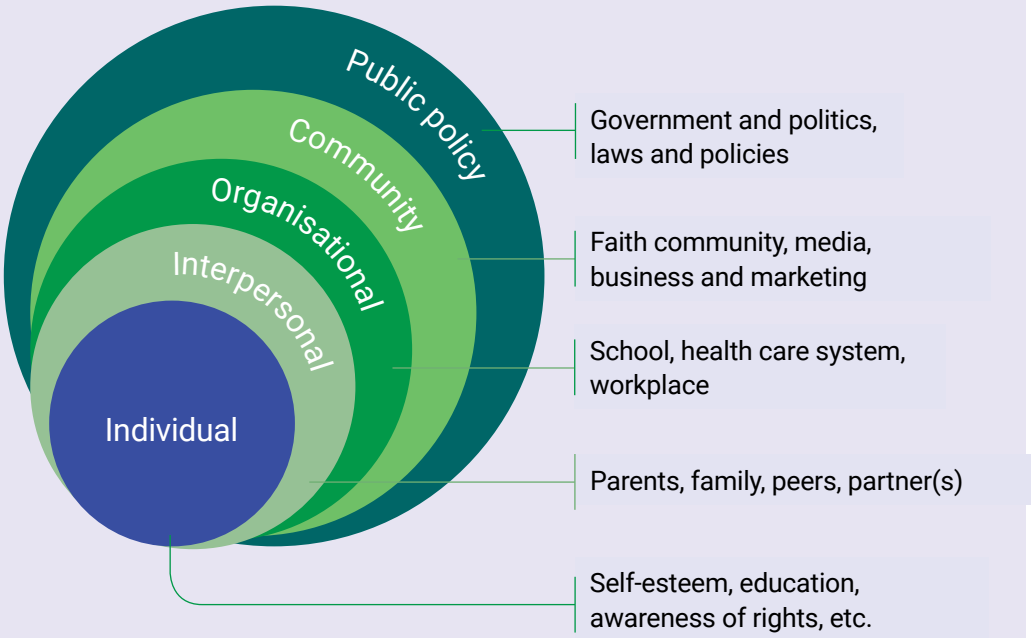


The socio-ecological model

Rutgers uses the socio-ecological model in its international programmes.[6] It is a model that shows that behavioural change needs to take place at different levels at the same time to really have impact: at the individual, the interpersonal, the organisational, the community and public policy levels. A meta evaluation by the World Health Organization (WHO) provides evidence that gender-transformative SRHR programmes that address gender inequality at these levels simultaneously have better outcomes than programmes that only focus on the individual.[7]

The GTA toolkit addresses these different levels of the socio-ecological model. This module on YFS focuses mostly on the individual, interpersonal and organisational levels.

Figure 2: Socio-ecological model



The target audience

The toolkit is intended to be used by trained facilitators who have a background in gender and YFS, and experts in gender and YFS who have the responsibility to facilitate learning and knowledge exchange in the field of GTA and YFS. It is meant to complement training for healthcare providers, peer educators, YFS/SRHR policy makers, programme managers and officers. While the modules are aimed at the training of trainers (ToTs) and other facilitators, exercises can also be applied directly in training healthcare providers.

6. The concept of the socio-ecological model was first used by Bronfenbrenner in 1979.

7. WHO (2007).

How to use this module

This module is designed to be used in a workshop setting: its users are assumed to be workshop facilitators. Therefore, it contains session outlines, including participatory activities and group work suggestions, as well as some theoretical background, handouts and a proposed programme for each workshop.

The activities in this module are not designed to give practitioners a comprehensive overview of YFS programming. Rather, the aim is to facilitate reflection on and analysis of existing YFS programmes and the extent to which they demonstrate a gender transformative approach. This is why participants in the training are required to have some background in SRHR and specifically YFS.

The module's activities are designed to be participatory, with varied learning styles and to offer space for participants' own personal and professional experience. The session can be made relevant to any setting; contextualisation is strongly encouraged.

Before you start

This module is designed with the assumption that participants will have a basic level of understanding of gender, power and norm change, preferably through participation in Module 1 of the Rutgers GTA toolkit.[8] If it is the case that participants do not have this knowledge, it is highly recommended you start your workshop with a selection of sessions from Module 1.

8. https://rutgers.international/gta-toolkit-M1

In Annex 1 there are two optional introductory exercises on gender, power and norm change taken from Module 1, which you could use as an introduction to the YFS workshop.

Module structure

The exercises in this module are structured around the six principles of GTA mentioned on page 6 and further explained in more detail on page 13. It is recommended that participants fill out the pre- and post-test questionnaire in Annex 2 before and after the training to give an indication of what has been learnt and where there is still room for improvement.

Facilitator notes

Facilitator notes are included for each session. Participant handouts are equally informative for facilitators as a resource. Here are some overarching principles that facilitators should take into account:

- Contextualise! This is key to making the module content really land with participants. The sessions in this module are developed in a way that makes it possible to adapt them to local contexts, thus making them more relevant for the group you are working with. As a facilitator, you are best placed to use examples from your country and background and integrate them into your sessions.
- Be aware of the sensitivities people may have in discussing sexuality. There may be people who do not feel comfortable discussing their own sexuality and no one should be made to discuss anything personal that they are not ready to talk about.
- It is important that facilitators present and guide discussions without bias or judgment of people's sexual diversity.
- You will know what is acceptable and what is not acceptable to cover according to the laws and policies of your country. This is different from what is socially acceptable or taboo to talk about. Taboo subjects, such as discussing the provision of contraception to adolescents stemming from norms against premarital sex should not be avoided, as a gender transformative approach seeks to challenge social norms and power dynamics. Laws and policies, however, can prove to be obstacles and these should be treated with care and sensitivity.
- The sessions encourage analysis which does not come naturally in some settings. Be prepared to move things forward with probing questions (examples are provided) during the sessions if participants are not forthcoming.
- Facilitators should be conscious of their own values and the gender norms that influence their attitudes and behaviours. It is important all facilitators have been through a reflective process of gender transformation prior to facilitating.

Applying a gender transformative approach to youth-friendly services

About youth-friendly services

There is no internationally accepted definition of youth-friendly services (YFS), but in general they refer to a broad range of sexual and reproductive health services that are responsive to the lived realities, specific needs and vulnerabilities of young people.

In line with findings of the Interagency Youth Working group's research[9] about the overall characteristics of YFS, this module endorses the idea that, in order to be youth-friendly, sexual and reproductive health services should at least meet the following criteria:

- trained providers communicate with youth in a respectful and non-judgmental manner
- facilities have policies of confidentiality and privacy in place
- facilities have convenient hours and locations for young people
- affordable fees

Furthermore, it is key that services are guided by the principle of informed choice and it is necessary that youth-friendly services are available and accessible to **all** young people regardless of their age, marital status, HIV status, sexual orientation, gender identity, social status, geographical location or ability to pay.[10]

In Annex 5 you find recommendations for youth-friendly service providers and facilities made by young people themselves.

Box 2: (Youth-friendly) SRHR services include:

- HIV testing, counselling and treatment
- Sexually transmitted infection testing and counselling
- Prescription of medications/products
- Pregnancy testing
- Contraceptive counselling and provision
- Maternal health
- Abortion and post-abortion services (to extent of the law)
- Sexual abuse counselling
- Relationship counselling
- Sexual and gender-based violence counselling
- Counselling on issues that undermine sexual health and wellbeing
- Referrals to other healthcare providers

The six interrelated principles of the gender transformative approach

This module makes use of the six interrelated principles of the gender transformative approach.

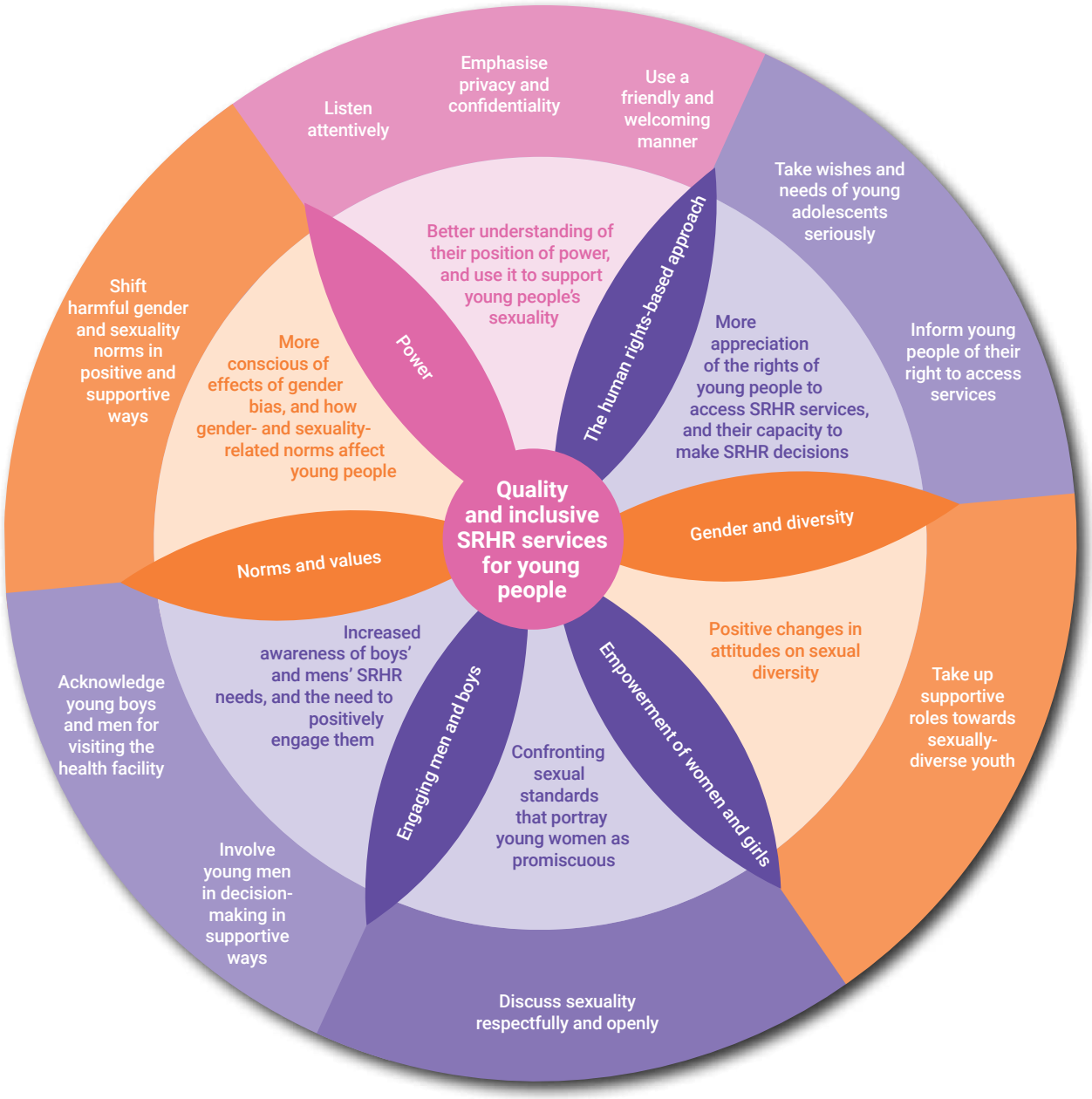
1. Human rights
2. Power
3. Norms
4. Gender and diversity
5. Empowering women and girls
6. Engaging men and boys in SRHR

9. Interagency Youth Working Group, Youth-friendly Services.
10. Choice for youth and sexuality. Accessed December 2020.

The framework below explains what applying the principles of the gender transformative approach to youth-friendly services looks like in practice.

For a more comprehensive explanation of how each principle contributes to more gender equitable knowledge, attitudes and skills of YFS providers, see the six descriptions below.

Figure 3: Rutgers GTA and YFS framework[11]



11. Both, R. and Kageha, E. (2020) *Gender transformative approaches to improving youth SRHR: Improving the sexual and reproductive health and rights of young people in Kenya by training healthcare providers in the GTA.*

1. Human rights

A human rights-based approach lies underneath the positive interpretation of youth-friendly services. In applying a human rights-based approach to YFS, the GTA:

- emphasises the need to take into account the right to health, the right to information, the right to personal autonomy, the right to privacy (for a more comprehensive overview see *Exclaim: Young people's guide to 'Sexual rights: an IPPF declaration'*[12])
- helps healthcare providers to recognise and acknowledge the evolving capacities of young people to make SRHR decisions; evolving capacities refer to the ability of a young person to make informed choices as it is related to age and their (psychological and physical) developmental stage
- helps healthcare providers to understand the importance of access to services and information for **all** young people, regardless of their age, ethnicity, socioeconomic background, gender identity, sexual orientation, HIV status, or marital status, without discrimination
- helps healthcare providers to be aware of young people's vulnerability to rights violations
- emphasises the need for information that is adapted in a way that it connects to the realities and development stage of a young person that seeks youth-friendly services.

2. Power

In applying a gender transformative approach to YFS, the principle of power helps us to understand power dynamics in relationships and how these dynamics keep harmful practices and norms in place. In applying a gender transformative approach to YFS, a power analysis can:

- help health workers to become more aware of power dynamics in their relations with the (young) clients
- seek to ensure that health workers are sensitive to power and gender dynamics in their work and use their power to support young people's sexual and reproductive health and rights
- help health workers to actively question gender stereotypes and power inequalities in intimate relationships
- make health workers aware of the power dynamics that affect the agency and choice of young people to claim their rights, which can be influenced by their ethnicity, level of education, age, socioeconomic background, gender identity, sexual orientation, HIV status, or marital status, without discrimination etc.
- hold those managing and running YFS programmes accountable for not abusing their power
- assist those running YFS programmes to set up and promote accountability structures where young people can safely and confidentially report any abuse of power.

3. Norms

Being aware of how (gender) norms and social expectations impact on YFS is crucial. It helps us to understand current practices, ways of working and provider bias. More awareness on norms and social expectations also creates the possibility to question harmful norms and work towards more positive ones.

12. International Planned Parenthood Federation (2011). Available at: https://www.ippf.org/sites/default/files/ippf_exclaim_lores.pdf

In applying a gender transformative approach to YFS, the principle of norms can:

- help to create a better understanding of social expectations within a specific context (i.e. sexual and gender norms) regarding masculinities, femininities and people with diverse SOGIESC (sexual orientation, gender identity and expression and sex characteristics)
- help to recognise the effects of gender bias, and how gender- and sexuality-related norms can affect young people's access to sexual and reproductive health
- help to understand that provider bias often stems from broader social norms, particularly judgments around sexual activity among youth
- help to shift harmful gender and sexual norms in positive and supportive ways by supporting the process of building on attitudes that promote gender equality and inclusion
- emphasise the need of contextualisation of a YFS training to be able to reflect on local gender and sexual norms.

4. Gender and diversity

In applying a gender transformative approach to YFS, its gender and diversity lens:

- improves health workers' knowledge on diversity amongst young people and its effects on YFS. For example, gender interacts with different other identity markers such as sexual orientation, gender identity, age, race, faith, ethnicity, socioeconomic status, HIV status, marital status etc. Each of these interactions either enables or obstructs a young persons' sexual and reproductive health and rights and access to information and services. Awareness of such 'intersectional' inequalities helps to improve services to be rights based and fair for young people in **all** their diversity.
- assists health workers to recognise discrimination and stigmatisation and its damaging effects
- contributes to positive change in health providers' attitudes towards young people with diverse sexual orientations and gender identities, and to the understanding that access to services and information should be available for **all** young people, without discrimination.

5. Empowering women and girls

In applying a gender transformative approach to YFS, the principle of empowerment of (young) women and girls:

- emphasises women's and girls' rights of bodily autonomy and integrity and informed choice at all times
- helps to increase healthcare providers' gender equitable attitudes
- helps healthcare providers to shift away from the view that (young) women and girls cannot make SRHR decisions without the permission of their partners/male family members.

6. Engaging men and boys

In applying a gender transformative approach to YFS, the principle of engaging men and boys:

- helps health providers to shift away from the view that SRHR issues are only women's issues
- emphasises the need to engage (young) men and boys in sexual and reproductive health issues because of their own health and rights, as well as the health and rights of their family members and (sexual) partners

- helps health providers to understand that (young) men and boys are a diverse group and that, related to SRH services, they can be engaged as clients, equal partners and agents of change[13]
- improves health providers' knowledge of how harmful gender norms can affect men's and boys' attitudes and behaviour regarding their own and others' sexual and reproductive health
- improves health providers' knowledge and reflection on possible ways that harmful gender norms can obstruct (young) men's and boy's access to SRHR services
- helps to analyse how negative ways of being a boy or a man can harm the rights of others, and how to assist them to adopt more positive gender and sexual norms
- helps to re-frame the dominant narrative within the development world that often still sees boys and men as 'perpetrators' only. Instead, it helps to see men and boys in all their diversity; they too can suffer negative health consequences, rights violations and structural discrimination because of gender and sexual norms and patriarchy. By seeing and treating men as a potential force for positive change and as potential supporters for gender justice and equality, programmers themselves can help to negate the harmful effects that patriarchy often exerts through abuse of power, privilege and the oppression of other gendered groups.
- creates awareness around power abuse, harmful norms and how patriarchy operates and affects the SRH of young people in all their diversity and helps to hold anyone who violates rights to account.

Addressing gender norms to minimise provider bias and improve services

Social norms have a huge impact on the SRHR of young people. Constructions of gender create social expectations related to young people's sexuality. 'Good' behaviour is rewarded, and 'bad' behaviour leads to social punishment like shaming, stigma, social rejection etc. Gendered sexual norms play an important role in determining what a community or culture sees as appropriate or not for young women and men and diverse groups.[14]

In addition, the literature on provider bias[15,16] shows that such norms also affect the attitudes and behaviour of health workers, often becoming obstacles to health-seeking behaviour of young people. We know that most health workers want the best for young people, but also that every human being has internalised the norms and biases of the community they grew up in. This is largely an unconscious process and is no different for health workers. Therefore, to support health workers to fully embody youth-friendly attitudes and behaviour it is sometimes necessary to further develop critical consciousness or awareness of the norms that lead to provider bias, e.g. young people might encounter providers who are judgmental about their situation, questions and needs, communicate in disrespectful ways, provide incomplete information and counselling and/or even deny them services.

Different types of provider bias have been described, such as client-related bias, e.g. based on the client's age, marital status, number of children etc. There are also method-related biases, e.g. for or against certain contraceptive methods. Box 3 highlights some of the underlying, and often invisible norms that can lead to provider bias.

13. Sonke Gender Justice (2012) *Building Male Involvement in SRHR*.

14. Kolundzija, Alana and Marcus Rachel (2019) *Gender norms and youth-friendly sexual and reproductive health services*. Sussex: Overseas Development Institute.

15. Solo, Julie and Festin, Mario (2019) Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations. *Global Health: Science and Practice* 2019 7(3).

16. Starling, Summer et al. (2017) *Literature Review and Expert Interviews on Provider Bias in the Provision of Youth Contraceptive Services: Research Summary and Synthesis. Beyond Bias.*

Box 3: Gender and sexual norms that underly provider bias

- **No sex until marriage:** Many providers have particular issues around the provision of contraception to unmarried adolescent girls and young women, stemming from norms against premarital sex and the assumption that providing these services would encourage promiscuity.
- **The sexual double standard (SDS):** The expectation of 'no sex until marriage' is one of many applied differently to men and women, boys and girls, demonstrating the inequity of the SDS. The sexual double standard is a gendered social norm that 'prescribes' that, among other things, adolescent boys be sexually tough, competitive, and heterosexual. Boys are supposed to take initiative and should be in charge, multiple sexual partners are often seen as a sign of being a 'real man'. On the other hand, the SDS says adolescent girls are expected to act passively, are often expected to 'please men' and therefore often find it difficult to say no. The SDS often places the focus for girls on physical appearance and controlling and shaming female sexuality .
- **Only contraceptives for couples who already have children:** Another common norm affecting the services that healthcare workers are willing to provide or not, is that only married women of proven fertility should be able to obtain contraceptives.
- **Third-party consent:** Another example of a social norm which especially affects the provision of services to (young) women and girls, has to do with the social pressure to get permission of third party, such as the husband or other senior family members. In some countries, this third-party permission is formalised in policy or legal norms, which in fact goes against the international human rights norms that most countries have agreed upon. On the other hand, consent also touches on the evolving capacities of young people, i.e. the ability of a young person to make informed choices as it is related to age and whether they are mature enough to make these decisions for themselves.

Navigating rights and the community

Research conducted in Kenya shows that healthcare providers report they often struggle with conflicting values and feelings. On the one hand, they want to value their cultural and religious beliefs, but on the other they also wish to respect young people's rights to access and obtain SRH services.[17] As mentioned, providers are usually well intentioned when interacting with adolescents, want to do no harm to their young clients and have their best interests at heart.[18] However, it is also clear that because of age, status and unequal power relations, healthcare workers often assume the role of 'impromptu caregivers' or another authority figure. This well-intended attitude can be to the detriment of a client's rights to information and choice. Please also note that a young client's ability to make informed choices regarding their sexuality is related to their age and developmental stage, or their evolving capacities (more on evolving capacities in Session 3.3).

A note on situational factors and the characteristics of young people

As we have seen, points of care and clinics exist in complex social settings which embrace social norms. Healthcare providers and other health professionals, who are also community members, often cannot help but take their own value systems and beliefs into the workplace. Their services are furthermore influenced by previous experiences, local

17. Godia, P., Olenja, J., Lavussa, J., Quinney, D., Hofman, J and Broek, N. (2013). 'Sexual and reproductive health service provision to young people in Kenya; health service providers' experiences. *BMC Health Services Research*. https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-476

18. Starling et. al. (2017). *Literature Review and Expert Interviews on Provider Bias in the Provision of Youth Contraceptive Services: Research Summary and Synthesis. Beyond Bias.*

contexts and their social position. A provider's bias or positive and supportive attitudes are also shaped by personality traits, level of knowledge and personal history.

Another important factor that affects how health workers perceive and treat young clients is their working conditions. Healthcare policies and procedures, remuneration, workload and workplace culture are known to have the potential to trigger provider bias and can lead to judgmental, non-empathetic behaviour and low-quality services or even outright discrimination, violation of privacy or refusal of service. These biases and the underlying harmful norms are often to the detriment of specific groups of young people, e.g those from diverse or minority groups and unmarried women.

Finally, young people themselves will exhibit certain behaviours that are part of their developmental stage and affect their demand for services. For example, they are in general more prone to risky behaviour (e.g. unprotected sex) and sometimes cannot see its long-term consequences (e.g. unwanted pregnancy, STDs and STIs, school dropout etc.) or simply do not see the need to seek medical advice.

Through (self)reflection and raising critical awareness on these personal and social factors, this module hopes to improve provider attitudes and facilitate high quality services that are informed by human rights and improve the choice and access to services of young people in **all** their diversity.

Applying the GTA to youth-friendly services: the sessions

Session 3.1

Introduction to GTA – six principles

Principles: All six

Time

1 hour

Materials

Flip chart

Marker pens

Learning outcomes

Knowledge	Attitudes	Skills
To introduce the six principles that underly a GTA	Familiarity with the six principles that underly a GTA	Recognising how all six principles work together and all of them are needed to ensure the sexual and reproductive health and rights of young people are protected, respected and fulfilled

Methods

Plenary, followed by group work

Description

Participants discuss the six principles on which the GTA is based and how these principles relate to YFS. The discussion will explore why each principle is necessary to transform harmful gender norms and relations, and which groups need to be included if we want our work to be rights based and effective.

Facilitator instructions

Step 1. Preparation

- Make sure that you have read and internalised the previous chapter in this module so that you can facilitate the plenary discussion at the end of this session. If you are still not clear on some of the principles refer to Module 1 of the toolkit, which discusses the six principles of a GTA in depth. You can always search the internet for more information if you are still not sure about one or more of the principles.
- Write the six principles on a flip chart for the whole group to see. You can keep this paper on the wall as a reference throughout the workshop.

Step 2. Activity

- Ask the group what the most important characteristics of YFS are. Write the answers down on a flip chart. **Make sure that the characteristics mentioned in the previous section, 'Applying a GTA to YFS – crucial background information' are included**.
- Divide the group into smaller groups. Depending on the group size you could opt for three or six small groups. The important thing is that each of the six principles of GTA should be discussed by at least one group, with each group allocated either one or two principles to discuss.
- Ask each group to discuss the principle(s) assigned to their group. What do they think the principle means and what is its importance for YFS?
- Ask each group to present their findings to the whole group.

Step 3. Plenary discussion and reflection

- In this discussion it is important that the participants understand that principles are crucial, because when internalised they determine our behaviour and practices. It is therefore crucial that we really internalise and understand their importance. As YFS providers we have to practise what we preach. As duty-bearers ourselves we have to make sure that we respect, protect and fulfil the human rights of young people and understand that this is our responsibility.
- Facilitate a group discussion by asking open questions like:
  - *Why do you think human rights are at the core of a GTA?*
  - *Why do you think the principles are interrelated and interdependent?*
  - *Why do you think we include boys and men?*
  - *Why should we also still focus on facilitating women's and girls' empowerment?*
  - *Why is it important to include (young) people with diverse SOGIESC?*
- To summarise the discussion and make their interdependence clearer, refer to the flip chart with the six principles that you stuck on the wall at the beginning of the exercise. Next to the first three principles write 'Why?' and next to the last three principles write 'With whom?'

Why? The core of a GTA is changing harmful norms and their underlying power relations, so that we can ensure the sexual and reproductive health and rights of young people.

With whom? We can't address unequal power relations and harmful norms by focusing on girls and women alone, as has often been the case for the past thirty years. To be successful we have to engage men and boys, and we should not forget groups that have been marginalised like people with diverse SOGIESC. The rights of these groups are often violated and not respected and therefore this group requires extra attention. In other words, we need equity to ensure their rights are met equally.

Session 3.2

Making sense of sexual rights

Principle: Human rights

Time

1 hour

Materials

Handout 3.1

Copies of *Keys to youth-friendly services*: www.ippf.org/sites/default/files/informed_consent.pdf

Copies of *Exclaim*: www.ippf.org/sites/default/files/ippf_exclaim_lores.pdf

Learning outcomes

Knowledge

Participants understand the challenges young people face with regard to SRHR

Attitudes

Participants are willing to explore their own values and feelings relating to SRHR issues that young people face

Skills

Participants define solutions to the SRHR problems for young people that they have identified

Methods

Plenary, followed by group work

Facilitator instructions

Step 1. Preparation

- The facilitator introduces the concept of 'sexual rights' by reference to the IPPF Declaration and ten sexual rights for young people explained in IPPF's *Exclaim*, which should be displayed prominently on either PowerPoint or a flip chart.

Step 2. Activity

- Using Handout 3.1, divide participants into groups. Ask them to discuss the situation and answer the questions in their groups.

Step 3. Plenary discussion and reflection

- In plenary, discuss the groups' work and explain that often it is easier to understand rights when you look at violations.
- Ask participants to come up with recommendations for how their project could address sexual rights issues in their work on the level of policies and activities.
  - Are the situations in the exercise sheet familiar?
  - Remind participants that in order to effectively address the sexual and reproductive health rights of young people, it is important that they take time to think about their own values and the rights of other people whose lives and lifestyles may be different to their own.
- Highlight the fact that emotions and perceived injustice are often the motivating factors for people who work for young people and advocate on their behalf.
- Share *Keys to youth-friendly services* and *Exclaim* as useful resources and ask participants for other possible resources that they use.

Session 3.3

Evolving capacities and the Convention on the Rights of the Child

Principles: Human rights, power, norms

Time

1 hour

Materials

Copies of Handout 3.2

Flip chart

Learning outcomes

Knowledge

Participants understand the concept of evolving capacities and how gender norms and power might intersect with evolving capacities

Attitudes

Participants are open to young people having rights and evolving abilities to make informed choices about their health and wellbeing and are positive regarding difference

Skills

Participants are able to assess their own ability to support young clients to develop the capacity to make decisions on their own about their health and healthcare, without gender discrimination or abuse of power

Methods

Group work, plenary discussion

Description

The concept of evolving capacity in YFS refers to the growth process and level of autonomy of young people. The path towards being able to take full responsibility for decisions and actions will be different for every individual. In this exercise, participants will learn about the evolving capacities of the child. They will discuss why it is necessary that young people's capacities and levels of maturity are taken into account in the decision-making process during the provision of SRHR services and how this can live up to the principles of informed choice or informed consent.

Facilitator instructions

Step 1. Preparation

- In preparing for this session make sure that you have sufficient knowledge about the concept of evolving capacities of the child. Therefore, you might want to read additional information about evolving capacities. For this you could study IFFP's *Keys to youth-friendly services: Understanding evolving capacity* to properly familiarise yourself with the concepts.[19] You also could share a copy with your participants after the exercise.

Step 2. Activity

- Briefly explain to the group what evolving capacities are.
- Share Handout 3.2 with the participants.

19. IPPF (2012) Keys to youth-friendly services: Understanding evolving capacity. https://www.ippf.org/sites/default/files/key_evolving_capacity.pdf

- Divide the group into three smaller groups and give them each one of the three questions below:
  1. *In your work context, which harmful gender norms might affect the capacity of young people to make informed choices about their sexual and reproductive health?* It is very important to distinguish different genders here.
  2. *In your YFS context, which (unequal) power relations affect the capacity of young people to make informed choices about their sexual and reproductive health?*
  3. *In your YFS context, how might young people's gender identity, sexual orientation or sex characteristics that differ from the norm affect their capacity to make informed choices about their sexual and reproductive health?*

Step 3. Plenary reflection and application

- *How can healthcare providers support young people to help them develop the capacity to make decisions on their own about their health and healthcare?*
- *How can healthcare providers involve care givers to help young people develop the capacity to make decisions on their own about their health and healthcare?* Taking in account confidentiality, possible abusive home situations etc.
- Make sure that the following topics are part of the discussion:
  - Awareness of legal provisions in their country of operation
  - Assessing on a case-by-case basis the competences and maturity of the young person to take responsibility and take action
  - The fact that getting informed consent before treatment is part of ethical medical practice and is enshrined by law in most nations

Session 3.4

Introduction to gender and sexual norms

Principle: Norms

Time
+/- 1 hour

Materials
Flip chart
Markers

Learning outcomes

Knowledge	Attitudes	Skills
Participants identify how norms can affect service provision	Participants are willing to reflect on how their norms can harm service provision and the SRHR of young people	Participants can critically self-reflect on how their own expectations can reinforce gender stereotypes and affect the SRHR of young people

Methods Role play

Facilitator instructions

Step 1. Activity

- Ask four participants to volunteer to take the roles of Romeo (a male client), Juliet (a female client), a male service provider and a female service provider.
- Ask the service providers to wait outside while you explain the situation to Romeo, Juliet and all the other participants:

  Romeo and Juliet are a young married couple and do not want to have children. Romeo has been using condoms for the last 6 months but wishes to stop using them. Juliet is reluctant to start using contraceptives and would prefer Romeo to continue using condoms. This has caused some tension in the relationship. They each visit a male and female service provider to discuss the problem.
- Inform Romeo and Juliet **separately** about the hidden aspects of their lives (you can introduce both or simply one or the other). Ask them not to reveal these aspects of their lives until the most appropriate moment in the consultation with the service provider:
  - Romeo has a boyfriend from before he was married to Juliet and regularly has sex with him
  - Juliet often sells sex to enhance the household income
- Tell the rest of the participants to watch the role plays and to note down any differences or similarities they see in how the service providers approach Romeo and Juliet. Ask the service providers back into the room.
- Watch the role plays.

Step 2. Reflection

- As a group, discuss how the male and female service providers responded similarly or differently to the needs of the young man and the young woman. Think about how social expectations of young men and women influence how information and services relating to sexual and reproductive health are given – does it reinforce gender stereotypes, or does it reflect the real needs of the clients? Which harmful gender norms are at play?
- Ask participants to brainstorm:
  - how these hidden elements of their lives would affect the service delivered to them
  - how service providers would find out about these hidden elements to ensure they receive optimum services
  - what the assumptions are that we make around sexuality and sexual diversity that may inhibit our service delivery

Session 3.5

Digging deeper into norms around gender and sexual health

Principle: Norms

Time
+/- 1.5 hours

Materials
Copy of Handout 3.3

Learning outcomes

Knowledge
Participants better understand why creating change within an organisation can be challenging; participants understand factors that can enable positive change

Attitudes
Participants are mentally prepared for possible resistance towards change that might be encountered as part of the change process

Skills
Participants can reflect on obstacles to and enablers of change

Methods

Group work, reflection and discussion

Background information on norms and YFS

Read Box 3 on page 16 on norms and provider bias. Key norms stated in the literature that affect adolescent SRH services are:

- The sexual double standard, i.e. the general norm that boys and men are rewarded and praised for (multiple) heterosexual sexual contacts, whereas girls and women are stigmatised for similar behaviours and are expected to be submissive and subservient
- Denial of adolescent sexual behaviour/activity or premarital sex, i.e. abstinence or no sex until marriage
- The norm that young women and adolescent girls should have a child immediately after marriage to prove their fertility and femininity
- The norm that young people should ask permission of an adult before seeking to access services like HIV testing, (post) abortion care etc.
- The norm that contraceptive use equals promiscuity or prostitution, especially for adolescent girls and young unmarried women
- Stigma around HIV services and treatment
- Stigma and judgment around abortion and post-abortion care

These gendered norms, as well as the working conditions at a clinic, the knowledge and experience of health workers and the policy environment all have an effect on the healthcare-seeking behaviour of young people and the quality of care they receive.

To transform gender norms is a slow process, as there are also interests at stake and many norms are maintained and reproduced by different forces, such as economic, kinship, religious and socio-political factors. We also refer to this as the 'stickiness' of the norms. The more factors there are keeping a norm in place, the stickier and more difficult it will be to change.[20] Ideally, therefore, any serious attempt to change community norms addresses multiple levels of society, for example, through education at the individual level,

20. See also the exercise on sticky norms in GTA Module 1 on page 37.

intergenerational dialogues at the community level and policy advocacy/reform and media campaigns at the police and community levels.

However, research by Rutgers conducted with health workers in Kenya provides evidence that the self-reflective exercises in this module alone are already effective in creating favourable attitudes and beliefs for youth-friendly services, which has led to more young people feeling comfortable in visiting health facilities.[21] Because some programmes might not have the resources to address norms on different levels, we start with change at the individual level of the healthcare provider. For change on other levels, like in the classroom or through advocacy, we refer to the other modules in our GTA Toolkit.[22]

Description

In this exercise we aim to create critical awareness in health workers around some of the key social norms that govern gender and sexuality of young people and how they relate to adolescent sexual and reproductive health services.

In the introduction we mentioned which norms have the most impact on health-seeking behaviour and the sexual and reproductive health of young people. After having walked in the shoes of these young clients we now dive a bit deeper into these potentially harmful norms and look at how we can adopt more constructive attitudes and improve the wellbeing and health-seeking behaviour of young people in all of their diversity.

Facilitator instructions

Step 1. Activity

- Divide the group into smaller groups. Each group will discuss one of the gendered sexual norms for young people described in the cards in Handout 3.3. Pick the cards that are most relevant for your context. For each norm the group reflects on how it might affect young people's sexual and reproductive health in the context that they work in.
- Finally, after the smaller groups have discussed for about 30 minutes, individual groups present the core of their discussion to the whole group. The other groups can ask questions for clarification.

21. https://rutgers.international/gta-toolkit-M1
22. https://rutgers.international/gta-toolkit-M1

Session 3.6

Power Walk for health workers

Principle: Power

Learning outcomes

Knowledge

Participants recognise power/privilege within the relationships they have with young clients

Attitudes

Participants are more sensitive towards the intersectionality of gender and other disempowering factors like race, ethnicity, age, caste, class etc.

Skills

Participants can apply the insights on their own power, biases etc to improve provider-client interaction and access to adolescent SRH services for young people in all their diversity

Time

1.5 hours

Materials

Copy of Handout 3.4

Scissors

Copy of statements on page 29

Methods

Participation in the Power Walk, discussion and reflection

Description

Intersectionality can be seen as the interaction between different identities such as gender, race, age, class, sexual orientation, educational level, etc. and how these categories can strengthen systems of discrimination or disadvantages. In other words, gender inequality is often strengthened by other forms of inequality. For example, a health worker's superior status and power as a professional and their higher level of education, plus their advanced age and strict religious beliefs can all influence service delivery. This unequal situation could result, for example, in a young unmarried and uneducated poor woman being denied access to contraceptives or information about her contraceptive options. Please note that power and privilege can also be a force for good, where we can use our social status and power to strengthen the choice and rights of young people in relation to services.

Facilitator instructions

Step 1. Preparation

- In Handout 3.4 is a list of characters that are related to your point of care or clinic. If some of the characters are not useful in your setting you can make up your own. Cut the handout up so you have one character per piece of paper.
- Find a big enough space for everyone to stand in a line. This could be outside but also in a big room.

Step 2. Activity

- Give one character to each participant, asking them to read it without showing it to anyone else. Explain that each person will act the role of this character during the exercise. It is useful to switch gender roles (i.e. to give men a female character to play and women a male person to play) and to give older participants a young character and vice versa. The idea is that by imagining themselves in a character of another gender/age/race, participants become more critically aware of gender, power and the intersectionality with age, race, ethnicity etc. In other words, through empathy, they will experience what is like to be in a disempowered (or empowered) state and how different social factors work together to affect the quality of service delivery to young people.

- Ask everyone to form a straight line, with each person standing side by side and facing the same way.
- Explain the following process:
  - I will read out a series of statements, situation or events
  - If your character answers 'Yes', you take one step forward
  - If your character's answer is 'No', you stay where you are and do not take a step
- Slowly read out the statements on page 29, giving participants time to move between each statement. You are strongly encouraged to contextualise the questions. You can pick questions you like for your context, add new ones and leave others out.

Step 3. Reflection

- Having read out all the statements, ask the participants to stay in the position that they are in and explain that you are going to ask a series of questions, and that participants need to answer them from the perspective of their character within the imagined community or clinic.
- Ask participants:
  - *How does it feel to be in the position where you are now?* (i.e. close to the line where they started indicating lack of power, somewhere in the middle indicating some power or in front which implies a lot of power).
  - *Why did this person end up in this position? Did gender have anything to do with this? Did age have anything to do with why you are standing here? Did sexual orientation have anything to do with the quality of services they receive?*
  - *What other social factors influence access to and quality of the youth-friendly services in this context?*

Step 4. Application

- Ask the groups to discuss how they can use their power and privilege to improve the sexual and reproductive health and rights of young people in their clinic or point of care.

Statements

1. I can influence decisions made at the clinic.
2. I have all the information about how to avoid unwanted pregnancy that I may I need.
3. I have time and access to radio and TV stations of interest for me.
4. I can afford WiFi.
5. I would never have to wait to meet clinic officials.
6. I have access to loans from a bank.
7. My opinion is important within my community.
8. I can negotiate condom use with my partner.
9. I went to secondary and/or tertiary education.
10. I will be consulted on technical issues to do with youth-friendly services.
11. I can pay for treatment at a private hospital if necessary.
12. I get invited to attend workshops and seminars.
13. I have access to plenty of information about HIV and AIDS and how to prevent it.
14. I am NOT in danger of being sexually harassed or abused.
15. I can buy contraceptives at a private clinic.
16. I can influence how money for the clinic is used and invested.
17. I make decisions about major purchases in my household.
18. I have control over decisions about my body, including when to have children and how many.
19. I have a say in who I marry and when.
20. I am NOT likely to experience gender-based violence
21. I am NOT likely to be discriminated against because of my sexual or gender orientation.
22. I am NOT likely to be discriminated against because of my age.
23. I am NOT likely to be discriminated against because of the number of children I have.
24. I am NOT likely to be discriminated against because of my marital status.
25. I have the power to deny the provision of contraceptives to someone who asks for them.
26. I have the power to lecture young people on how they should behave in their sex lives.
27. The ministry of health is willing to listen to my advice and feedback.
28. I can email or call a donor at any time and they will respond to me.
29. I am aware of the adolescent sexual and reproductive health policies in my country.
30. I have in-depth knowledge on different types of contraceptives.
31. I am aware of the policy guidelines regarding (post) abortion care in my context.
32. I am aware about the laws and policies around sexual and gender-based violence in my country.
33. I understand how human rights frameworks work.
34. I know the benefits and possible side effects of long-acting, reversible contraceptives.
35. I know the possible risks of unsafe abortion.
36. I am an expert on family planning.
37. I am aware of how the healthcare budgeting process works in my district or province.
38. I fit in the gender norms that are accepted in the context where I live.
39. My sexual orientation is accepted within the context where I live.
40. My gender identity fits within the norms that are accepted in the context where I live.

Session 3.7

Facilitating empowerment

Principle: Empowerment of women and girls

Time

1 hour

Materials

Flip chart

Paper

Markers

Learning outcomes

Knowledge

Understand how power works in a specific context, how it can facilitate or harm young people's access to services and affect the quality of care

Attitudes

A critical attitude to see what can facilitate empowerment and choice regarding services provision

Skills

Participants can take actions that enable choice and rights of young people in regard to SRH services, with a special focus on young people that are often most disempowered

Methods Group work, plenary discussion and reflection

Description

In this session participants explore the ways in which practitioners can use their power to facilitate choice and reduce obstacles to informed choice.

We cannot empower someone, but we can facilitate their empowerment. Most often girls and young women and young people who do not fit gender and sexual norms are most affected by power relations and the frequently harmful norms that are linked to unequal power relations. Empowerment can be described as gaining the ability to make choices that someone could not make before. Besides educating young people to claim their rights and make informed choices, this also means changing obstacles in the environment. For example, provider bias, location, and working conditions can also affect the quality of care and the choices young people make.

Facilitator instructions

Step 2. Activity

- In plenary ask the group to draw a table with three columns on the paper. One for the category of women, one for the category of men and one for people who do not identify as men or women (non-binary). The aim is to see the difference between the powers (i.e. inequality) these different gendered groups have in your context and society. There can be all kinds of power, do not worry if the kinds of power are different to the examples given in this table.

Men	Women	Non-binary /Neutral
Economic power		
Religious power		
	The power of prayer	
Political power		
	The power to decide in the household	
Power of education		
		Spiritual power
Power to decide how many children to have		

Step 3. Reflection

- In plenary, discuss for each gender category how they feel the powers of these genders can affect their access to sexual and reproductive health services and quality care.
- Note down the summary of the discussion in bullets, for each of the categories. Try to make room for the fact that people will see that most power lies with men.

Step 3. Application

- Divide the group in three and assign each group to one gender category. That is; one male group, one female group and one diverse group.
- Ask each group to imagine that they are the manager of an SRH clinic. What would they do to facilitate the empowerment of their group, now that they have conducted a power analysis for their clients and clinic?
  - *How would they facilitate more choice for their group?*
  - *How would they facilitate more information and knowledge about services for their target group?*
  - *How would they facilitate better access to services for their specific group?*
  - *How does your empowerment strategy as clinic manager change when it concerns very young clients?*
  - *How did you feel having this power to decide on the health of young people?*
  - *How do you think young people feel when others decide for them?*

Session 3.8

In their shoes

Principles: Gender, diversity

Learning outcomes

Knowledge	Attitudes	Skills
Understanding of how GTA has the potential to impact young people's 'health seeking' behaviour	Enhanced empathy for young people in all their diversity in seeking services and the gendered barriers they must overcome	Critical consciousness regarding the impact of gender on health seeking behaviour of young people

Time

1 hour

You will need additional time when you decide to do a value clarification session and/or an introductory exercise on gender and sexual diversity

Materials

Copy of Handout 3.5 cut into individual case studies

Copy of Annex 5

Flip chart

Methods

Group work, plenary discussion and reflection

Description

By putting themselves in the shoes of different young people seeking youth-friendly services, participants learn about the positive impact they can have on the sexual and reproductive health and rights of young people in all their diversity.

Before you start – important notes

- It is likely that not all participants are familiar with sexual and gender diversity and that it is necessary to further explain the concepts of sexual orientation, gender identity and expression and sex characteristics (SOGIESC). You can use the Genderbread Person and explanation in Annex 4. You can also find introductory exercises on SOGIESC in Module 1 of the toolkit.[23]
- Topics that refer to sexual and gender diversity might not be socially accepted in the context where the healthcare providers live and work. Therefore, please consider whether it is necessary to do a value clarification exercise before you start the activity. An example could be that you let participants agree that all humans have the same human rights, and these rights should be respected in all situations, no matter someone's gender identity, sexual orientation and sex characteristics. As a facilitator you are responsible for creating a safe and respectful learning environment.
- Take into account that both a value clarification and an introduction to the concepts of sexual orientation, gender identity and expression and sex characteristics will cost additional time.

Facilitator instructions

Step 1. Preparation

- Read the box above, 'Before you start – important notes'.

23. Rutgers GTA Manual, Module 1: https://rutgers.international/gta-toolkit-M1

Step 2. Activity

- Pose the following questions to the group to open up a discussion.
  - *Do you ever think about how a young person feels when they walk away from your health centre, clinic, outreach programme or school health services?*
  - *How should every young person feel when they walk away? No matter their age, gender, ethnicity, socio-economic status, marital status or sexual orientation.*
  - *How does the feeling that a young person has after receiving a service impact upon whether or not that young person returns again in the future?*
- Explain that for this session, we will put ourselves in the shoes of diverse young people who seek YFS. How can we ensure that **every** young person who walks out of our services feels listened to, supported and empowered?
- Divide the group up into smaller groups. Each group will look at one case study in Handout 3.5.

  Note: If you feel that you cannot create a safe and respectful learning environment to discuss the case studies that are described below (despite a value clarification session), it is an option to slightly adapt the case studies. In doing so please keep in mind the learning outcomes and overall aim to create more empathy for young people's gender and sexual diversity, sexual orientation, gender identity and expression and sex characteristics.
- Once they have read the case studies, each group will write an ending to the story in which the young person walks away feeling supported and empowered. Participants can think about not only the interaction with the provider (although this is an important part), but the way in which the young person accesses the services, interactions with other members of staff, materials given to or read by the young person in the waiting room, and the manner in which privacy and confidentiality are respected. Optionally the group could also draw the ending on a flipchart.
- Once groups have been working for 10 to 15 minutes, you may wish to pose a few questions to help them think through their scenario. Potential questions that groups could ask themselves are:
  - *Is the young person reassured that their gender identity and sexual orientation is respected? If so, how?*
  - *For each case study, think about what the young person would feel when they walk into the clinic and how you want to change that when they walk out.*
  - *What needs to change in the community to ensure that these young people have the freedom to make informed, free choices about their sexual and reproductive health?*
  - *What could the provider say in each case study to challenge the gender norms at play? What services could that provider offer?*
  - *What information could the clinic provide to the young person?*

Step 3. Reflection and application

- Back in plenary, do not ask each group to 'report.' Rather, ask the following general questions:
  - *What do you want to share about how you have experienced the exercise?*
  - *What was difficult?*
  - *What did you learn from the exercise that you can apply in your own work?*
- Use the recommendations for YFS made by young people themselves, see Annex 5. How can participants link their reflections to the recommendations made by young people themselves?
- Make sure that participants recognise that the core of the exercise is to show how healthcare providers can positively contribute to the rights and lives of young people in all their diversity.

Session 3.9

Engaging young men and boys in youth-friendly services

Principle: Engaging men and boys

Time

1 hour

Materials

Big sheets of paper

Coloured markers

Post-it-notes

Learning outcomes

Knowledge

Participants understand the need to engage (young) men and boys in sexual and reproductive health issues because of their own health and rights, as well as the health and rights of their family members and (sexual) partners

Attitudes

Health providers shift away from the view that SRHR issues are a women's issue only

Skills

Participants are able to identify the different needs in engaging boys and young men in YFS

Methods

Group work, plenary discussion and reflection

Description

This exercise contributes to participants' reflection on the reasons why it is important to engage boys and young men in youth-friendly SRH services and how this can be done. The exercise aims to explore diversity among men and to think about men in different roles such as clients of SRH services and supporting partners/parents.

Facilitator instructions

Step 1. Preparation

- Make sure that you have sufficient knowledge and feel comfortable hosting a session about male engagement in SRHR, and that you have background information about why it is beneficial for all and how involving (young) men and boys in SRH can be done inclusive and gender equitable ways. The toolkit *Building Male Involvement in SRHR* can be helpful for background reading.[24]
- Read the paragraph about engaging men and boys in YFS on page 15.
- Make sure that you understand what a mind map is and can explain this to the participants.
- You can find more information about mind mapping here: www.mindmapping.com/mind-map

Step 2. Activity

- Ask participants to discuss briefly in **pairs** what their experiences are with involving (young) men and boys in YFS/SRHR services.
- Explain that sexual and reproductive health is not just a women's issue. Each individual is equally responsible for their own and their partner's sexual and reproductive health. In addition to seeing young men as supportive partners and parents, it is also important that (young) men are seen as individuals with male-specific sexual and reproductive health needs.

24. Sonke Gender Justice (2012) Building Male Involvement in SRHR.

- Ask participants to form groups of 4–5 participants, with at least two different groups in total.
- Ask each of the groups to focus on one of sub-questions below (make sure that the division is more or less equal).
  - *Why is it important to engage boys and young men in youth-friendly SRH services?*
  - *How can boys and young men be engaged in youth-friendly SRH services in gender equitable and inclusive ways?*
- Ask the groups to make a poster of a mind map that answers the sub-question. If needed, first explain what a mind map is. The participants can use coloured markers, Post-it-notes, etc.

Step 3. Reflection

- Ask the different groups to present their poster in plenary. Invite other participants to reflect on the presentations and to ask critical questions. According to available time and total number of participants you can also choose two groups to present, one for each sub-question.
- Make sure that during the reflection specific attention is paid to:
  - **Male-specific** sexual and reproductive health needs
  - **The different roles of boys and young (men)** in SRHR: clients of SRHR services, supporting partners and/or parents, agents of change
  - **The do no harm principle:** the involvement of (young) men and boys in YFS should in no way harm the rights, choice and health of others
  - **Diversity** among young men and boys based on their age, socio-economic status, ethnicity, sexual orientation, gender identity and marital status

Session 3.10

Taking it forward

Time

1 hour

Materials

Copies of Handout 3.6

Pens

Learning outcomes

Knowledge	Attitudes	Skills
Participants identify lessons learnt and practical next steps and think about ways to integrate those in their daily work as health workers	Participants are willing to reflect on what GTA and YFS can mean in providing SRHR services to young people	Participants are able to apply lessons learnt from the GTA and YFS exercises to their work as healthcare providers

Methods Plenary, individual work, work in pairs

Description

This exercise helps to build the bridge between a workshop environment (with theory, exercises, simulations) and participants' daily work. The focus of the exercise is on identifying personal lessons and takeaways, taking into account the participants' working conditions.

Facilitator instructions

Step 1. Preparation

- Make copies of Handout 3.6, one for each participant.

Step 2. Activity

- Explain that this exercise helps to build the bridge between a workshop environment and participants' daily work by identifying practical steps forward.
- Ask participants to take a moment to individually reflect on their personal learning process regarding applying a gender transformative approach to youth-friendly services, and what would be the opportunities to apply lessons learnt in their daily work as healthcare providers. After a few minutes, ask participants to complete the sentences below (share Handout 3.5). Emphasise that it is important to take into account their own local working conditions.
  - Based on my personal lessons learnt, in my work as SRH service provider for young people **I will continue to …**
  - Based on my personal lessons learnt, in my work as SRH service provider for young people **I will stop …**
  - Based on my personal lessons learnt, in my work as SRH service provider for young people **I will do differently …**
- Ask participants to discuss their completed sentences in pairs. Guiding questions for this conversations are:
  - *Why do you think these are important steps forward to integrate into your daily work?*
  - *What motivates you to bring these steps into practice?*
  - *What could be challenges? How can these challenges be addressed and overcome?*

Step 3. Plenary reflection

- Give participants the opportunity to share their reflections and next steps with the bigger group.

Annexes

Annex 1: Additional introductory exercises on the GTA

Session 1: The gender box[25]

Time
2.5 hours

Materials
Flip charts

Pens, pencils or coloured markers

Post-it notes in different colours

Learning outcomes

Knowledge

Understand the socially constructed nature of gender norms and how these are enforced

Understand how masculinity and femininity are connected to power and inequality, and the links between harmful gender norms and SRHR

Attitudes

Is able to look critically to one's own socialisation and gender norms, and at how this relates to SRHR

Have increased awareness of socially expected masculine and feminine norms and behaviours

Skills

Can identify socially expected masculine and feminine norms and behaviour

Methods

Group work, plenary reflection and discussion

Facilitator instructions

This session provides a good starting point to discuss gender norms and how they are enforced. It can be used and adapted for different groups – young men, young women, mixed youth groups, adults, people with diverse SOGIESC or coming from different classes/castes. The idea is to connect the findings with SRHR when doing the session.

Step 1. Activity

- Divide the group into males and females, young and older people, different sexual or gender identities, people belonging to different castes/classes, etc.
- Ask the respective groups to brainstorm a list of words that come to mind when they hear the phrase 'Act like a man/boy' (for the men or people who identify as such) or 'Act like a woman/girl' (for the women or people who identify as such). Explain that this is not a list of things they think are true, but the messages children receive about what they must do 'to act like good boy/man', 'to act like a good girl/woman'.
- Ask the groups to write the different ideas or concepts about what it means to be a 'good' man or a 'good' women on Post-it notes (these can be different colours for the men and women) and then stick them on the flip charts with the title **Act like a man** or **Act like a woman**.
- Ask a representative of each group to present. In plenary, people can add comments if they want. Write the new ideas on Post-it notes and put them on the flip charts.

Step 2. Reflection

This step helps participants to think about where these messages come from – who is the messenger? – and how early influences in children's lives affect socialisation – when do we first receive these messages?

25. Taken and adapted from: Mosaic, Rutgers WPF, Rifka Anisa, Women's Crisis Centre Cahaya Perempuan 2011: 102-105.

- Draw a box around the two lists on the flip charts, and say “This is a man box”, and “This is a woman box”. You can then ask:
  - *Does this seem familiar?*
  - *Do you visit this box in your daily life?*
- Ask participants to share experiences and feelings related to the messages.
- Ask how it feels to fit or not fit into these boxes – exactly or not at all.

Note: These boxes represent society’s expectations of males and females and the binary nature of these. The responses of diverse SOGIESC individuals or groups to the following questions will add another useful dimension to the discussion but are unlikely to challenge the idea that rigid gender norms can be harmful.

- Ask: *What are the advantages/likes to following these rules and fitting into the box?* Write the responses to this question on another flip chart or next to the Post-it-notes under the heading **Likes/advantages of staying in the box**.
- Ask: *What are the disadvantages/dislikes to staying in the box?* Write the responses on a flip chart or next to the Post-it notes under the heading **Dislikes/disadvantages of staying in the box**.
- Ask: *Are there any advantages to coming out of the box?* Write the responses on another flip chart or next to the Post-it notes under the heading **Likes/advantages to stepping out of the box**. Or write the responses around the outside of the box.
- Ask: *Are there any dislikes/disadvantages/costs to stepping out of the box?* Write the responses on flip charts under the heading **Disadvantages/costs related to stepping out of the box**.
- Looking at the common horizon of both men and women and people who identify differently from this binary division, you can finish this step by reminding participants that there is more that binds us together than separates us. We all want a healthy, fulfilled and happy life, where everybody can realise their dreams and enjoy friends, families, children, etc.

Step 3. Application

This last step is to ask the group how women can support other women, men can support other men, and how women and men can support each other and show solidarity in the process of change and gender transformation.

Step 4. Additional exercise

You could also ask the groups to write down what the ‘costs’ of gender norms are for each box regarding SRHR. For example, how do gender norms affect the right to choose with whom, when, how and how often to have sex? Ask if this is this the same for men, women and people with diverse SOGIESC. Think of things like sexual coercion, unwanted pregnancy, abortion etc. How are men, women and people with diverse SOGIESC affected differently because of social, gendered norms around sexuality? The goal is to establish that harmful gender norms and social expectations linked to each gender box might lead to negative sexual and reproductive health outcomes.

Session 2: Clarification of gender and sexual norms and values[26]

Time
1 hour

Materials
Three cards or flip charts

Marker pens

Tape

A room with enough space for people to walk around and stand in three small groups

Learning outcomes

Knowledge	Attitudes	Skills
Understand general gender beliefs/values, norms and perceptions (masculinity and femininity) including one's own	Can acknowledge different perceptions of masculinity and femininity Is open to critically examining one's own gender norms	Can recognise how gender can be used to maintain power and control

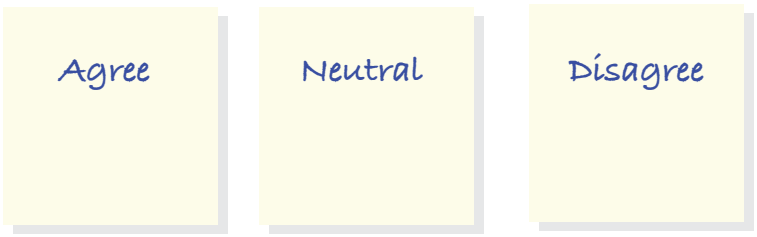
Methods

Agree–disagree, reflection and discussion.

Facilitator instructions

Step 1. Activity: Agree–disagree

- In large letters, print or write each of the following titles on separate cards or flip charts. You can do this in advance of the session.



- Display the cards around the room, leaving enough space between them for a group of participants to stand near each one.
- Show the participants the value statements and ask them to choose five or six that are most relevant to the context you and the participants are working in. You may also come up with a few new statements, adapted to the context.
- Read the first selected statement aloud and ask the participants to stand near the card that represents their own response to that statement.
- First allow the groups to have an internal discussion about why they are standing with the cards they have chosen. Afterwards you can have a broader discussion between the different groups. Allow participants to change their position.

Step 2. Reflection

- In the discussion address the gender stereotypes, false assumptions and myths that the statements represent. Try to provide examples of how they are damaging to both women/girls and men/boys.

Step 3. Application

- Ask participants what they have learnt from the session and how it relates to SRHR programming.

26. Taken and adapted from: Mosaic, Rutgers WPF, Rifka Anisa, Women's Crisis Centre Cahaya Perempuan 2011: 101-102.

Value statements

- It is easier being a man than a woman
- Women make better parents than men
- Gay people cannot be parents
- All lesbian, gay, bisexual, transgender, intersex (LGBTI) rights should be equal to the rights of other men and women
- Family planning is a woman's responsibility
- Abortion is exclusively a women's issue
- A man is more of a man once he has fathered a child
- Sex is more important to men than to women
- Sex is more important to gay couples than to heterosexual couples
- Lesbian and gay couples have one partner that is more female and one that is more male
- It is okay for a man to have sex outside the marriage as long as his wife does not find out
- A man cannot rape his wife
- Men are smarter than women
- A woman who uses a sex toy is unnatural
- Sex before marriage by a man is not a problem
- Sex before marriage by a woman is a real problem

Annex 2: Pre- and post-workshop test sheet

Pre- and post-training questionnaire

1. How well would you say you know the sexual and reproductive health needs of young people in the context where you work? **Circle one.**

Very well | Well | Somewhat | Not very well | Not at all

2. Which of the following do you think are the greatest barriers to young people's access to sexual and reproductive health services in your context? **Circle up to three choices.**

- Laws and policies
- Social and gender norms
- Judgmental service providers
- Knowledge level of the service providers
- Working conditions of the service providers
- Lack of confidentiality
- Fear of stigma from communities
- Young people are not given SRH information
- Boys and men are not engaged in SRH services
- Sexually and gender diverse groups are discriminated
- Geographical distance from services
- Other:

3. When it comes to accessing sexual and reproductive health services, which groups of young people have the least access? And why?

_____

_____

_____

4. If someone asked me what I do for a living, I would feel comfortable saying, 'I work for young people's sexual and reproductive health and rights.' **Circle one.**

Strongly agree | Agree | Disagree | Strongly disagree

5. I would refer a 15-year-old for contraceptive services without their parents' or guardians' knowledge if I thought they needed it. **Circle one.**

Strongly agree | Agree | Disagree | Strongly disagree

6. If a young person comes alone to a sexual and reproductive health clinic, my most likely response would be: **Circle one.**

- Congratulate them for seeking services
- Treat them like any other client in the clinic
- Tell them to leave and come back with her parent or guardian

7. I feel comfortable discussing sexual pleasure with young clients. **Circle one.**

Strongly agree Agree Disagree Strongly disagree

8. I believe that messages about safe sex for young people should not focus solely on abstinence. **Circle one.**

Strongly agree Agree Disagree Strongly disagree

9. I believe that sexual and reproductive health services are as relevant for adolescent boys and men as they are for adolescent girls and women. **Circle one.**

Strongly agree Agree Disagree Strongly disagree

10. I believe that sexual and reproductive health services are as relevant for sexually and gender diverse groups as for other adolescent girls and boys. **Circle one.**

Strongly agree Agree Disagree Strongly disagree

11. How youth friendly and gender equitable are the services that your organisation (or the organisation to which you refer young people) provides?

- The most youth friendliest and most gender equitable in the country
- Youth friendly and gender equitable but improvements can always be made
- Many elements of youth friendliness and gender equity are lacking
- The services are not youth friendly at all and ignore gender equity

12. List any ways that you think your services (or those to which you refer) could be improved.

_____

_____

_____

_____

13. How many trainings on youth-friendly services (YFS) or gender have you attended?

Please put the number of trainings attended:

- In your lifetime:

  _____
- In the past 5 years:

  _____
- In the last year:

  _____

Annex 3: Handouts

Handout 3.1

Making sense of sexual rights for young people

1. A young 17-year-old couple have sex but neither of them knows about contraception or where to get advice and they are too afraid to discuss it

- How do you feel about this?
- Which rights are violated in this situation?
- What could the project do to address these rights?

2. A young girl who is living with HIV is told by a service provider that she should not have sex and that she should not go to school.

- How do you feel about this?
- Which rights are violated in this situation?
- What could the project do to address these rights?

3. A young couple has no information about where to find safe abortion services. They visit a doctor who performs an illegal and unsafe abortion. She suffers a severe haemorrhage and dies.

- How do you feel about this?
- Which rights are violated in this situation?
- What can the project do to address these rights?

4. A young boy cannot go to the local clinic to get tested for HIV because it is in the middle of the town centre and he fears that people he knows might see him and that the nurse might tell his parents

- How do you feel about this?
- Which rights are violated in this situation?
- What can the project do to address these rights?

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

- How do you feel about this?
- Which rights are violated in this situation?
- What can the project do to address these rights?

6. Young people are not able to access contraceptive or abortion services without the signed consent of their parents.

- How do you feel about this?
- Which rights are violated in this situation?
- What can the project do to address these rights?

7. A young person is denied services because of their sexual orientation, as this goes against the religious beliefs of the service provider.

- How do you feel about this?
- Which rights are violated in this situation?
- What can you do to respect these rights?

8. A young couple experience pressure from their families and peers to immediately have a child to prove the young woman's femininity and the young man's fertility.

- How do you feel about this?
- Which rights are violated in this situation?
- What can you do to respect these rights?

Handout 3.2

Evolving capacities: excerpt from General Comment 12 of the Convention of the Rights of the Child

Evolving capacities have been recognised in international human rights law since 1989. Since then, Article 5 and 12 of the Convention on the Rights of the Child (CRC) recognise children as active agents in exercising their rights in all spheres of life, which includes healthcare.

General Comment 12 of the United Nations Committee on the Rights of the Child provides a lot of information and if you are interested you can find a copy online.[27]

The following excerpts of the special comments are relevant for this exercise. Read them out loud in your group:

Article 12 of the Convention on the Rights of the Child provides that,

"States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child."

Section 29. "By requiring that due weight be given in accordance with age and maturity, article 12 makes it clear that age alone cannot determine the significance of a child's views. Children's levels of understanding are not uniformly linked to their biological age. Research has shown that information, experience, environment, social and cultural expectations, and levels of support all contribute to the development of a child's capacities to form a view. For this reason, the views of the child have to be assessed on a case-by-case examination."

27. www2.ohchr.org/english/bodies/crc/docs/AdvanceVersions/CRC-C-GC-12.doc

Handout 3.3

Norms around gender and sexual health

Card 1: Sexual double standard

In your group, read out loud the following explanation of the gendered norm you will discuss:

According to the sexual double standard (SDS), adolescent boys and men are rewarded and praised for (multiple) heterosexual sexual encounters, whereas girls and women are belittled and stigmatised for similar behaviours. Boys with many sexual 'conquests' are for example well liked at school, while sexually active girls experience low regard and status in school and within their wider community.

Answer the following questions as a group (take notes on a flip chart):

- How does the SDS affect the sexual and reproductive health and wellbeing of adolescent girls and young women in your context?
- How does the SDS affect the sexual and reproductive health and wellbeing of adolescent boys and young men in your context?
- How does the SDS affect the sexual and reproductive health and wellbeing of youth whose gender/sexual identity does not fit the two dominant 'gender boxes'?
- Do you know examples from your work where young women, young men and young people who identify differently are treated differently by service delivery? Please share in the group.
- Given the above shared stories, what would you do to improve service delivery and health seeking behaviour?

Card 2: Denial of adolescent sexual behaviour or activity or premarital sex

In your group, read out loud the following explanation of the social gendered norm you will discuss:

Research shows that in certain parts of Uganda 84% of young people from 14-24 years of age say that they are sexually active, despite their community's strict societal norms that condemn sex before marriage and that deny adolescent sexuality. Of these unmarried young people, about half report that they do not use condoms when they have sex.[28]

Answer the following questions as a group (take notes on a flip chart):

- How do you think the norm of 'no sex until marriage' affects the sexual and reproductive health and wellbeing of adolescent girls in this context?
- How do you think the denial of adolescent sexuality affects the sexual and reproductive health and wellbeing of adolescent boys and young men?
- How do you think the norm of 'no sex until marriage' affects the sexual and reproductive health and wellbeing of youth who do not fit the two dominant 'gender boxes'?
- Can you give examples of how health workers might have contributed to the norm of 'no sex until marriage' and how has this affected service delivery to young people?
- How would you convince these health workers to adopt an attitude or norm that promotes the health, wellbeing and rights of young people in their clinic or point of care? In other words, how do you promote an attitude that opposes the negative effects of the denial of adolescent sexuality?
- What effects do you think this attitude change can have on the quality of services and on the sexual health and wellbeing of the young people?

28. Get Up Speak Out (GUSO) Alliance (2017) *Gender Attitudes, Empowerment and Self-esteem in Relation to SRHR of Young People in Uganda: Baseline Study.*

Card 3: The norm that young women and adolescent girls should have a child immediately after marriage to prove their fertility and femininity

In your group, read out loud the following explanation of the social gendered norm you will discuss:

Research indicates that social expectations for young, married women to bear children immediately after marriage can drive provider bias and also can impact on unmarried female clients.[29] This norm links to other norms like held beliefs about sexual promiscuity and the appropriateness of contraception or sexual activity for single women. These norms disproportionately impact on younger, unmarried female clients. Social norms and beliefs about the value of young women proving their fertility might affect unmarried and married young women in their right to choose when to have children, the number of children they want and the spacing of children.

Answer the following questions as a group (take notes on a flip chart):

- How do you think the norm of 'proving your fertility right after marriage' affects the sexual and reproductive health and wellbeing of married young women?
- How do you think this norm, or mix of norms, affects the sexual and reproductive health and wellbeing of adolescent boys and young men?
- How do you think the norm of 'proving your fertility right after marriage' affects the sexual and reproductive health and wellbeing of youth who do not fit the two dominant 'gender boxes'?
- Give examples of how the norm of 'proving your fertility immediately after marriage' can negatively affect unmarried young women.
- Can you give an example from your context where proving fertility negatively affected services or quality of care?
- What could you do to create a more conducive environment that does not discriminate according to marital and fertility status?
- What effects do you think this attitude change could have on the quality of services and on the sexual health and wellbeing of the young people involved?

Card 4: The norm that contraceptive use equals promiscuity or prostitution, especially for adolescent girls and young unmarried women

In your group, read out loud the following explanation of the social gendered norm you will discuss:

Research shows that many providers have particular issues with policies around provision of contraception to adolescents, with more than two-fifths saying they would not be comfortable providing services to young, unmarried women without children.[30] These attitudes mostly arose from the belief that providing these services would encourage promiscuity and contribute to the spread of HIV.

Answer the following questions as a group (take notes on a flip chart):

- How do you think the norm of 'no contraceptives for youth' affects the sexual and reproductive health and wellbeing of adolescent girls in your context?
- How do you think the norm of 'no contraceptives for youth' affects the sexual and reproductive health and wellbeing of adolescent boys and young men?
- How do you think the norm of 'no contraceptives for youth' affect the sexual and reproductive health and wellbeing of youth who do not fit the two dominant 'gender boxes'?
- Can you give examples of how health workers might have contributed to the norm of 'no contraceptives for youth' and how this has affected service delivery to young people?
- How could you promote an attitude that promotes the right to informed choice?
- What effects do you think this attitude change can have on the quality of services and on the sexual health and wellbeing of the young people?

29. Solo, Julie and Mario Festin (2019) Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations. *Global Health: Science and Practice*. Vol 7. Nr. 3.
30. Solo, Julie and Mario Festin (2019) Provider Bias in Family Planning Services: A Review of Its Meaning and Manifestations. *Global Health: Science and Practice*. Vol 7. Nr. 3.

Card 5: The norm that young people should get third party (parents or spouse) consent to seek sexual and reproductive health services

In your group, read out loud the following explanation of the social gendered norm you will discuss:

Provider bias towards youth exists in several forms, one such bias that can negatively affect the quality of service or right to health and information is when providers seek consent of husbands or parents before issuing contraception to a young woman. This often happens for fear that if they did not, their personal or their clinics' reputation might suffer. Sometimes consent based on age can also be required by national policy, in that case these policy guidelines should of course be taken in account. It is also important to take in account the evolving capacities of the young person in question. (See Handout 3.2 for more information on evolving capacities.)

Answer the following questions as a group (take notes on a flip chart):

- How do you think the norm of 'third party consent' affects the sexual and reproductive health and wellbeing of adolescent girls in your context?
- How do you think the norm of 'third party consent' affects the sexual and reproductive health and wellbeing of adolescent boys and young men?
- How do you think the norm of 'third party consent' affects the sexual and reproductive health and wellbeing of youth who do not fit the two dominant 'gender boxes'?
- Can you give examples of how health workers might have contributed to the norm of 'third party consent' and how this has affected service delivery to young people?
- How would you convince this health worker to adopt an attitude or norm that promotes the health, wellbeing and rights of young people in their clinic or point of care? i.e. how do you promote an attitude that promotes the right to informed choice and healthcare?
- What effects do you think this attitude change can have on the quality of services and on the sexual health and wellbeing of the young people affected?

Card 6: Stigma around HIV services and treatment

In your group, read out loud the following explanation of the social gendered norm you will discuss:

Stigma and discrimination around HIV services and treatment and their negative effects on sexual and reproductive health are well documented, for example, healthcare professionals refusing to provide care or services to a person living with HIV.[31] *For young people, discrimination might even be worse because of their age and the additional norm that they are not supposed to be sexually active.*

Answer the following questions as a group (take notes on a flip chart):

- How do you think the norm of 'HIV carries stigma' might affect the sexual and reproductive health and wellbeing of adolescent girls in your context?
- How do you think the norm of 'HIV carries stigma' might affect the sexual and reproductive health and wellbeing of adolescent boys and young men?
- How do you think the norm of 'HIV carries stigma' might affect the sexual and reproductive health and wellbeing of youth who do not fit the two dominant 'gender boxes'?
- Can you give examples of how health workers might have contributed to HIV stigma and discrimination, and how has this affected service delivery to young people?
- How would you convince this health worker to adopt an attitude or norm that promotes the health, wellbeing and rights of young people in their clinic or point of care? i.e. how do you promote an attitude that promotes the right to informed choice and healthcare?
- What effects do you think this attitude change can have on the quality of services and on the sexual health and wellbeing of the young people affected?

Card 7: Stigma and judgment around abortion and post-abortion care

In your group, read out loud the following explanation of the social gendered norm you will discuss:

Often women do not seek abortion or post-abortion care because of the stigma around abortion. In many settings, they fear abuse, ill treatment or legal consequences.

Answer the following questions as a group (take notes on a flip chart):

- How do you think the stigma attached to (post)abortion (care) affects the sexual and reproductive health and wellbeing of adolescent girls in your context?
- How do you think the stigma attached to (post)abortion (care) affects the sexual and reproductive health and wellbeing of adolescent boys and young men?
- How do you think stigma attached to (post) abortion (care) might affect the sexual and reproductive health and wellbeing of youth who do not fit the two dominant 'gender boxes'?
- Can you give examples of how health workers might have contributed to stigma attached to (post)abortion (care), and how has this affected service delivery to young people?
- How would you convince these health workers to adopt an attitude or norm that promotes the health, wellbeing and rights of young people in their clinic or point of care? i.e. how do you promote an attitude that promotes the right to informed choice and healthcare?
- What effects do you think this attitude change can have on the quality of services and on the sexual health and wellbeing of the young people affected?

31. CDC (2021) Division of HIV/AIDS Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention, Centers for Disease Control and Prevention. Washington: Centers for Disease Control.

Handout 3.4

Power Walk characters

You are a very religious, heterosexual married female nurse of 47 years of age. You do not believe in sex before marriage and think contraception is for married people only.

You are a young, heterosexual girl of 14 years of age, working as a nanny and housekeeper. You were raped by your employer and you are now pregnant against your will.

You are a bisexual, HIV-positive male orphan of 16 years of age who needs to get permission from an adult to get an HIV test. You dropped out of school and do not have much information about contraceptives. Your partner wants sex without a condom.

You are the Minster of Health, a 56-year-old, heterosexual man who is part of the ruling party, you are married with children, but also have several girlfriends in secret.

You are a 24-year-old white lesbian, who is an NGO worker who manages a youth-friendly services programme funded by the Dutch Ministry of Foreign Affairs.

You are a young man, 27 years old, who is insecure about his sexual orientation and does not know if he ever wants to get married to a girl. His family pressures him to get married soon.

You are a young person of 20 years of age and you do not want to get married. You do not feel at home in your female body and feel you could identify as man.

You are a divorced young, heterosexual woman of 25 with five children who has no education and is dependent on handouts from her relatives. You do not want any more children, but your sexual partners do not want you to use contraception.

You are a medical doctor of 30 years who identifies as a woman and who is from the dominant political group in the country and is friends with the president. You do not mind when men have many girlfriends like your boss the minister of health, but hate it when women cheat on their husbands.

You are an underpaid and overworked female nurse of 50 who is impatient with young clients because you don't have the time or motivation to listen to their needs. You believe young people should listen to their elders and should not have sex before marriage.

You are a young person of 19 who lives 20 miles from the clinic or nearest point of care, and you can't afford to pay for transport to get to your clinic. You question your gender identity and sexuality, but you are afraid to tell your family, because you do not want to dishonour them.

You are a deaf, homosexual boy of 16 and have no access to information about your sexual health or where the nearest point of care is. Your grandmother takes care of you.

You are a heterosexual man of 22 who just got married. Your partner wants to continue her education and explained to you she is not yet ready to have children. You support her choice. You have to visit the clinic together to ask for contraceptives, because the nurse would not give the contraceptives to your partner when she visited the clinic by herself.

You are a 54-year-old midwife who believes that (young) women should get a child immediately after they are married to prove their femininity and fertility, regardless of their age. You are scared that young women will otherwise be stigmatised and bullied.

You are a young male peer educator of 20 years old who teaches about contraceptives at outreaches, but at the same time has sex with different girls without using a condom.

You are a married woman of 25 who is pregnant, but with three children already you are very worried you will not be able to feed another child. You don't have knowledge about the different contraceptives that are available.

You are a male guard of 60 years of age who works at the clinic. You did not finish high school. You believe young people should not have sex before marriage.

You are the white donor representative who just flew in from abroad to look at the success of the Youth-friendly Services programme that your government is sponsoring. You are 46 years old and believe that everyone should be liberal in their thoughts about sexuality and you look down on anyone who has a different opinion.

You are 33-year-old male researcher of a local university who gets paid from the programme, and is pressured to make the results look good, so that the NGO can promote its services to donors and get more money.

You are a female 60-year-old receptionist at a clinic and your strict religious beliefs prohibit young unmarried people from having sexual relationships, especially when they are with the same sex.

You are a 14-year-old female immigrant with no residency permit who has to work as a maid to help your family back home financially. You think you might have contracted a sexually transmitted infection, but you are scared that health workers will call the police to report you as an illegal immigrant if you go to the clinic to seek treatment.

Handout 3.5

Case studies – In their shoes

Note: If you feel that you cannot create a safe and respectful learning environment to discuss the case studies that are described below (even after a value clarification session), another option is to slightly adapt the case studies. In doing so, please keep in mind the learning outcomes of Session 3.8 and aim to create more empathy for young people regardless of their gender and sexual diversity, sexual orientation, gender identity and expression and sex characteristics.

Case study 1: Ana

Ana is 17 years old. Ana's parents and other family members are telling Ana that it is time to find a husband, to get married and to start a family. They can't talk about anything else. Instead of getting married Ana wants to focus on school and her sport career in the regional football team. Ana's teachers helped her with applying to a university in the capital city and her application is approved. Because of her good grades and talent she will get a full scholarship. Another reason why Ana doesn't want to get married soon is because she's doubting her sexuality. She's secretly in love with a girl from her football team, but until now she has felt too confused and ashamed to tell anyone about her feelings and how she struggles. Ana is afraid that she's not normal and it makes her sad that she'll probably dishonour her family when they find out.

Online, Ana read that there are health clinics where professionals help young people with their questions about marriage and sexuality. That's why Ana is visiting the clinic. She feels very vulnerable but hopes that by sharing her story with a professional, she will get some useful advice.

Case study 2: Paco

Paco is 15 years old. Although everyone says that Paco is a boy, Paco doesn't really feel that way, and is confused about their* identity. It's been like that for a long time. Paco likes to express themselves* in what other people would call "girly" ways. Paco is bullied at school and boys from the neighborhood have beaten Paco up multiple times, because of the way Paco looks and acts. Paco's father thinks that it is Paco's own fault and that Paco should "man up". Paco's mother often says that she is ashamed of Paco and that Paco should get a girlfriend like all the boys in the neighborhood. Paco feels alone and doesn't know if anyone feels the same way. Paco thinks it will never be possible to be happy with themselves* .

One time after Paco is being called names at school, an older girl from a higher grade approaches Paco and says that Paco is not alone. That there is a safe and confidential place at the health clinic where Paco can go to and talk about their struggles. Paco is hopeful and decides to go to this clinic.

*They/them/their are the correct pronounces to use, if the gender of the person you're referring to is unknown or the person doesn't identify as either male/female.

Handout 3.6

Based on my personal lessons learnt, in my work as SRH service provider for young people,

I will continue to …

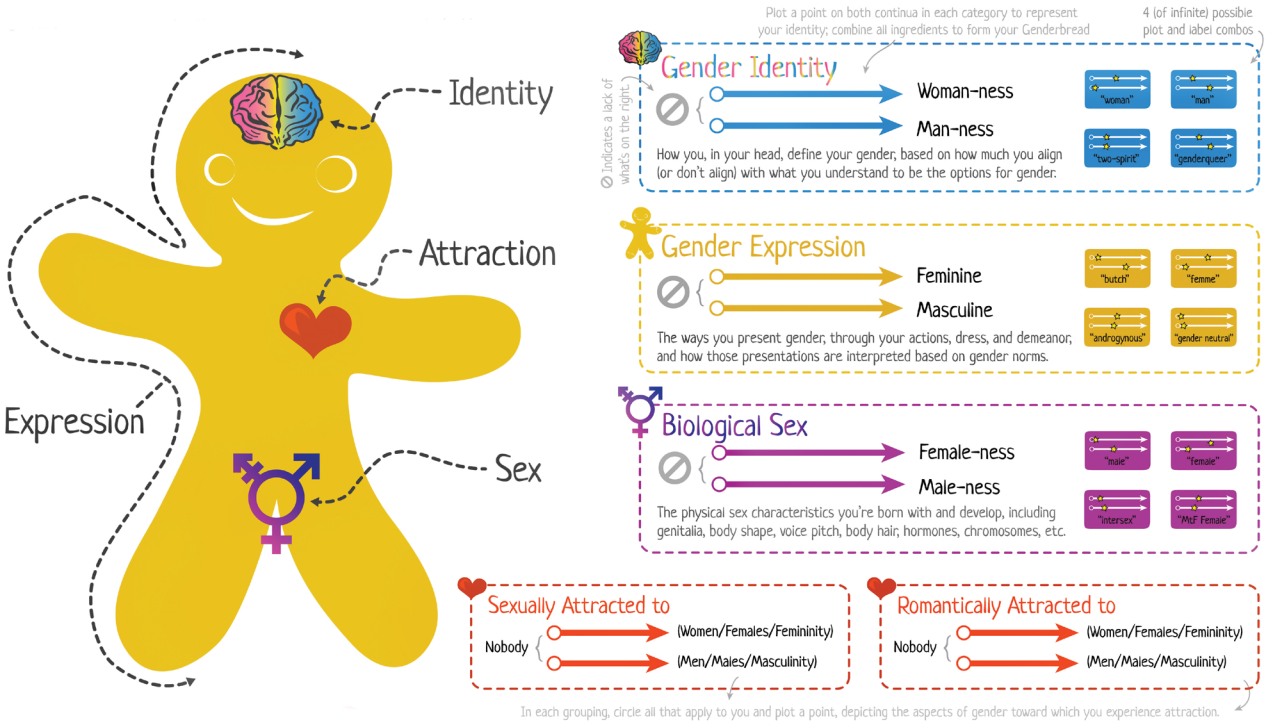
Based on my personal lessons learnt, in my work as SRH service provider for young people,

I will stop …

Based on my personal lessons learnt, in my work as SRH service provider for young people,

I will do differently …

Annex 4: Genderbread Person



Explanation of the Genderbread Person[32]

- **Biological sex** includes physical attributes such as external genitalia, sex chromosomes, sex hormones and internal reproductive structures. At birth, it is used to assign sex, that is, to identify individuals as male or female.
- **Gender identity** is someone's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. Your gender identity can be the same or different from the sex assigned at birth.
- **Gender expression or gender presentation** is one's outward appearance, body language, and general behaviour. Society has to date categorised this using the conventional gender binary.
- **Sexual attraction** is commonly understood as an emotional response resulting in a desire for sexual contact with a person. There are different types of sexual attraction: **heterosexual** attraction – towards the opposite sex; **homosexual** attraction – to a person of the same sex; **bisexual** attraction – to two or more genders; and people who lack sexual attraction (**asexual**).
- **Romantic attraction** is an emotional response that most people experience, resulting in a desire for a romantic relationship with the person for whom the attraction is felt. Asexual people often experience romantic attraction even though they do not feel sexual attraction. Romantic attractions can be experienced towards any person and any gender. This understanding has led to the distinction between sexual orientations and romantic orientations.
- Also explain that **gender is fluid** and that sexual identity and expression, as well as gender identity and expression, vary between people and even within one person over time.

32. Illustration Sam Killerman. Source: http://itspronouncedmetrosexual.com/2015/03/the-genderbread-person-v3/

Annex 5: Young people's recommendations for youth-friendly service providers and facilities

Young people in a study in Kenya were asked what could be improved in the provision of sexual and reproductive health services to them.[33]

The issues they brought up most were:

1. Healthcare providers should receive training on providing services to young people in a friendly and non-judgmental way.
2. The number of youth-friendly clinics/corners should be increased.
3. The types of services available in youth-friendly services should be expanded, so that referral is required less often and young people can get everything they need in one place.
4. The working hours of youth-friendly services should include weekends and evenings.
5. Always have a suggestion box so that young people can share and give feedback on the services that are given to them; create youth involvement forums.
6. Healthcare providers should close the doors during consultations to maintain privacy and to make you feel that anything you say is confidential.
7. Healthcare providers should sensitise the community about diverse sexual orientations and gender identities so that LGBTIQ people are not stigmatised, and their confidence is built.
8. Healthcare providers should create more awareness in the community about young people's SRHR issues; this would also create more demand.
9. Every facility should ensure there are enough male and female youth-friendly healthcare providers/youth mentors so that young people can choose whether they prefer to seek services from a male or female.
10. There is a need to make SRHR services more attractive and welcoming for boys; this will make them more likely to come and seek a service when they need one.
11. Healthcare providers should be patient with young people who come to access services and take time with them until they feel comfortable to open up about their needs.
12. Healthcare providers should make youth-friendly services more welcoming for young people with diverse sexual orientations by: creating easy access to services for them, through in-reach (direct service at home or in the community) and outreach (mobile services in community settings); treating them equally like everybody else; sensitising healthcare providers on how to address them; tailoring information to them; and running positive campaigns using young people with diverse sexual orientations and gender identities as role models.

33. Both, R. and Kageha, E. (2020) *Gender transformative approaches to improving youth SRHR: Improving the sexual and reproductive health and rights of young people in Kenya by training healthcare providers in the GTA.* https://rutgers.international/resources/gta-research-report-kenya/

Annex 6: Glossary

Accountability: Hold duty-bearers to account to respect, protect and fulfil human rights.

Agency: The capacity of individuals to act independently and make their own choices.

Asexual: Not motivated/attracted to have sexual relationships.

Attitude: A feeling or opinion about something or someone, or the resulting behaviour.

Behaviour: The way in which one acts or conducts oneself, especially towards others.

Bisexual: People who are consistently (sexually and/or romantically) oriented to attraction to more than one sex.

Bisexual attraction: Attraction to two or more genders.

Choice: The ability of women/girls and men/boys to make and influence choices that affect their lives and futures.

Consent: Informed agreement for a particular course of action.

Duty-bearers: Institutions and people who have to respect, protect and fulfil the human rights of all people, and to abstain from the violation of those rights.

Comprehensive sexuality education: Formal, effective sex education can happen in or out of school, but it must always be based on fact. To be comprehensive it should not focus solely on sex and sexuality but also emphasise the importance of forming healthy relationships. Young people should gain self-esteem and understand how to protect their physical and emotional wellbeing. They should understand the consequences of having sex and the importance of safer sex. In CSE, young people should learn that they have SRH rights.

Empowerment: The expansion of choice and strengthening of voice through the transformation of power relations.

Evolving capacities of the child: The competences and maturity of the young person to take responsibility and take action. The acknowledgement that the path towards being able to take full responsibility for decisions and actions will be different for every young person.

Femininity: The socially constructed roles and relationships, and attitudes, beliefs and behaviours associated with being female. Different cultures, tribes, social classes, ages or other sub-groups have different 'femininities'. However, there are many characteristics of femininity that are consistent across groups.

Formal leadership: Political participation or representation in leadership and management positions. Leadership can manifest itself individually and collectively and it can encompass power over, power within, power to, and, in the case of collective action, power with.

Gay: Men who are consistently sexually and/or romantically oriented to men.

Gender: The social, psychological and cultural representations of masculinity and femininity, as a construct that entails gender identity, roles, stereotypes, norms, attitudes and expression. A set of socially constructed relationships which are produced and reproduced through people's actions by dynamic, dialectic relationships. Ascribed by society, gender is identified in one's actions, and in interactions with others. Most importantly, gender does not reside in the person, but rather in social transactions defined as gendered. From this perspective, gender is viewed as a dynamic social structure.

Gender-based violence: Any crime committed against persons, whether male or female (including gender and sexual minorities), because of their sex and/or socially constructed gender roles.

Gender equality: When women and men have equal conditions, treatment, and opportunities for realising their full potential, human rights and dignity, and for contributing to (and benefiting from) economic, social, cultural, and political development. Gender equality is, therefore, the equal valuing by society of the similarities and differences of men and women and the roles they play. It is based on women and men being full partners in the home, community and society.

Gender equity: Referring to the process to achieve gender equality, gender equity recognises the different needs, preferences and interests of men and women. This means true fairness and justice in the distribution of benefits and responsibilities between men and women.

Gender expression/gender presentation: One's outward appearance, body language, and general behaviour.

Gender fluidity: A flexible range of gender expressions, behaviours and identification can change from moment to moment. Children and adults who are 'gender fluid' often feel they do not fit within the restrictive boundaries or stereotypical expectations defined by the operating gender binary in their society.

Gender identity: Someone's innermost concept of self as male, female, a blend of both or neither – how individuals perceive themselves and what they call themselves. Your gender identity can be the same as or different from the sex assigned at birth.

Gender expression: One's outward appearance, body language and general behaviour that are associated with gender.

Gender norms: Powerful, pervasive values and attitudes, about gender-based social roles and behaviours that are deeply embedded in social structures. They manifest within households and families, communities, neighbourhoods, and wider society, ensuring the maintenance of social order, punishing or sanctioning deviance from the established norms.

Gender roles: Activities, expectations and behaviours assigned to people on the basis of gender by the society they live in. Many cultures recognise two basic gender roles: masculine (having the qualities attributed to males) and feminine (having the qualities attributed to females).

Gender stereotypes: Gender stereotypes are preconceived ideas whereby females and males are arbitrarily assigned characteristics and roles determined and limited by their gender. Stereotypes about women both result from, and are the cause of, deeply ingrained attitudes, values, norms and prejudices against women/girls and people with diverse SOGIESC. They are used to justify and maintain the historical relations of power of men over women and minority SOGIESC as well as sexist attitudes that hold back their advancement.

Gender transformative approaches: Approaches that actively strive to examine, question, and change rigid gender norms and imbalances of power as a means of achieving SRHR objectives, as well as gender equality objectives at all levels of the socioecological model. Programmes and policies may transform gender relations through:

- Encouraging critical awareness of gender roles and norms
- Questioning the costs of harmful, inequitable gender norms in relation to SRHR and making explicit the advantages of changing them
- Empowering women/girls and people with diverse gender and/or sexual identities/ orientations
- Engaging boys and men in SRH and gender equality

By applying these four strategies, we can change harmful, inequitable gender norms into positive, equitable and inclusive ones thar lead to improved SRH of men/boys and women/girls, the prevention of GBV and gender equality.

Heteronormativity: Where male and female sexuality are depicted as fundamentally different and complementary: that the activity of sex comes from a masculine drive, that masculine sex is active and active sexuality is a precondition for masculinity (male assertiveness, competitiveness) and that feminine sexuality is the opposite, reluctant, subservient and vulnerable (compare feminine modesty and caregiving).

Heterosexual: People exclusively attracted to the opposite sex; consistently (sexually and/or romantically) oriented to people of a different sex than their own.

Heterosexual attraction: Sexual attraction towards the opposite sex.

Hidden power: Conscious use of power, applied in such a way that it is not open or visible to those who suffer the consequences.

Homosexual attraction: Attraction to a person of the same sex.

Human rights-based approach: Key elements are accountability, participation, non-discrimination, equality and transparency. Human rights (political, civil, social, economic and cultural) as enshrined in international/national legislation can be held onto when advocating for and claiming equality, human dignity and opportunities for all people to receive education, healthcare and to fight poverty, violence, discrimination and exclusion.

Informed choice is when a person is given options to choose from several diagnostic tests or treatments, knowing the details, benefits, risks and expected outcome of each.

Informed consent is when a person agrees to the test or treatment they have been offered, knowing the details, benefits, risks and expected outcome.

Intersectionality: An analytical tool for studying, understanding and responding to the ways in which gender and other identities intersect (gender, race, social class, ethnicity, nationality, sexual orientation, religion, age, mental or physical disability), and how these intersections contribute to unique experiences of oppression and privilege.

Intersex: A combination of the 'objectively' measurable organs, hormones and chromosomes, i.e. female = vagina, ovaries, XX chromosomes; male = penis, testes, XY chromosomes.

Invisible power: This resides in people because of norms, values and beliefs that are generally accepted in society and seem to be true and normal. It operates outside of our consciousness.

Lesbian: A woman who is consistently sexually and/or romantically oriented to women.

Masculinity: The socially constructed roles and relationships, and attitudes, beliefs and behaviour, associated with being male. Different cultures, tribes, social classes, ages or other sub-groups have different versions of 'masculinity'. However, there are many characteristics of masculinity that are consistent across groups.

Norms: Patterns of behaviour that are widespread, are generally tolerated or accepted as proper, are reinforced by responses of others and are quite hard to resist even if they run against what is felt to be right.

Queer: Questioning or critiquing the binary notions of gender and/or sexual orientation; a term increasingly used by some as an umbrella for all diverse SOGIESC, but remaining controversial with sections of the LGBTI community.

Romantic attraction: An emotional response that most people experience, resulting in a desire for a romantic relationship with the person that the attraction is felt towards. Romantic attraction may be felt without sexual attraction and can be experienced towards any person and any gender.

Reproductive rights: "Embrace certain human rights that are already recognised in national laws, international laws and international human rights documents and other consensus documents. These rights rest on the recognition of the basic rights 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. It also includes the right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents." International Conference on Population and Development, Programme of Action 1994, Para 7

Rights-holders: Refers to all people.

Sex: The biological characteristics that we are born with, that define humans as either male or female, such as the 'objectively' measurable organs (i.e. female = vagina, ovaries; male = penis, testes), hormones, genetics/chromosomes (XX, XY).

Sexual attraction: An emotional response resulting in a desire for sexual contact with another person.

Sexual orientation: A person's sexual identity in relation to the gender to which they are attracted; the fact of being asexual, heterosexual, homosexual, or bisexual.

Sexual rights: "Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination" WHO, 2006a, updated 2010.

Socio-ecological model: Visualises the personal, interpersonal, organisational, community and public levels, where arrangements of formal and informal rules and practices enable and constrain the agency of women/girls and men/boys and where rigid stereotypical and discriminatory gender ideologies and norms are often perpetuated.

SOGIESC: Sexual orientation, gender identity and expression, and sex characteristics – used in phrases like "people with diverse SOGIESC" and "avoiding discrimination on grounds of SOGIESC".

Stigma: A complex social phenomenon or process that results in powerful and discrediting social labels and/or radically changes the way individuals view themselves and are viewed by others.

Transgender: A person whose gender identity is different from their sex assigned at birth; they can have any sexual orientation.

Visible power: Derives from assigned authority and control over human and other 'resources'. The capacity of more powerful people or institutions to affect the thoughts and actions of people with less power. It frequently has negative connotations (e.g. domination, force, repression, abuse) and often serves to maintain inequality, poverty and disempowerment.

Voice: The capacity of women/girls and men/boys to speak up, be heard and share in discussions and decisions – in public and private domains – that affect their lives.

Women's/girls' rights: The rights and entitlements claimed for women and girls worldwide.

Youth-friendly services: A broad range of sexual and reproductive health services that are responsive to the lived realities, specific needs and vulnerabilities of young people.

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