

Sexual and Reproductive Health Training Manual for Young People





DSW

GERMAN FOUNDATION FOR WORLD POPULATION

Sexual and Reproductive Health Training Manual for Young People

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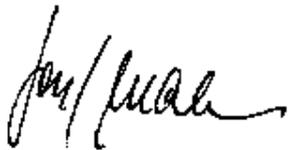
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German Foundation for World Population (DSW)
Ethiopia

Introduction

The purpose of the manual

This manual is prepared as one of the main tools of the German Foundation for World Population (DSW) to address sexual and reproductive health issues among young people aged 10–24 years.

According to UNFPA State of World Population 2005, young people under 25 years of age now comprise nearly half of the world population - more than 3 billion. 85 percent of youth live in developing countries and nearly 45 percent of all youth (515 million) survive on less than \$ 2 a day.

Besides its demographic significance, this age group has increasingly become victim of sexual and reproductive health problems, which has endangered the lives of so many young people. Every year, some 14 million adolescent girls give birth. They are two to five times more likely to die from pregnancy related complications than women in their twenties and their babies are also less likely to survive. In the next 10 years 100 million girls are likely to be married before the age of 18 (UNFPA 2005).

Estimates suggest that one out of every 20 young people worldwide contracts a sexually transmitted disease (STD) each year. By the end of 2001, 11.8 million young people aged 15–24 were living with the Human Immunodeficiency Virus (HIV) that leads to the Acquired Immuno Deficiency Syndrome (AIDS) (UNAIDS 2002, Population Concern 2002, Webb 1998).

According to UNAIDS 2002, about half of all new adult HIV infections, around 6,000 daily, are occurring among young people between 15 to 24 years of age. Every day, at least 4,000 people under age 25 are infected with HIV, mainly in Sub-Saharan Africa and parts of Asia.

Therefore, addressing the sexual and reproductive health needs and rights of young people is of significant importance to the global community. The German Foundation for World Population (DSW) is one of the international non-governmental organizations involved in this endeavor.

DSW works to improve the sexual and reproductive health of adolescents and young people through establishing, strengthening and networking youth clubs. More specifically, the Initiative aims at changing the attitudes and behaviour of adolescents and young people towards improved sexual lifestyle by preventing unwanted pregnancy, abortion, STIs, including HIV/AIDS and other SRH problems by empowering the youth to learn from each other.

At the adolescent age, between 10 and 19 years, the youth is undergoing a tremendous change both physically and emotionally. With the growth and change of the reproductive organs, youth experience dynamic unfolding of emotions leading to sexual activities.

At this critical and vulnerable age the inexperienced youth need knowledge, guidance and services to protect themselves from dangers and lead a healthy sexual life. In most African tradition neither the parents nor the educational institutions provide such guidance on sexual issues. As a result, young people learn from each other about sexual issues, which are sometimes full of misconceptions and prejudices. In the process of trial and error the youth might end up in risky sexual behaviour with grave health consequences such as unwanted pregnancy, STIs, and HIV/AIDS.



The tradition of learning from each other is to be maintained, organized and developed through peer education programs (peer learning groups) which youth to youth sexual and reproductive health clubs promote. Through the youth to youth approach, young people can learn from each other's experiences and discover their sexual identity, using the latest knowledge and participatory methodologies. It is with this intention that this training manual on young people's sexual and reproductive health has been prepared.

The manual has been developed for use at three levels: A few young people with interpersonal communication abilities will be selected and trained intensively as **Core Facilitators** at central level using this manual. **Core Facilitators** in turn will train **Peer Educator Trainers** appointed from different clubs at local level. This will empower the clubs to train their own **Peer Educators** locally at their convenience. The peer educators are expected to use the essence of this manual in facilitating the **Peer Learning Groups** at the grass root level of the clubs concerned.

German Foundation for World Population (DSW)

German Foundation for World Population (DSW) is a non-profit and non-governmental private foundation, which was founded in 1991 by two entrepreneurs from Hanover, Germany. Since then, DSW has grown, in response to its extensive work, from a small foundation based in Hannover, Germany, to an international organization with offices in Brussels, Ethiopia, Kenya, Uganda and Tanzania addressing population, sexual and reproductive health (including HIV/AIDS), environment and development issues.

DSW is committed to a sustainable development of world population. Alongside working in developing countries, DSW raises awareness on the challenges presented by world population growth and HIV/AIDS and advocates for the improvement of the global sexual and reproductive health situation among decision makers and opinion formers in developed countries.

DSW started its involvement in Africa in 1994 by supporting projects in Ethiopia. Currently, the organization has developed a Youth-to-Youth model based on the rich experiences and lessons learnt from its programs there. In addition, it is also running different projects including integrated development projects, and youth training centers among others.

Youth-to-Youth

Youth-to-youth (Y2Y) is a comprehensive program that addresses HIV/AIDS and sexual and reproductive health issues among young people aged 10–24 years of age using a peer-to-peer approach. For the last ten years, DSW has worked with partner organizations in empowering youth to youth self-help initiatives, usually known as Anti-AIDS/sexual and reproductive health clubs, in prevention of HIV/AIDS and improving sexual and reproductive health conditions of young people.

Y2Y has many components that supplement one another. These components are:

- **Intensive IEC/Peer learning:** Is the core component of Y2Y supported by Youth-to-Youth Sexual and Reproductive Health Training Manual (this manual) whereby trained Peer Educators play the central role by organizing Peer Learning Groups and facilitating peer learning at grassroots level based on their local context.
- **Mass IEC/Edutainment activities:** Is widely used among youth clubs as a means to reach young people with educational messages while they are entertaining using dramas, theatres, puppet shows etc.



- **Reproductive health service provision through referral arrangements:** Trained Peer Educators facilitate sexual and reproductive health service provision to their peers through referrals using existing health facilities at local level.
- **Advocacy on all levels:** Youth clubs identify and advocate on harmful traditional practices and other issues that affect the overall psychosocial and health status of young people in their locality. This enables clubs to win the heart and minds of people in their community and create friendly environment that supports their cause. Besides, DSW and its partner organizations advocate at higher level to improve SRH services to young people.
- **Production and distribution of IEC materials:** Youth friendly IEC materials including newspaper, leaflets and others are centrally produced and supplied to young people in the program to supplement the peer learning.
- **Capacity building of Y2Y initiatives:** This is part of ensuring the standardized service delivery and sustainability of the program by building leadership, management, planning and implementation skills of young people involved in overall activities of the club.
- **Income generating schemes:** Advanced youth clubs are supported to run their own income generating activity to complement their activities, motivate members and sustain their activities.
- **Networking amongst Y2Y clubs:** Local, national and regional networking is encouraged so that clubs are able to learn from each other, avoid duplication of effort and form a support system.
- **Monitoring and Evaluation:** It is an integral part of Y2Y that is conducted at all levels through active involvement of young people and all stakeholders.

What makes this manual different?

Participatory approach forms the foundation of this manual. Training is conceived here as an exchange between the trainer and the participants. The role of the trainer is, thus, to assist the participants in the learning process. Unless peer education activities are captivating and sustain interest, peers may not continue in the group and fall out. The more peers are engaged the more they are able to develop positive attitudes, behaviour and skills. They cannot develop positive behaviours by listening to lecturers, instructors or by acquiring knowledge without trying them with others and practicing them. To enhance the learning process for everyone, participants explore and share their experiences and knowledge, critically analyze attitudes and behaviours, seek for solutions, practice life skills and draw action plans. The main assumption is that adolescents and younger people know many things. Regardless of his or her level of formal education, each participant has a valuable contribution to make, if encouraged to be an active partner in the learning process. Due to the emphasis placed on this “active partnership”, “trainers” are referred to as “facilitators” throughout this manual. This manual focuses on broader young peoples’ sexual and reproductive health issues, including HIV/AIDS. It attempts to integrate SRH issues with participatory methods and tools in the course of learning activities. As such the manual does not deal with methods and techniques as separate issues. Furthermore, the manual is intended to facilitate peer education not as transfer of knowledge or individual counseling alone but as an ongoing learning activity of peers organized in clubs and peer learning groups. For more information find a list of participatory learning techniques in the glossary at the end of this manual.

How to use this manual

To this end, the manual is prepared in 10 Units assuming that they will be covered in 7 days, which in fact depends on the level of education and experience of the participants. The 7-day training program was in terms of anticipated need of the trainees and the cost.

Each Unit consists of two major parts;

- Factual information on sexual and reproductive health issues of young people, and
- The participatory learning process, including methods, techniques, activities and exercise guides.

The factual information on young people's sexual and reproductive health issues are presented first as "Basic Information" for the consumption of the facilitator, be it the Core Facilitator, the Peer Educator Trainer, or the Peer Educator. These basic information materials will be used as handouts for the particular training sessions. Young people need basic information and facts on sexual and reproductive health issues to be able to know what constitutes a risky or safer practice and make informed choices or decisions. Knowledge alone, however, does not ensure that young people will change to adopt safer behaviour. In the second part of each unit, in the „Process Facilitation“, positive attitudes are promoted and encouraged, unhelpful attitudes are changed and development of skills is focused on, through exercises. Even though this manual, as an experimental training, follows the problem solving approach, it does not claim to offer simple solutions, because we strongly believe that young people are capable of developing their own solutions to their particular problems and concerns. The manual merely sets the young people on the right path to solve their own problems.

Process Facilitation, the activities the facilitator(s) and the trainees perform during the training sessions, are presented and elaborated under the following major titles: the topic of the session or exercises, the purpose of the topic or exercises, the methods, the tools to be used, the time estimated and the learning activities to be performed. The facilitator may prepare training sessions using these suggested methods, tools and approaches. Participatory methods and tools are not discussed in the body of the manual. The manual can be used on "closed shop" basis for continuous training over 7 days. The Peer Educators' training and the Peer Learning Group teaching may be done on "spread out approach" where peer learning is conducted over several weeks or months. This has its advantages in that participants will learn at their convenience and also have the chance to relate the contents with reality.

Time management

The facilitator should make sure to have planned enough time for the sessions. It should be kept in mind that participatory tools are time consuming and they will face time shortages. The facilitator should be time conscious and manage the allotted time carefully. A timekeeper should assist him/her. Ways and means should be sought to shorten the time needed for sessions, for example breaking into two larger groups takes less time. In some exercises reporting back to the large group can be skipped if the participants fully understand the activities and there is no need for further discussions. Handouts, role-plays and similar exercises should be distributed in advance. This will save time and participants will benefit from the discussions. The facilitator has to rehearse each training session so that he/she is well prepared and is sure that the tasks to be given as exercises are realistic and that sufficient time is allotted. All necessary materials as handouts should be ready the day before. Let trainees know in advance that they will receive training handouts (or this manual) so they do not have to write down everything that is being said and done. In this way

participants can focus all their attention on listening and practicing. Trainees also appreciate well-prepared training documents that they can use later as a reference. The following schedule for the training gives an idea of the range of training courses for which this manual has been prepared.

Day one		Day two	
Unit 1:	Getting started		
Unit 2:	Participatory methods and tools	Unit 4:	Gender and sex in relation to adolescent sexuality
Unit 3:	Reproductive anatomy and physiology *Hormones and reproductive life cycle *Male and female reproductive organs	Unit 5:	Adolescent sexuality *Adolescence *Sexuality *Pregnancy *Menstrual cycle *Ovulation *Conception
Day three		Day four	
Unit 5:	Adolescent sexuality (continuation) *Unwanted pregnancy *Obstetric fistula *Social consequences of unwanted pregnancy *Abortion *Harmful traditional practices *Drugs and drug abuse	Unit 6:	Life skills in developing positive sexual behaviours
		Unit 7:	Sexually Transmitted Infections (STIs)
Day five		Day six	
Unit 8:	HIV/AIDS	Unit 9:	Contraceptive Methods
Day seven			
Unit 10:	Peer counseling service		

Example of a day's training agenda

- Check in
- Warm-up
- Brief summary of previous day's sessions (recap) and review of the schedule for the day
- Introduction of the topic for the session
- Large group, small group learning/exercise
- Coffee break
- Presentation, large group, small group learning/exercise
- Lunch break
- Recap and introduction of the topic for the session
- Large group, small group learning exercise
- Coffee break
- Presentation, large group, small group learning/exercise
- Closing session - review and evaluation of the workshop

Participants

For a formal training workshop, the number of participants should be limited to about 18 to 22. Keeping the number of participants to a small size will allow quality training and achieve higher participation, involvement, intimacy and rapport among participants. A Peer Educator may limit the Peer Learning Group members to 10 or less. The group should be well mixed according to sex. In some exercises, girls may be rather shy to express their views in the presence of boys. The facilitator may assess the situation and form female only groups. The training for Core Facilitators (and Peer Educator Trainers) will be most beneficial for the participants and most rewarding for the trainers if all participants stay together at the same place at night rather than returning to scattered hotels after each day's sessions. This intensive learning and sharing experience is very important for the effectiveness of the training. If this is impossible, at least, try to arrange meals together after the daily sessions.

Planning and Logistics

The planning and logistics should be done far in advance. The less familiar the trainer is with the area, the more time is needed for preparation. The facilitators should keep checklists of things to do throughout the training session and enlist the help of participants in working on these tasks as much as possible.

Trainer's checklist for workshop planning (an example)

Activity	Who is responsible?	By when?
Recruit trainees and send invitations		
Prepare the training program		
Arrange training documents, handout, etc.		
Purchase training materials, charts, markers, etc.		
Prepare charts, tools, illustrations		
Photocopy handouts for each participant or groups Rehearse sessions		
Try out exercises		
Check suitability of training location		
Arrange food and refreshments		
Arrange transportation		
Arrange accommodation		
Budget items	Estimated cost	
Materials		
Transportation		
Food/refreshments		
Accommodation		
Per diem		
Others		
Total		

Training materials needed

The use of this manual requires thorough preparation by the facilitators. Core Facilitators and Peer Educator Trainers should prepare all materials before the training begins and before going into an area where some of the materials are not available, e.g. make photocopies of the handouts, procure enough flip charts, etc. before traveling to clubs or an area without electricity.

Peer Educators may not find the materials needed readily available. During the training, Core Facilitators and Peer Educator Trainers have to explore alternatives using locally available materials at the outreach of clubs.

Youth-to-Youth training toolkit

1. Youth-to-Youth manual
2. Club Management guideline
3. Training manual on club management
4. Cards or slips of paper, scrap paper
5. Scissors
6. Eraser
7. Flip chart stand (if available)
8. Flip charts or large piece of paper
9. Markers, if possible in different colors
10. One Cello tape
11. Glue stick
12. Pen/pencil
13. Notebook
14. Ruler
15. Pins
16. Condom/pills for demonstration
17. Penis model

Note: You might not need all of these but most will be used at some point during the training with the exception of the manuals that should be supplied centrally, Core Facilitators felt that the rest of the content of the toolkit could be obtained locally. For flip chart stands, it is proposed to use walls.

Evaluation and feedback

Evaluation is very important in any peer education training. It will enable everyone in the training, even the quietest participant, to comment on the learning, and allow the facilitators to get an idea of what the trainees feel and think about the training or learning. This form of feedback will help Core Facilitators and Peer Educator Trainers revise the upcoming sessions. At the end of each day's learning, time is left for evaluating the performance of the training in which participants will give their feedback to the facilitators.

Participants will be asked to evaluate the day's activities and comment on the agenda of the next day as a process of planning. The last day of the workshop should include a thorough evaluation of the entire training. Under no circumstances should a facilitator or Peer Educator get defensive, especially not during evaluations. It is best if the facilitators refrain completely from commenting during the evaluations, except to ask questions if comments are unclear. Evaluations can be done either verbally in the large group, with responses written on a flipchart, or individually written and returned to the trainers. Written evaluations can be taped to the wall so that the trainees can review the comments of others. Both methods are useful and should be mixed. The following can be used to close each day.



Closing the day (an example)

At the end of the day you may use this schedule to close the session. Sit in a circle together and thank everyone for participating. Then...

1. Distribute the handout for the next day.
2. You may give other assignments, such as role-play, etc. for the next day.
3. You may ask each of the trainees to prepare for facilitating one of the upcoming exercises.
4. Go round and ask each person to say one thing that they have learned today.
5. Ask participants to evaluate the work of the day and react to the following questions:
 - What was best about today's learning?
 - What was not good and should be changed or improved? How?
 - What other comments do you have?
6. Write the responses on a flip chart or a large piece of paper and post on the wall.
7. Thank participants again and ask for 3 volunteers to stay behind for about 10 minutes afterwards for a quick review of this session.
8. Finally, meet again with your co-facilitator (if any) to compare notes on how your sessions went and what you learnt from them.

Certificates

Prepare certificates to give to each participant at the end of the training. Certificates are appreciated and provide a good closure to a training course.

<h1 style="font-size: 2em; margin: 0;">Certificate <small>(sample)</small></h1>	
<p>This is to certify that _____ has successfully completed training of Trainers (TOTs) on Sexual and Reproductive Health facilitation organized by DSW/Uganda for seven days from to, 2006 at DSW/Bonita Youth Training Center, Kampala, Uganda.</p>	
<hr style="width: 80%; margin: 0;"/>	<hr style="width: 80%; margin: 0;"/>
DSW/ Uganda Country Director	Training Manager

Unit 1. Getting started

Basic information: Handout

The training will start with the Unit 'Getting started', which guides participants in the process of initiating a participatory workshop. This unit is presented in seven sections.

Far in advance, facilitators have to plan and make the necessary preparations for getting the training program started for a good start greatly contributes to the success of the training. For a longer training that may extend for four or more days, the facilitator will use activities 1–7 as outlined below. For shorter training sessions not longer than a day or two, however, you may omit activity 4, 5 and 6 and/or reduce the amount of time overall allocated to this first session.

A comprehensive preparation “to start things off” includes the following activities, which are addressed in separate sections below:

1. Introducing participants
2. Opening ceremony
3. Expectations of participants
4. Objectives of training
5. Agreeing on time table
6. Climate setting, and
7. Training norms

Process facilitation

Exercise 1: Introducing participants

Purpose: At the end of this session participants will be familiar with each other

Methods: Pair wise introduction or everyone introducing her/himself

Tools: Large pieces of paper or flip charts and markers

Duration: 30 minutes

Note: In any participatory training it is important to have participants introduce themselves to each other in order to facilitate participation, experience sharing and effective communication. The length of the introduction may depend on the duration of the training. For a ten day residential core facilitators training, for example, it is worth devoting about 30 minutes to the introduction. The assumption is that participants may know little about each other. In addition, if participants become comfortable with one another right at the outset, they will deal with each other in a much better way. However, it is worth noting that peers in the peer learning groups may not need an elaborated introduction activity.

Participatory methods and tools will be used right from the beginning. Therefore, start by introducing yourself to the participants. Do not start with announcing administrative matters such as, coffee break, lunchtime, or stating the “Dos” and “Don'ts” of the workshop.

For this session, the facilitator will:

- Ask the group to suggest what information they should give to best introduce themselves.
- Write the headings for the introduction on a flip chart; if participants do not have suggestions, use your own (see table below)
- Arrange participants in pairs and ask them to stand up and gather in the corners of the room to interview one another (for 2–3 minutes)
- Ask each participant to introduce the person they interviewed to the whole group perhaps adding some additional information, such as the meaning of the name and/or something special about the person.

Note: These introductory activities can sometimes be very amusing. Right from the beginning there will be a lot of interaction between the participants, which will help them to relax and be more spontaneous. Such activities will also facilitate the building of group cohesiveness leading to “instant involvement” of everyone. In this way participants learn a lot about one another.

Besides, such an introduction acts as an icebreaker; since participants come from different places and backgrounds, this will help to break down the “walls” that may exist between them. Because participants are engaged early on in activities that are marked by movement, standing up and sharing, they become acquainted with one another, so that they are more comfortable working with one another. This also helps the “trainers” to be seen right from the beginning as real facilitators and not lecturers.

Heading for introduction (examples)

- Name
- Education level
- Club membership
- Engagement in ASRH
- Something special about the trainees
- Meaning of names etc.

Exercise 2: Opening ceremony

Purpose: To demonstrate procedures on how to open training session formally

Method: Opening speeches addressed to participants

Duration: 15 minutes

Activities: On the first day of the training a short but official opening ceremony may be held. The Chairperson of the organization or a representative(s) of a relevant institution should welcome the participants to the training workshop and convey a message of encouragement.

The official opening should be considered as part of advocacy or networking which underlines the importance of peer educators’ activities in the community, not only to the participants but also to different institutions and individuals invited to the opening session. Care should be made not to take more time than allocated.

After the opening ceremony, the guest(s) should be excused to leave and the next session will continue.



Opening ceremony

Exercise 3: Expectations of participants

Purpose: To identify what participants expect to gain from the training

Method: Brainstorming, whole group discussion

Tools: Flip chart or large pieces of paper/blackboard

Duration: 30 minutes

Activities: Young people have their own individual interests. They will be more active participants if the process incorporates these interests. In order to identify their interests and give them due attention, facilitators may follow the indicated steps:

1. Ask participants to write down what they expect from the training by asking them to write/express their hopes and fears – giving one example each. These notes are then collected by the facilitator and read out to the group OR
2. Ask the participants generally, “What are your expectations about the training?”
3. The facilitator will display or write down the list of expectations on the flip chart;
4. In either method, repeated and overlapping statements may be screened and merged.
5. Keep these lists displayed throughout the training, and refer to them as appropriate, and in particular for the evaluations.

Expectations (an example)

- Gain knowledge of ASRH issues
- Develop skills on how to conduct peer educators' training
- Exercise various skills
- Gain experience in using participatory methods and tools
- Enhance knowledge of contraceptive methods

Fears (an example)

- Time allocated for the training is not enough
- Not respecting others' ideas
- Participation is limited to very few

Exercise 4: Objectives of the training

Purpose: To enable participants to understand and harmonize the objectives of the training by comparing them with their expectations

Method: Large group discussion

Tools: Flip chart paper

Duration: 10 minutes

Activities: The facilitator presents the objectives of the training on a flat paper/ blackboard and asks the participants to comment or add if need be, and compare it with their expectations (show the chart/list of expectations displayed in session 3).

If the objective of the training is well prepared in advance, there will be few negative comments. A clear understanding of the objectives will facilitate participation and make the workshop flow smoothly and help facilitators and participants to assess whether the expectations will be realistically met or not by the training program.

Such an approach will allow participants to express their expectations freely. If participants expect something beyond the scope of the training, the facilitator should address this clearly at this point. Lack of clear understanding of objectives vis-à-vis expectations can lead to misunderstandings between the facilitators and participants later in the training.

Objectives of the training

- Improve knowledge and skill of participants on ASRH issues
- Equip trainees with ASRH training facilitation techniques and skills
- Develop skills of trainees in the use of participatory methods and tools

Exercise 5: Agreeing on time table

Purpose: To enable participants to have input in the time schedule for the training

Method: Large group discussion

Tools: An overview chart and a time schedule

Duration: 15–20 minutes

The facilitator will:

1. Quickly introduce the training content to be covered so as to give an overview of what will be done (3–5 minutes). Inform participants that this will be reviewed daily and that they should not worry if they don't understand everything.
2. Present the daily schedule for major activities (see the example) as a proposal, which is left for the participants to decide and agree upon.
3. Ask participants to agree to or suggest changes to the proposed time allocation for each major activity.
4. Leave the schedule on the wall for the rest of the training period.
5. Review the schedule daily to include the various parts of the training to be covered each day.

Time schedule for the training (an example)

Proposed by facilitator		Agreed with participants	
8:30	Start	?	Start
10:30–11:00	Tea break	?	Tea break
12:30–14.00	Lunch	?	Lunch
14:00	Start with energizer	?	Start with energizer
15.30–16.00	Tea break	?	Tea break
17:30	Closing	?	Closing

Exercise 6: Climate setting

Purpose: To enable participants to learn how to set the tone for an open and participatory training atmosphere

Method: Large group discussion

Tools: Chart

Duration: 30 minutes

Note for the facilitator: To make the training sessions pleasant, a conducive atmosphere should be created by pre-arrival preparations.

Employing a participatory style and methods throughout the training extends to creating a conducive atmosphere for the learning process.

Learning which takes place in a group setting is affected by the social relationship between the people involved. Moreover, the relationship between the facilitator and the participants and among the participants themselves can influence the learning situation either positively or negatively.

Participants normally respond best to an atmosphere of acceptance, respect and encouragement. They should therefore be encouraged to ask questions and contribute to the discussion. They will not do so if the facilitator humiliates them or makes them look foolish in front of their fellow participants nor will they be at ease if the trainer shows favoritism towards some members.

Creating an atmosphere where individuals feel able to work, learn and contribute depends on the facilitator displaying an attitude of respect for the participants. Participants who are treated with respect will respect each other and will also treat others with respect when they themselves are facilitating. The physical surroundings can also affect learning. The basic principle is that the best learning takes place best when there are no distractions.

The physical environment should therefore be quiet and at a comfortable temperature. There should be sufficient light in the room. The room should be equipped with the necessary materials for the session such as flip charts, papers, markers and ideally, a flip chart stand or a substitute.

In this session, the facilitator will:

1. Briefly explain (use note as above) what climate setting is all about (3 minutes)
2. Ask participants to form the seating arrangement in a circle so as to facilitate a better interaction and eye-to-eye contact,
3. Check with the participants whether there is enough space to allow free movement in the room so that participants can readily re-arrange themselves for buzz groups, small group activities, role-play, team work etc.,
4. Ask participants to participate actively in the life of the workshop. Ask for volunteers to perform the following roles daily:
 - Check-in
 - Recap
 - Energizer
 - Time-keeper and
 - Evaluation at the end of each day

Post on the wall the flip chart paper with the assignments (see the example below)

Involving participants in the life of the workshop (an example)

Activities	Saturday	Sunday	Monday
Check-in	Mohamed	Christine	Elisabeth
Recap	Helen	Abdurahman	Abraham
Energizer	David	Peter	Leila
Time-keeper	Amina	Sofia	Samuel
Planning and evaluation	Michele	Sara	Abdule

Exercise 7: Training norms

Purpose: At the end of this session participants will be able to develop a code of conduct for the training sessions

Method: Small group/large group discussions

Tools: Flip Chart Paper

Duration: 20 minutes

Note for the facilitator: During the training three casts of characters interact with one another; a participant as an individual, participants as a group, and a facilitator as a leader. For smooth running of the learning sessions, it is advisable that the participants enter into an agreement and set procedures as to how to behave with one another. Participants want to be listened to, understood, respected and appreciated and not put down.

Therefore, rules of the training session need to be established by the participants themselves. These “training norms” (also called „group rules“ or „key to cooperation“) should be negotiated and developed in small groups.

Even though peer learning groups training sessions may not follow all the steps 1 to 6, they should discuss and reach an agreement upon a few essential training norms.

To accomplish this, the facilitator will:

1. Ask participants to form a small group of 4, 5 or 6 individuals
2. Ask each group to choose a leader and reporter
3. Ask each group to come up with training norms
4. When the allotted time is up, ask each group to have a representative to present the agreed upon norms to the whole group on a flip chart or large pieces of paper
5. Screen and merge repeated and overlapping suggestions
6. Summarize the main “training norms” and get the agreement of all participants to adhere to the negotiated norms throughout the training sessions
7. Keep the flip chart paper on the wall throughout the training period

The facilitator may refer to this as the need arises.

Training Norms (an example)

- We will participate actively
- We will cooperate with the facilitator
- We will be punctual
- We don't undermine others' opinions
- We don't take too much time talking
- We don't interrupt others
- We will listen well to what others say
- What is talked about in the group will be confidential

UNIT 2. Participatory methods and tools

A. Background information: Handout

We identify, for the purpose of this manual, two general approaches in training: the traditional and the participatory ones.

1. The traditional approach

There are many differences between the traditional training and participatory learning. In the conventional approach, training is characterized by lecturing or teaching, which is termed “banking approach”. Traditional training assumes that:

- The teacher knows and the pupil does not know;
- Knowledge is passed from the teacher to the learner;
- Instruction is teacher-oriented;
- The acquisition of information is emphasized;
- Delivery is based on presentation, teaching, lecturing and preaching: the teacher talks, the learners listen.

Many schools use this method: teachers lecture and believe that their listeners have learned. In fact, through listening alone one learns very little.

2. Participatory learning

This approach to learning differs from the “banking approach” significantly. Accordingly, participatory learning is based on the belief that:

- Knowledge is discovered through mutual investigation of problems and issues;
- The trainer manages the learning process as a **facilitator of learning**;
- The trainer works in partnership with learners;
- The trainer allows trainees to take more responsibility in learning;
- Training is helping other people to learn;
- Participatory learning methods and tools are used;
- Learning is a continuous process, performed in a **learning cycle**.

The participatory approach is employed with the intention that the learners should be empowered to take control of their own learning. It seeks to involve and enable the learners to be aware of alternatives in their sexual lives in order to make responsible choices for themselves. Thus, core facilitators and peer educator trainers are introduced to the participatory methods and tools with the intention that they will use these methods and tools while training peer educators trainers and peer educators. In their turn, peer educators will employ the participatory approach in peer learning groups.

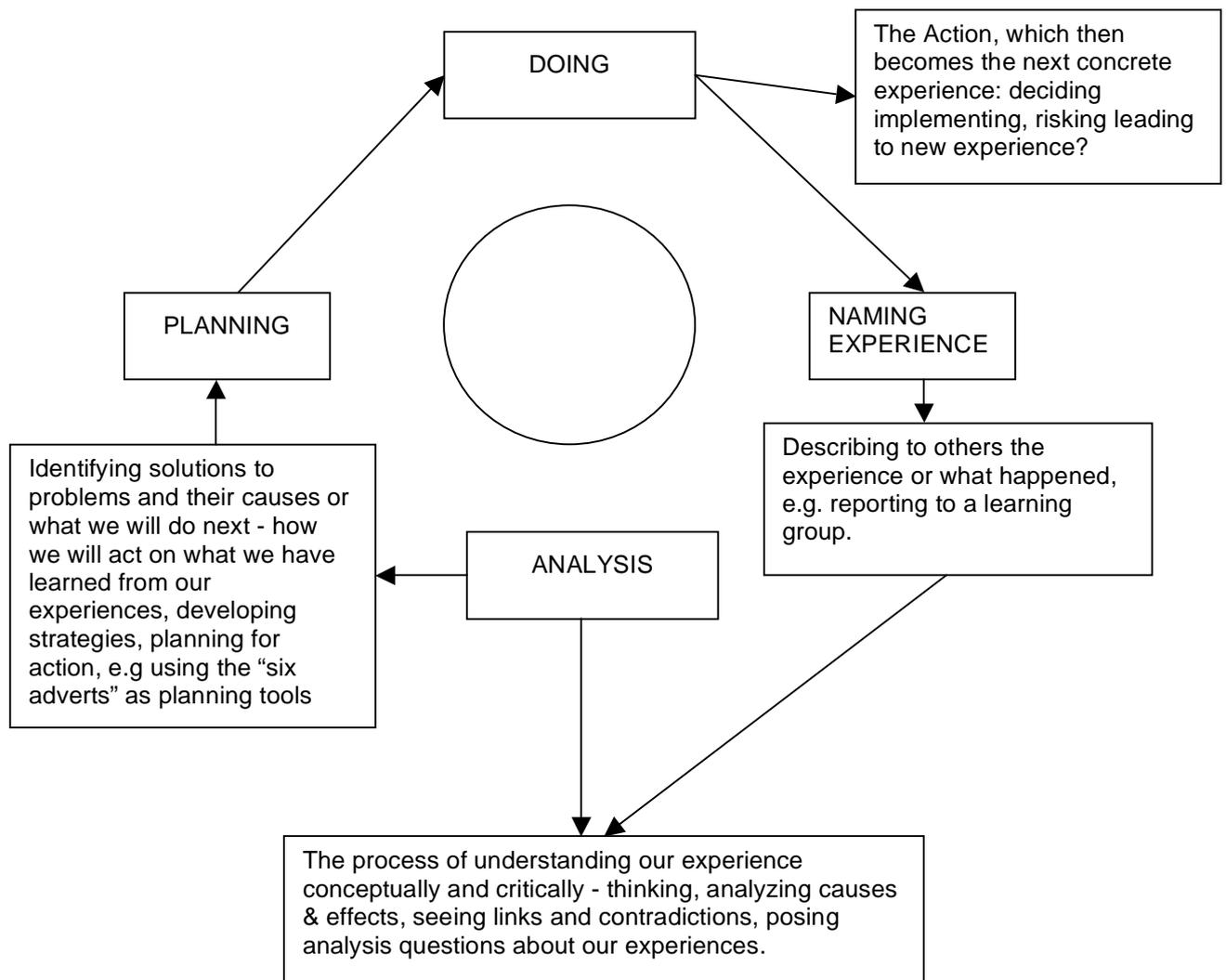
The success of the training depends to a large part on the participatory training method. Most importantly, the training should always emphasize practical methods, reflection and more practice, rather than simply presenting information. Using a wide range of participatory training techniques makes the training as interesting as possible and generates a high energy level among the participants.

2.1 The Learning Cycle

The learning cycle, also called the “Learning Spiral”, is the basic participatory approach followed in this manual. It is based on the principle that learning is a continuous process and not a single event. Learners go through the following steps of the learning cycle:

1. Start by identifying, expressing and sharing their experiences in adolescent reproductive health issues;
2. Analyse their causes and effects, and prioritise them;
3. Search for solutions: skills needed;
4. Plan and take action;
5. The action creates a new experience, thus forming the learning cycle.

Through the facilitation of the learning cycle for example young people evolve from having a *low level of awareness* about high risk sexual behaviours to a *higher level of awareness* – which can then be used to feed back into the cycle for behavioural change. Participatory methods and tools are applied and exercised at all steps of the learning cycle. Trainers are facilitators of the learning process.



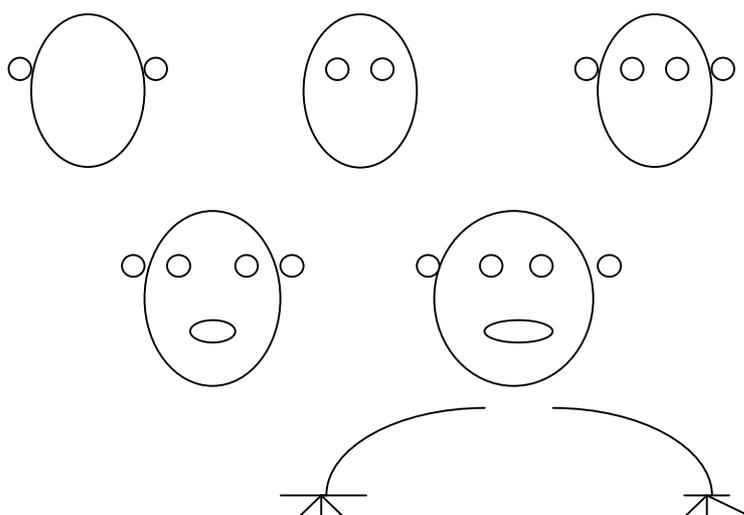
In brief, the above-described learning cycle illustrates that learning:

1. Begins with people's own experiences;
2. Moves from experience to analysis of causes and effects;
3. Moves from analysis to encouraging collective action;
4. Reflects and evaluates new experiences emanating from the action.

2.2 The Principles of learning

Participatory training uses the **mind, hands and emotions** (see figure below) in the process of the learning cycle. It is based on the assumption that people learn:

20%	by hearing only
30%	by seeing only;
50%	by hearing and seeing;
70%	by hearing, seeing and talking;
90%	by hearing, seeing, talking and doing.



What I HEAR I forget, what I SEE I remember, what I DO I know!

Using participatory methods makes learning more interesting and using games and exercises activates more senses to increase creative learning of new information and assimilation of new ideas. This is especially more important in the training of peer educators and sharing of knowledge on reproductive health where new criteria, values and worldviews must be taken into account.

Dominant processes that can marginalize people and impede intercultural exchange and progress need to be avoided.

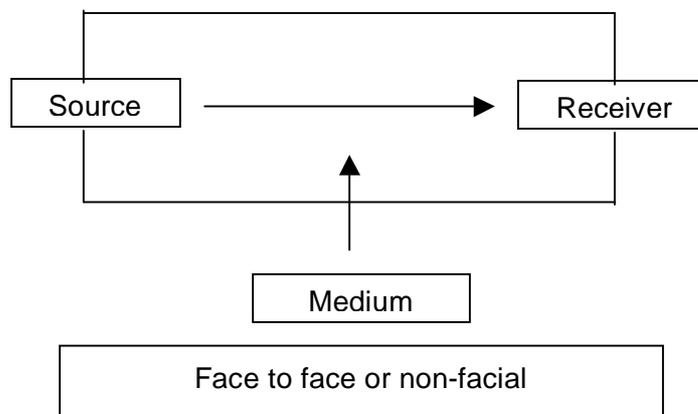
2.3 Communication

Communication is the passing and receiving of information from one “source” to a “receiver” and back to the “source” which in this case becomes a receiver too.

In between the source and receiver is the “medium” of communication. The medium is either face-to-face or non-facial. For the sake of our training, this will be face-to-face.

Once a medium of communication has been selected, then the channel to be used for communication too needs to be identified. This could be via radio, TV or theatre if it’s face to face.

Source and receiver



Logical flow of Communication



Whenever flow of communication is interfered with, the interfering factor is called a *communication barrier*. These barriers result from the selection of medium, channels and other existing social factors (age, sex, religion etc.). It is important to address communication barriers in advance to any communication activity in case they might hinder the activity.

Games and exercises have many purposes and fulfill many needs in training. The criteria for the choice of one game over another are often complex. They will depend on the overall topic and objective of the group event and the conditions at the time you want to use a game or exercise.

How far has the group progressed? How concentrated are the participants? What is the mood of the group? Is there a need to energize the group or to slow it to allow the participants to relax and think about their input? Is there conflict in the group? These are some of the factors, which will determine the choice.

However, there is no universal guide or prescription. Choosing a game/ exercise that will work is an art. It depends on the ability of the facilitator to perceive the state of the group and to predict the outcome of different choices.

There should be no games/exercises that are threatening but demonstrate the value of differences between individuals and not single out individuals for ridiculing.

Communications Skills

What are communication skills? One can define them as the skills used by a facilitator who has a message or a topic that he/she has to: introduce, explain, tell, recap, summarize, inform, persuade, listen, demonstrate, role-play, etc.

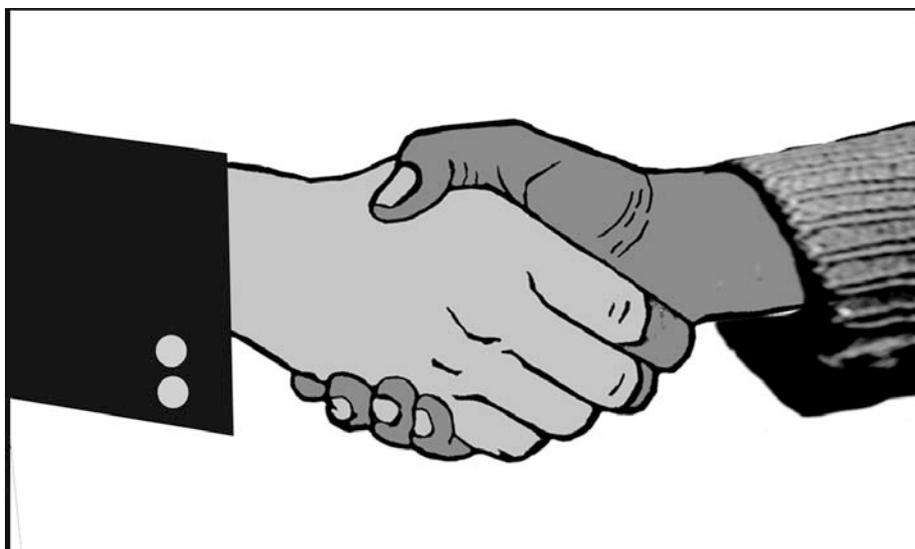
The facilitator should be clear of three aspects involved in the process of communication:

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

A facilitator needs to be clear, first about the content of the topic and then in identifying what communication means or which participatory tools are needed to deal with specific topics, e.g. asking analysis questions, brainstorming or employing role-plays. Most of participatory tools presented below are, if used effectively, good means of communication (also see communication check list next page)

The facilitator has to have personal skills in using these participatory tools to effectively pass the messages. Such skills can be acquired through continuous practicing in the course of this training. To help the trainees improve their skills, the following checklist will be used after demonstrations. The observation should then form the basis of a detailed discussion of what could have been done better and how it could have been done, what was done well and why it was good.

- Communication skills are essential in ASRH club activities.
- Communication is much, much more than telling. It involves listening, asking, explaining, and persuading.
- Communication skills should be analyzed, described and demonstrated.
- Every trainee should practice communication skills in discussion, role-play, etc.



Communication skills observation form/check list needs

<ul style="list-style-type: none"> • Facts <p>How clear is the message or content?</p>	
<ul style="list-style-type: none"> • Manner <p>Are participants greeted</p> <p>Spoken to by name</p> <p>Friendly</p> <p>Bossy/rude</p>	<p>Blaming participants</p> <p>Shy</p> <p>Confident</p> <p>Indifferent</p>
<ul style="list-style-type: none"> • Language <p>Verbal language</p> <p>Loud enough</p> <p>Clear language</p> <p>Understandable words</p>	<p>Listens well</p> <p>Talks, lectures too much</p> <p>Well prepared</p>
<p>Body language</p> <p>Eye contact</p> <p>Movement, Hands etc.</p>	<p>Facial expression</p>
<p>Time management</p> <p>Too slow</p> <p>Hurried</p>	<p>Balanced</p>
<ul style="list-style-type: none"> • Techniques <p>Did the facilitator use usual aids to help in the explanation?</p> <p>Were the participatory tools/methods used?</p>	
<ul style="list-style-type: none"> • Success <p>How successful was the facilitator in performing the facilitation?</p> <p>What were the reasons for his/her success?</p>	

2.4 Participatory training tools or techniques

These tools are used to involve our senses as we learn. The facilitator needs to be creative in employing selected tools or techniques. The following is a list of only a sample of the many tried types of participatory training techniques a facilitator can use. However, a facilitator should search for more and even “invent” some from his/her own experience.

- “Lecturette” short presentation
- Brainstorming
- Card activity
- Charts
- Check-in
- Demonstration
- Energizer
- Exercises
- Warm-up/ice breakers
- Analysis questions
- Buzz groups or pairs
- Cases
- Drawing
- Handouts/self study activities
- Illustrations, Visual Aids
- Large group discussions



- Fishbowl
- Group-diving techniques
- Introduction
- Recapitulation or summarizing
- Songs/Dances
- Story telling
- Ranking
- Role-plays
- Round turn
- Small group discussions
- The six tools of planning

Tips for Facilitators:

1. Start every day by reviewing the previous day's learning. This helps "fix" concepts for the trainees.
2. If things don't work well, ask yourself "what did I/we do wrong?" and learn from your mistakes.
3. When a task is given to the group, present it verbally or in written form on a flip chart in a very clear language. Always ask if the participants have understood the task.
4. To vary the composition of small groups, create them by group-dividing techniques.
5. A facilitator should always be a few steps ahead of the trainees and has practiced upcoming exercises, developed a plan, anticipated problems, etc.
6. If participants are having difficulties in answering questions, the facilitator should rephrase the question or give hints to help them respond, rather than supplying the answer directly.
7. Always be sensitive to the level of concentration and energy of the participants. If it drops and you feel some of the trainees are not paying attention, it is very important to stop and do energizer. Don't worry about losing this valuable time, because time when people aren't paying attention is wasted.
8. Remember that the way the training is being held and the methods used during the training are at least as important as the content. The most important thing to remember is that people learn by doing.
9. Learn-----practice -----reflect -----learn.
10. If you do not know something, be ready to admit: "I don't know". Ask if anyone else knows.
11. Be well prepared and relax.

B. Process Facilitation: Participatory methods and tools

Purpose: Participants will be introduced to participatory learning methods and tools

Methods: Large group, small group discussions, and exercises

Tools: Quiz, drawing, learning cycle diagram, round turn

Duration: 90 minutes

Note for the facilitator: We assume that the handout on the background information has been distributed and has been read by participants in advance. The participatory methods and tools can be best learned through practicing. The participants will have opportunities to make use of the methods and tools during the training. At this stage, the facilitator may introduce

the methods and tools. For detailed information, refer participants to read the definitions of the tool in the Glossary. Conduct the following introductory exercises but do not spend too much time discussing the tools since they will become clearer in the process.

Make participants aware that a facilitator above everything has to develop abilities of communicating effectively with trainees. Throughout the training, effective communication skills will be emphasized. Communication is necessary in all aspects of peer learning groups, e.g. in sharing experiences, knowledge, awareness creation; persuading adolescents to improve their sexual behaviour, etc.

Introduce briefly what the communication skills are and the checklist that will be employed in the course of the training to assist trainees to improve communication skills.

Exercise 1: Introducing the participatory methods and tools

The facilitator will:

1. Introduce briefly the basics of the participatory methods and tools, including communication skills, using the diagram of the “learning cycle”, on a flip chart (10–15 minutes).
2. Conduct the quiz (you may form buzz groups) to check whether participants have grasped the basic approach (10 minutes). Ask participants the following questions:
 - What is the difference between the “traditional approach” and “participatory learning”?
 - Explain the steps of the learning cycle?
 - Explain the five “learning heads”?
 - What are “communication skills”?
 - Ask each participant to name one “participatory training tool”?

Exercise 2: Learning the participatory methods

The facilitator will:

1. Divide participants into three small groups of 4, 5 or 6.
2. Ask one group to draw the learning cycle.
3. Ask another group of five to demonstrate the learning heads.
4. Ask another group to prepare a role-play on a traditional training in which trainees do not participate and are bored.
5. Allow 15 minutes for preparation (attempt should be made to distribute assignment in advance).
6. When the allotted time is up, pull the groups together and ask each work group to present in turns. (Allow 5 minutes for each).
7. After each presentation, ask presenters of each group to explain what they have represented.
8. Ask for comments.
9. Write the major points on a flip chart.
10. Finally, summarize the main methods and tools learned.

11. Ask for feedback from participants: Was this exercise helpful in introducing you to the methods and tools? What was not helpful?

Exercise 3: Application of participatory methods and tools in training

Purpose: To enable core facilitators to apply participatory methods and tools

Methods: Exercise, observation

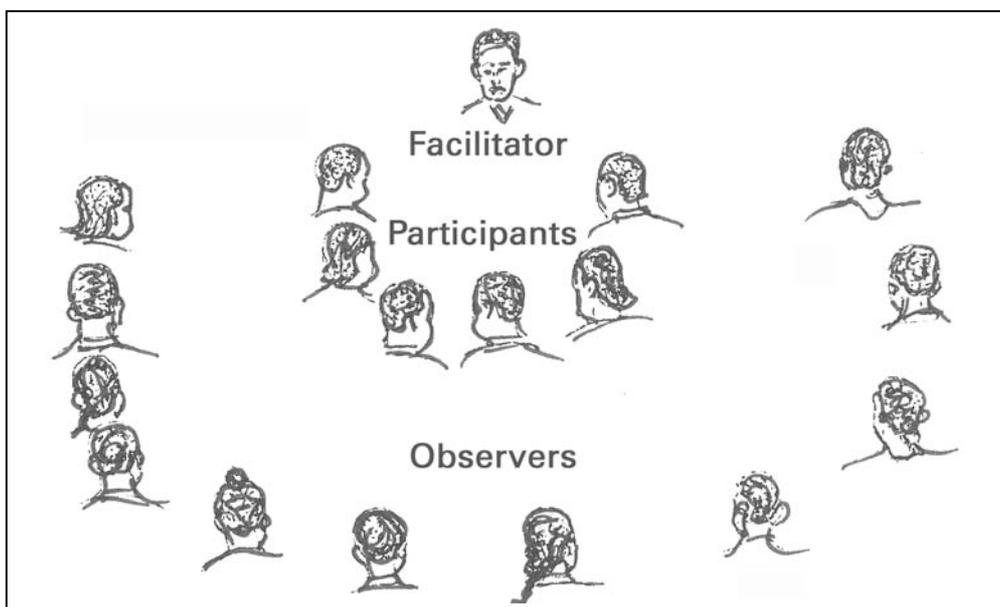
Tools: Fish bowl

Duration: 30 minutes

Activities: Every Core Facilitator and Peer Educator trainer should be allowed to practice facilitation at least once during the course of the training. It is advisable to start this exercise after this Unit. The trainer should tell each trainee to prepare a session far in advance.

For this purpose, all participants will come together and form a “**fish bowl**” (see figure). One person assigned in advance will conduct the facilitation. In this particular exercise, ten minutes facilitation on the qualities of an effective facilitator (see summary below) may be attempted. A group of five acts as trainees, the rest of the participants sit around and observe the whole facilitation and learning and record their impressions in the Communication Skill Observation Form.

Before performing the facilitation, the practicing “facilitator” is asked to indicate the type of the trainees he/she is dealing with and the tools to be used.



The Fish Bowl

At the end of the facilitation exercise, the “facilitator” will be asked to evaluate his/her performance.

- Do you think you have done well?
- What was wrong with your facilitation?

e.g. effective communication: body language, visualization, effective use of tools, listening, time consciousness, etc.

The “trainees” will be asked what they felt about the facilitation (Naming experiences) and their constructive criticisms (Analysis).

Finally, the “observers” will give their comments on the strengths and weaknesses of the facilitation based on the Communication Skill Observation Form.

The outcome of the exercise will be written on a flip chart by the facilitator. In summarizing, the trainer relates the above exercise with the qualities or characteristics of a good facilitator.

Exercise 4: Qualities of an effective facilitator

Ask participants to come up with and list desired qualities of an effective facilitator. Use plenary discussions to generate consensus. An effective facilitator has to:

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



An effective facilitator has the knowledge about all tools

Unit 3. Reproductive anatomy and physiology

Introduction

This Unit is divided into two sections: Section 1 examines female anatomy and physiology while Section 2 focuses on male anatomy and physiology. Each section has two parts. In part one, factual information is provided as a background. This should be distributed to workshop participants as a handout and the facilitator should refer to it during the course of the session. In Section 2 (Process Facilitation) the actual learning activities are presented.

Basic information: Handout

A human being undergoes physical and emotional changes from childhood to adulthood. The changes are gradual and occur at different ages and speed in different people. These stages may be identified in a simplified way as childhood, adolescence, adulthood and old age. In this guide we are concerned with the adolescent stage of human development, which is characterized by dynamic changes in physical and behavioural traits.

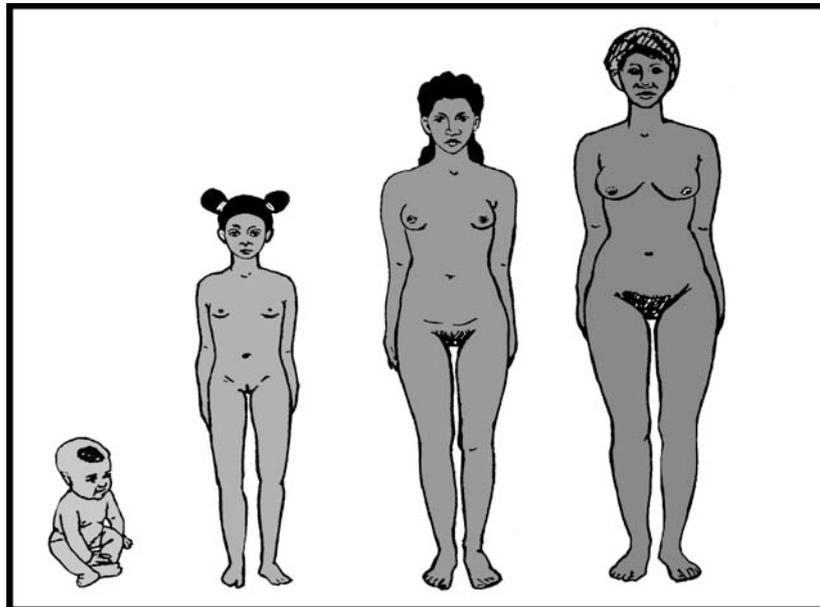
In spite of their different appearances, the sexual organs of men and women arise from the same structures and fulfill similar functions. Each person has a pair of gonads: ovaries are female gonads; testes are the male gonads. The gonads produce germ cells and sex hormones. The female germ cells are ova (egg) and the male germ cells are sperm. Ova and sperm are the basic units of reproduction; their union can lead to the creation of a new life.

Hormones and reproductive life cycle

There are many powerful cultural and personal factors that shape the expression of ones' sexuality. But biology also plays a role, particularly through the action of hormones, chemical messengers that are secreted directly into the bloodstream by endocrine glands. The sex hormones produced by the ovaries and testes greatly influence the development and functions of the reproductive system throughout life. The sex hormones made by the testes are called androgens, the most important of which is testosterone.

The female sex hormones, produced by the ovaries, belong to two groups: estrogens and progestins, the most important of which is progesterone. The cortex of the adrenal glands (located at the top of the kidneys) also produces androgens in both sexes.

The hormones produced by the testes, the ovaries, and the adrenal glands are regulated by the hormones of the pituitary gland, located at the base of the brain. This gland in turn is controlled by hormones produced by the hypothalamus in the brain. Sex hormones exert their primary developmental influences first in the embryo stage, where they control the development of a male or female reproductive system, and later during the individual's adolescence.



Section 1: Female reproductive organs

Basic information: Handout

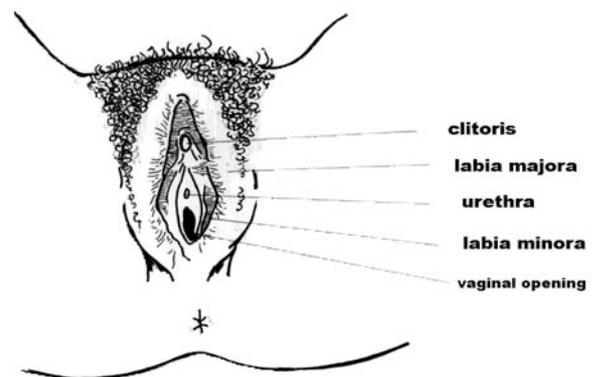
The female reproductive organs are those parts of the body that are directly involved in sexual activity, pregnancy, and childbearing. They comprise of external parts, internal parts and the breasts.

External reproductive organs (Vulva)

The vulva is the area surrounding the opening of the vagina, which can be seen from the outside (see figure). They consist of the clitoris, vagina opening, labia majora and labia minora.

The outer folds of skin, called the labia majora, are thick and covered with hair. The two inner folds of skin, called labia minora, are much thinner. They cover and protect the vaginal opening. These inner folds form a hood around the clitoris. The clitoris is a small, sensitive organ above the vagina that responds to stimulation and makes sexual intercourse pleasurable for women.

Inside the vaginal opening is a pair of glands that produces a thin fluid, which moistens the vagina, especially during sexual intercourse.



*The external female reproductive organs
Adapted from Arkutu A.A., 1995*

Internal reproductive organs

These are organs of the female body that are located inside the lower part of the abdomen, called the pelvis, and are protected by bones and muscles (see figure below). They consist of the vagina, the uterus (womb), two ovaries, and two fallopian tubes.

The vagina, covered at the opening by a thin membrane called the hymen, is the largest of the three openings in the genital area. It is made up of soft folds of skin and is about 7 cm deep and 3–4 cm wide. The other two openings are the anus (below the vagina) and the urethra (above the vagina).

The walls of the vagina produce a fluid or discharge that serves to keep the region clean. At different times of each month the amount of discharge increases - particularly at times of sexual excitement - and it is important to note that this is completely normal.

However, if that discharge changes its usual normal colour, causes itching or takes on a bad smell, it may indicate an infection. So it is important to pay attention to the discharge and how it changes during the monthly cycle.

During childbirth the baby leaves the womb and enters the world through the vagina. This is why it is sometimes called a “birth canal”. The walls of the vagina are elastic and can stretch to allow the passage of the baby’s head and body.

The uterus (womb) is the muscular organ inside a woman’s body where the baby grows. The cervix is sometimes called the opening/neck/mouth of the womb. It connects the uterus to the vagina and normally has a very small opening. This protects the uterus from infections. During pregnancy this opening stays small so that the baby stays inside the womb. During labour the cervix opens up (dilates) so that the baby can be born.

The ovaries are two small egg-shaped organs on either side of the uterus that store eggs and release one mature egg each month during a girl/ woman’s reproductive years of life.

The fallopian tubes are two hollow-like structures that connect the ovaries to the uterus on either side. The tubes are 10–12 cm. long. After the mature egg has been released from one of the ovaries, it travels down the fallopian tubes to the uterus.

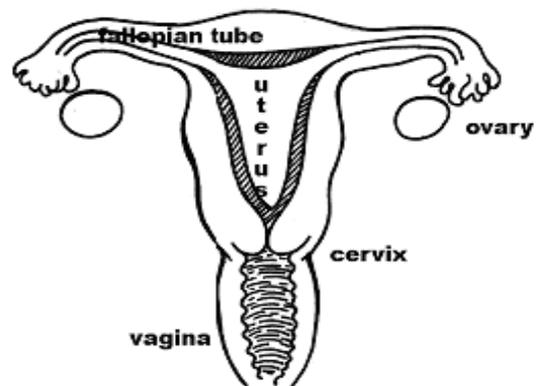
The breast

The main external feature of the breast is the nipple and the dark skin around it, called the areola. A hormone called estrogen causes the tissues and glands in the breasts to grow so that when a woman becomes pregnant, she is able to produce and store milk. Often, both breasts swell slightly during the menstrual period. In many women, one breast is larger than the other.

Hormones and their functions

There are many hormones involved in the physical development and the normal reproductive and sexual functioning of a girl or woman. The major ones are oestrogen, progesterone, follicle-stimulating hormone and luteinizing hormone. Below is a brief description and function of each hormone.

The follicle-stimulating hormone (FSH) is a hormone produced by the pituitary gland found in the brain. FSH stimulates or activates the ovarian follicles (immature eggs) to grow and release estrogen and progesterone hormones.



The internal female reproductive organs



The luteinizing hormone (LH) that is produced from the pituitary gland makes the immature eggs grow faster of which only one matures ready for fertilization. It is then released into the fallopian tube.

The ovaries produce estrogen that supports the growth of the uterine lining in preparation for implantation of the fertilized egg. Estrogen also makes cervical mucus thin, clear and stretchy to assist entry and nourishment of the sperm.

Progesterone, which is produced by the ovaries, makes the uterine lining and wall thicker and richer in blood supply. The uterine wall becomes rich in nutrients ready for implantation. Progesterone enables the cervical mucus to become thicker and stickier, preventing germs from entering the uterus and blocking the passage of sperm.

Process facilitation: The female reproductive organs

Getting started: We assume that the facilitator has read the basic information in advance and prepared the methods, tools and the illustrations for this session. We also assume that participants have received the handouts the day before and have read them before this session. If it is not possible to distribute handouts, the facilitator should at least be able to write the headings on a large piece of paper and explain briefly.

To start with, the facilitator will:

- Invite the trainee assigned to perform an energizer (3–5 minutes), then
- Recap the previous session very briefly (3 minutes), and
- Introduce the handout about the female reproductive organs (5–7 minutes)
- Make participants aware that knowledge of female reproductive organs is essential for understanding the sessions coming up on adolescent sexuality, pregnancy, contraception and STIs/STDs.
- Conduct the four exercises, which concentrate on enhancing knowledge of participants on female sexuality

Exercise 1: Enhance knowledge on female reproductive organs

Purpose: Participants will acquire in-depth knowledge of female reproductive organs

Method: Large group discussions

Tools: Cards

Duration: 20 minutes

The facilitator will:

1. Ask participants to stay in the whole group and form a circle.
2. Distribute cards or slip of paper with names of the female reproductive organs and other cards with corresponding functions or descriptions of these names.
3. Ask each participant to read the card/paper he/she has at hand.
4. Ask for the corresponding card/paper owned by one of the participants to be read out loud.
5. Ask participants to give the name in the local language, explain the part and its functions. Encourage other participants to ask questions.
6. Summarize the main points learnt on female reproductive organs and

7. Ask for feedback. How did the card activity help to clarify the female reproductive organs?

Card game

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

Exercise 2: Exploring own experience

Purpose: To enable participants to understand the physical foundation of female sexuality

Method: Exercises by small group

Tools: Drawing, handouts, and illustrations

Duration: 30 minutes

Note: The assumption here is that participants learn better about the functions of the human body from their experiences of being a boy or a girl. The actual experience will be processed more concretely as follows:

The facilitator will:

1. Divide the participants into small groups of 4–6. If need be, form separate male and female groups. Encourage everyone in the group to be involved in sharing views actively.
2. Give each group flip charts or large pieces of paper and markers, and then,
3. Ask them to draw the female reproductive parts, write the names and identify the functions (15 minutes).
4. When the allotted time is up, bring participants together,
5. Ask the presenter of each group to explain their drawings. This is the process of sharing experiences through reporting (5 minutes for each group).
6. Ask the following questions:
 - Identify the functions of each organ, and their importance for healthy sexual life, like:
 - What would happen, if the clitoris, labia majora and minora were removed?
 - Or if STIs attack the organs?
7. To save time, remind participants not to go into the causes and effects or solutions. Write the major responses on a flip chart.
8. Summarize the main points learnt on female reproductive organs.
9. Ask for feedback from participants: Was the exercise difficult? Can peer groups use this exercise?



Group work

Exercise 3: Myths about the female reproductive organs

Purpose: To make participants aware of misconceptions about female reproductive organs

Method: Large group discussions

Tools: Buzzing, brainstorming

Duration: 30 minutes

The facilitator will:

1. Ask participants to form a circle.
2. Ask them to form a buzz group of 2 or 3 with their neighbours.
3. Ask them to identify three myths, prejudices or misconceptions associated with the female reproductive organs (e.g., slang terms which are used as an insult – “cunt”; “slut”, etc.)
4. Ask one of the groups to brainstorm the myths identified.
5. Record the major points of the responses.
6. Screen and merge repeats and overlaps.
7. Summarize the main myths identified and discuss/clarify for participants.
8. Ask for feedback from participants. Are participants clear that the myths or false.



A buzz group

Exercise 4: Hygiene of the female reproductive organs

Purpose: Participants will know the importance of proper hygiene for the female sex organs (external genitalia)

Method: Combining experience with facts

Tools: Discussions in pairs and brainstorming

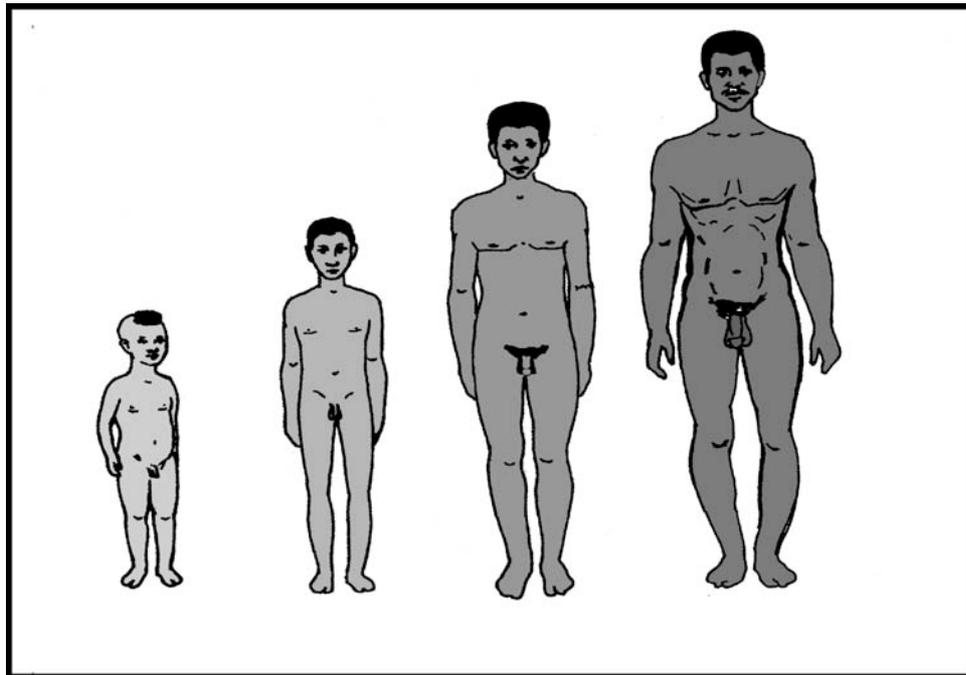
Duration: 20 minutes

The facilitator will:

1. Ask participants to form pairs or small groups of three.
2. Ask the pairs/small groups to list down three methods (cultural as well as what they read) used to clean the external female reproductive organ (5 minutes).
3. At the end of the 5 minutes, ask them to brainstorm and/or list down their answer on the flip chart paper or a blackboard
4. Conclude by comparing the list with basic information on the hygiene of female reproductive organ (female genitalia)

How to keep external female reproductive organs clean

- Use soap and water to wash the external genitalia and under your arms every day, especially during menstruation.
- Use either a disposable pad made of cotton, which has a nylon base, or a clean piece of cotton cloth to absorb blood during menstruation.
- Properly dispose of the pad after each use. Or, wash and dry the piece of cloth used as menstrual pad before reuse.
- Wash only the external genitalia. Do not try to clean the inside part of the vagina.
- While washing, wash starting from the vagina towards the anus. Do not wash from the anus towards the vagina. This will allow germs to enter the inner genitalia easily and cause infection.
- Be aware of abnormal fluids from your vagina. Do not confuse this with normal vaginal fluids.
- If you see any changes in the vaginal fluid – a change in color or odor, please visit a health professional.



Section 2: The male reproductive organs

Basic Information: Handout

The reproductive organs of the male are those parts that are directly involved in sexual activity; they consist of the external and internal parts.

External reproductive organs

These are the male organs that are on the outside and can be seen or felt. They comprise the penis, the scrotum and the testes.

The penis

The penis is the organ that carries the semen with the sperm into the vagina. During sexual arousal, blood is pumped into the muscles of the penis. This makes the penis stiffen or become erect so it can easily enter the vagina. Although both semen and urine pass through the tube called the urethra in the penis, at the time of ejaculation the opening from the bladder is closed so that only semen comes out of the penis. After ejaculation, the blood quickly drains away into the body and the penis returns to its normal state.

The penis has a prepuce also called the foreskin that protects the head of the penis. Usually the penis produces a whitish creamy substance called smegma, which helps the foreskin to slide back smoothly. When smegma accumulates under the foreskin, it causes a bad smell or even infection.

Therefore, boys who are not circumcised (have not had the foreskin removed) need to pull back the foreskin and gently wash underneath it with clean water everyday.

The scrotum

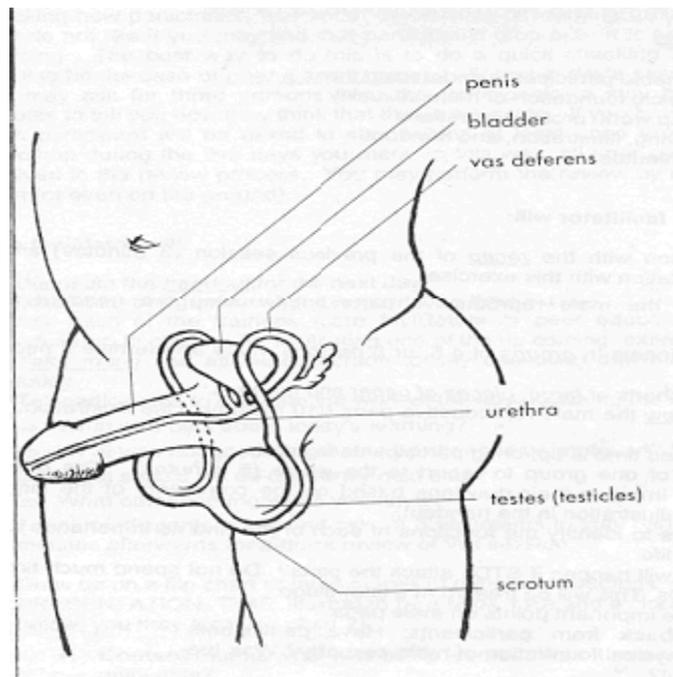
It is a sac of skin containing two egg-shaped organs called the testes, found in front of and between the thighs. The scrotum protects the testes from physical damage and helps to regulate the temperature of the sperm.

The testes (testicles)

They are two sex glands that produce sperm and male hormones, responsible for the development of secondary sexual characteristics in a man.

At the onset of puberty, in boys the testes begin to produce sperm. This usually happens between the ages of 12 and 15, although it can also happen earlier or later. From puberty until old age, a man's testes produce sperm – millions of sperm cells are released every time he ejaculates, or reaches climax, during sexual activity.

It is the sperm which fertilize the woman's egg to start the process of reproduction. During ejaculation, the sperm are carried in liquid called semen that is produced by the man's reproductive organs. The semen passes through a tube called the vas deferens and out of the penis, one of the millions of sperm may reach an egg and fertilize it; the rest simply die in a few days and disappear.



Adapted from Arkutu A.A., 1995

Internal reproductive organs

The internal male reproductive organs lie within the lower part of the abdomen called the pelvis that is protected by the bones and muscles (see figure above). They consist of the epididymis, the vas deferens, the seminal vesicles, the prostate, and the cowpers gland.

Epididymis

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

Vas deferens

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

Seminal vesicles

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

Prostate

Situated below the bladder, the prostate produces fluid that makes up part of the semen; it helps create a good environment for the sperm in the penile urethra and vagina, aids movement of the sperm and provides nutrients for the sperm.

Cowpers gland

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

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

Hormonal functions

The testosterone is the major male hormone produced mainly by the testes but there are other glands called the adrenal glands that also produce some testosterone. In case a man has lost his testes, these glands would continue to produce testosterone to support the male physical appearance.

Testosterone is responsible for the growth and development of a boy during adolescence and for the development of sperm and secondary sexual characteristics.

Process facilitation: The male reproductive organs

Getting started: We assume that the facilitator has read the basic information in advance and prepared the methods, tools and the illustrations for this session. We also assume that participants have received the handouts the day before and have read them before this session. If it is not possible to distribute handouts, the facilitator should at least be able to write the headings on a large piece of paper and explain briefly.

To start with, the facilitator may:

1. Allow the participants to perform an energizer (3–5 minutes), then
2. Recap the previous session very briefly (3 minutes), and
3. Introduce the handouts on the male reproductive organs (5–7 minutes)
4. Make participants aware that knowledge of the male reproductive organs is essential for understanding the up-coming sessions on adolescent sexuality, pregnancy, condom use, and STIs/STDs.
5. Conduct the four exercises, which concentrate on enhancing knowledge of participants on male sexuality.
6. Remind the time-keeper to be alert.

Exercise 1: Enhance knowledge on the male reproductive organs

Purpose: Participants will acquire in-depth knowledge of male reproductive organs

Method: Large group discussions

Tools: Card activity

Duration: 20 minutes

The facilitator will:

1. Allow participants to stay in the whole group in a circle.
2. Distribute cards or a slip of paper with names of the male reproductive organs and other cards with descriptions of these names.
3. Ask each participant to read the card he/she has at hand.
4. Ask for the corresponding card owned by one of the participants to be read aloud.
5. Ask participants to explain the part and the functions; encourage others to ask questions.
6. Summarize the main points learnt on the male reproductive organs and
7. Ask for feedback. How did the card activity help to clarify the male reproductive organs?

Card game

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

Exercise 2: Exploring own experiences

Purpose: To enable participants to understand the physical foundation of male sex organs

Method: Exercises, small group activity

Tools: Drawing, handouts, and illustrations

Duration: 30 minutes

Note: The assumption here is that participants learn better about the functions of the human body from their experiences of being a boy or a girl. The actual experience will be processed more concretely as follows:

The facilitator will:

1. If there are more than 7 participants, divide them into small groups of 4–6, if necessary there can be separate male and female groups. Encourage everyone in the group to be involved in sharing views actively.
2. Give each group flip charts or large pieces of paper and markers, then
3. Ask them to draw the male reproductive parts and write the names and identify the functions (15 minutes).
4. When the allotted time is up, bring participants together.
5. Ask the presenter of each group to share their drawings. This is the process of sharing experiences through reporting (5 minutes for each group).
6. Ask analysis questions:
 - Identify the functions of each organ.
 - Their importance for a healthy sexual life, such as:
 - What happens if STIs including HIV/AIDS attack the organs?
7. To save time, tell participants not to go into the causes and effects or solutions.
8. Write the major responses on a flip chart.
9. Summarize the main points learnt on male reproductive organs.
10. Ask for feedback from participants: Was the exercise difficult? Can peer groups use this exercise?

Exercise 3: Myths about the male reproductive organs

Purpose: To make participants aware of misconceptions regarding male reproductive organs

Method: Large group discussions

Tools: Buzzing, brainstorming

Duration: 30 minutes

The facilitator will:

1. Ask participants to form a circle.
2. Tell them to form a buzz group of 2 or 3 with their neighbours.



3. Ask them to identify three myths, prejudices or misconceptions associated with the male reproductive organs such as about male circumcision, wet dreams, virginity etc.
4. Ask one of the groups to brainstorm the myths identified.
5. Record the major points of the responses.
6. Screen and merge repeats and overlaps.
7. Summarize the main myths identified and discuss/clarify with participants.
8. Ask for feedback from participants. Are participants clear that the myths are false?

Exercise 4: Hygiene of the male reproductive organs

Purpose: Participants will know how to clean the male sex organ (external genitalia)

Method: Combining experience with facts

Tools: Discussions in pairs and brainstorming

Duration: 20 minutes

The facilitator will:

1. Ask participants to discuss in pairs or small groups of three.
2. Ask the pairs/groups to list three methods (cultural as well as what they read) used to keep the male reproductive organs clean (5 minutes).
3. At the end of the 5 minutes, ask them to brainstorm and/or list their answers on the flip chart, paper or a blackboard.
4. Conclude by comparing the list with basic information on how to keep the the male reproductive organs (male genitalia) clean.

How to keep the male reproductive organs clean

- Wash the external genitalia at least daily with soap and water, as you wash the rest of the body.
- Boys who are not circumcised need to pull back the foreskin and gently wash underneath it with clean water.
- Be aware of any abnormal fluids coming from your penis. Do not confuse this with the presence of normal fluids.
- If you see any abnormal fluid or wound, please visit a health professional.

Unit 4. Gender and sex in relation to adolescent sexuality

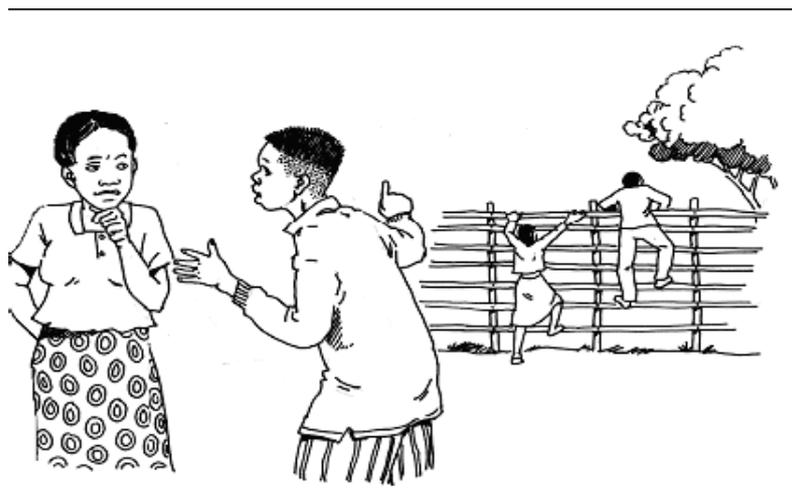
Basic information: Handout

Gender relationships: Adolescents and young people need to reflect on their social roles as boys and girls and learn how these roles influence their sexual relationships, both positively and negatively. In order to understand these roles, they need to see the difference between “sex” and “gender”. Sex is a biological term referring to whether a person is male or female; gender is a social term referring to the idea of what it means to be a man or a woman. Therefore, gender relates to socially determined characteristics, roles and ideas, attitudes and beliefs that the culture or a particular society has attributed to males and females. From childhood on, we learn and acquire these gender characteristics. Remember, gender relations are socially constructed and therefore, can be changed.

The roles of the different sexes are biologically determined characteristics; they are inborn and cannot change. Women menstruate and can become pregnant. Men have penises and can impregnate women. Sex roles are common to all women and all men.

Starting from childhood, a girl learns her gender role, usually from her mother. For example, in some countries household chores (like cooking, fetching water, grinding grain, serving food etc.) are considered to be “women’s work”. In other countries, a woman may be expected to be submissive and shy, and it is seen as her duty to satisfy her partner. These are socially constructed or gender roles. In other countries the same rules do not necessarily apply.

A boy also learns his gender role, usually from his father. He’s the one who leaves the house to go to work, owns property, goes to war, and tells his wife what to do. He is expected to be bold and assertive and be superior to a girl. Again, in other countries the same social rules do not necessarily apply. For example, many American women own their own property and run large corporations.



Outside of biology, there are no absolute differences between men and women.

In various countries around the world, the social roles men and women take on are interchangeable. Men cook and clean, women drive tractors and climb fences, men grind grain and women look after the family wealth. Therefore no biological difference can justify a gender-based imbalance in wealth, position in society, or sexual rights!



Because we have been taught a certain way, we often take gender imbalances for granted. Here are some examples:

- Girls are always expected to be faithful to their sexual partner; boys are not.
- Girls should not agree to have sexual intercourse before marriage; boys are expected to have sex.
- Girls are expected to hide their sexual feelings; boys are not.
- Girls should be shy and submissive in their sexual relationships; boys should be bold and assertive.
- Girls are not expected to negotiate sexual practices with their partner; boys are free to set the rules.

Because of his sex a man is often thought to be superior to a woman and due to this gender-based and socially constructed imbalance, it is usually a man who dictates how a woman should behave sexually. Women are therefore often considered the sexual possessions of men and suffer accordingly.

Men also suffer. Because they are put in a superior position, they run the risk of falling out of touch with their feelings and thus avoiding deep and healthy intimate relationships. Because of their own socially constructed roles, men are never permitted, and therefore cannot allow themselves to be vulnerable and sensitive. Men also have the tendency to separate intimacy from sex and will give love in order to get sex. Therefore, men often engage in sex without any deep emotional attachment, whereas for a woman the opposite is usually true.

Family and community roles, behaviour and practice in child development

Introduction

Everyone belongs to a specific family and community. Usually one is proud to be identified and associated with a good family and community. However, one family and community differs from another in many aspects of which some are good and others are bad.

In Africa, “family” refers to all relatives: mother, father, aunts, uncles, cousins, grandparents, and children. They might be closely related, like brothers, or they might be more distant relatives - a cousin’s husband’s mother for example. In an African family there are often many children and adults who have been “adopted” and are cared for within the family even when they have no biological relationship with the head of family, who in most cases is a male (father). However, in other countries “family” is understood to mean only one man, one woman and their children, as it referred to as a „nuclear family“.

There are also other family types, such as single parent families where only one adult is present in the home, and child-headed households where an older child is responsible for raising his/her younger brothers and sisters. There is an increasing number of child-headed families around the world, particularly in Africa, as a result of HIV/AIDS, internal conflict and war.

Children without a caring, supportive and loving environment are considered to be “vulnerable”. They are at greater risk of poor health and in some instances are exploited as child laborers, sexually abused and forced into early marriages. Some children lack care as a result of parental or community neglect because of family breakdown or lack of awareness about what it means to be a good parent.

All children have a right to basic necessities and care including food, clothes, shelter, education and medical care. This is primarily the responsibility of the family and the community in which these children live. When this is not possible, other means of support must be sought.

Youth and their rights: A human rights perspective

Every individual is entitled to some basic rights, just by being human. These basic human rights include survival, protection, basic human health and dignity. These are clearly manifested in official legally binding documents: for example the Universal Declaration of Human Rights adopted by the United Nations General Assembly on December 10, 1948.

This was the first multinational declaration that mentioned human rights by name and explanation. It has been ratified by most countries in the world.

The various human rights declarations/treaties/conventions spell out rights from survival to development, to protection from exploitation, abuse and full participation in family, cultural and social life. In the last decade human rights declarations have made provisions for more specific and vulnerable population categories such as children and gender rights.

Children and young people remain amongst the most marginalized members of our society today. The various human rights doctrines set in place, like the United Nations Convention on the Rights of the Child and the African charter on the Rights and Welfare of the Child (amongst several others), actually give young people a solid platform to speak for themselves, to defend themselves and to stand up for themselves.



Moreover they assure that young people are human beings with needs, wants, allowances and RIGHTS like anyone else. Specific to the African context and to youth (below the age of 18) is the establishment of the „African Charter on the Rights and Welfare of the Child“, which came into force in November 1999. To-date 34 countries have ratified and signed it.

“In adopting this charter African Heads of States and Governments have committed themselves individually and collectively to take all the necessary steps and measures, legislative and others to ensure the protection, survival and development of the Child in conformity with the provisions of the charter and to discourage any inconsistency with regard to the rights, duties and obligations contained there.” (Barassa & Amay, 2002)

This charter makes provisions for certain rights that are not even stated in the United Nations Convention on the Right of the Child (CRC).

Origins of human rights perspectives and movements

Human rights conventions have been written and implemented in the aftermath of the Holocaust, revelations from the Nuremberg war crimes trials, the Bataan Death March, the atomic bomb and other horrors of the 20th century. There was almost universal agreement that humanity could no longer look the other way while people were abused, tortured, subject to mass genocide and killing. This led to the modern Human Rights movement. Today, most advocacy work and indeed broader work targeting socio-economic and political development has its foundations in the need to respect these basic human rights.

Adolescent Sexual and Reproductive Health (ASRH) issues are also founded on the idea of basic health rights of the youth (10–24 years). Adhering to these internationally agreed doctrines and ensuring that every youth knows his/her individual human right, and is protected by them, is fundamental.

Knowing your basic human rights

Every one of us is entitled to our rights. Knowing these will go a long way in boosting confidence and ensuring that you will not be cheated, abused, or taken for a ride by your peers, political counter parts and even friends and family. Knowing your basic rights will also ensure that you know there are tools and mechanisms set in place to protect you, and give you a fair chance to develop as an individual just as any other member in society.

Being aware of your basic human right is the key ingredient to promoting equity, justice; self-awareness and personal development in our society. Youth are amongst the most vulnerable members of our society. They often lack the opportunity and power to speak out for themselves; to stand up for what they are and what they believe in; for issues that are affecting them and for issues that need to be addressed and have gone unrecognized.

Empowering yourself with an understanding of the basic rights that have been developed to protect you, could ensure that you have a solid platform and legal backup to speak out for yourselves and your peers. Youth represent our societies' future. They must be empowered to make informed choices by knowing that they have rights and responsibilities like every other member in society.

Moreover we all have a role to play to ensure that the rights of the youth in our society are respected and protected at all times. It is also important for youth to know what to expect from their governments, their communities and families. In addition they should also respect their communities and families and perform accorded duties. Indeed they must even demand their rights.



The most important documents where more information on human rights issues, details of articles and YOUR RIGHTS can be found in:

1. African Charter on the Rights and Welfare of the Child

(<http://www1.umn.edu/humanrts/africa/afchild.htm>)

The charter has 48 articles that spell out 48 different RIGHTS that every African child is entitled to. It makes certain provisions for rights that the UN CRC does not.

2. United Nations Human Rights documents:

(www.hrweb.org/legal/undocs.html)

- Universal Declaration of Human Rights: this makes provisions for 30 rights defined in 30 articles
- Covenant on Civil and Political Rights
- Optional Protocol to the Covenant on Civil and Political Rights
- Covenant on Economic, Social, and Cultural Rights
- Convention Against Torture
- Convention Against Genocide
- The Geneva Conventions
- Convention on the Rights of the Child: states that every person under the age of 18 is considered a child. It lists 54 articles spelling out 54 different rights that every child is entitled to.
- Convention on elimination of discrimination against women
- Charter of the United Nations

Some basic rights that every youth must be aware of as adopted from:

- a. The African Charter on the Rights and Welfare of the Child (child friendly connotations):
 - There should be no discrimination against children because of their race, religion, colour, sex, disability, language or ethnic group. We have the same rights whether our families are rich or poor
 - Every child should be healthy. We should be immunized, live in a clean home, eat good food and drink clean water
 - We should be protected from drugs and other harmful things like alcohol and cigarettes that interfere with our growth and education. They spoil our future
 - All of us have the right to be educated
 - All of us have the right to think and express ourselves
- b. The UN Convention on the Right of the Child (CRC): Article 24 spells out a child's right to health and health services (some detail and appropriate child rights are quoted below)

Article 6: Survival and Development

- "Every child has the inherent right to life, and the State has an obligation to ensure the child's survival and development."



Article 13: Freedom of expression

- “The child has the right to express his or her views, obtain information, and make ideas or information known, regardless of frontiers.”

Article 15: Freedom of association

- “Children have a right to meet with others, and to join or form associations.”

Article 24: Health and health services

- “The child has a right to the highest standard of health and medical care attainable. States shall place special emphasis on the provision of primary and preventative health care, public health education and the reduction of infant mortality. They shall encourage international co-operation in this regard and strive to see that no child is deprived of access to effective health services.”

Note: How knowing your right can save you and your health and therefore reduce the chances of contracting STIs and HIV/AIDS (an example)

A girl may be very close to being raped or forced into a sexual act, contrary to her consent. She may fuss, shout, scream and still get no help. Moreover her opponent could be bullying her saying you cannot do anything, what will you do?

If the girl/woman knew even her most basic human rights, she could use these to defend herself and speak up for herself. For example, in this particular case she could say she has a right to the protection of law and solid mechanisms against such brutal interference or attacks against her (see Article 16 of the UN CRC), which she could use to prosecute her opponent if he attempted any form of interference with her privacy. This would have extreme consequences and hence he could be frightened by this and back away, probably letting the girl/woman loose.

Reversibly, if everyone was informed about his or her basic right, the boy/man wouldn't even attempt to think about attacking the girl. He would know the consequences associated with engaging in such acts and more importantly he would know that like him, the girl/woman also has her dignity, respect and entitlements to her human rights.

Note: What should one do if he/she is aware that his/her rights are being violated?

Most countries these days have human rights commissions, which have been set up due to countries having ratified national and universal human rights doctrines. These commissions are usually accessible and will have advice, information and even legal representation (if need be) to protect you at a higher/court level.

Moreover, most NGO's these days are adopting a rights based approach of working towards promoting development and eliminating poverty. They would have information on what to do, where to go and how to access the necessary help.

Help can hence be sought at the ministerial level, private human rights practitioners' level, from respective country's human rights commissions or from any Non Governmental Organization or charitable institution near to you.

Process facilitation

Getting started: If this session begins in the morning, the facilitator may conduct a check-in to see how the group is doing. A few warm-up exercises and a brief summary of what has been learned during the previous day will follow, conducted by the person assigned to do so. The facilitator will then take 5–7 minutes to introduce the previously distributed background information. Then the following exercises will be introduced during which participants will



explore gender-based biases – resulting in a final action plan to alter their socially constructed behaviours.

Exercise 1: Understanding the difference between sex and gender

Purpose: Enable participants to differentiate between gender and sex

Method: Large group work and exercise

Tools: Statement sheet

Duration: 20 minutes

The facilitator will:

1. Distribute the statement sheet (see below) to each participant.
2. Ask participants to write in the empty space: “G” if the statement describes a gender-based behaviour and “S” if the statement indicates a sex-based trait. (10 minutes).
3. Ask each participant to read his or her statement with the responses.
4. Ask for comments.
5. Analyze the responses. Is it possible to change the stated behaviours?
6. Finally, summarize the main lessons learned about the differences between sex and gender and ask for feedback. Has the exercise made it clear which behaviours change and which do not?

Statement Sheet

Statement	G	S
Only women are responsible for pregnancy		
Only women can feed babies		
Only women give birth to babies		
Men don't cook		
A man does not have to abstain from sexual intercourse before marriage		
Men cannot menstruate		
Financial matters should be handled by men alone		
Girls cannot work outside the home		
If there is not enough money for school fees, it is always the girl that should leave		
Girls should be shy and submissive, boys should be bold, assertive		

Exercise 2: Challenging our gender roles

Purpose: Enable participants to be aware of both positive and negative gender roles

Method: Small and large group discussion

Tools: Brainstorming

Duration: 45 minutes

The facilitator will:

1. Divide the large group into two smaller groups composed of boys and girls and assign them to brainstorm the positive sexual roles they have learned to play. Ask them to list the experiences on a flip chart or large pieces of paper. Questions:
 - What five things do we like about our gender roles as boys/girls? (10–15 min)
 - What five things do we dislike about our gender roles as boys/girls? (10–15 min)
2. When the allotted time is up, bring the participants together and ask a presenter from each group to report their findings. Post the flip chart on the wall.
3. Identify and discuss negative gender perceptions from the lists taking care to indicate any imbalances between the roles of boys and girls. E.g. a boy can choose a girl he likes, a girl cannot, etc.
4. Finally, summarize the negative and positive gender perceptions of boys and girls and ask for feedback.

Possible responses of boys group (negative)

“We dislike our gender role as boys”, because a boy;

- Always has to be strong and tough
- Is expected to have many girl friends at the same time
- Must have a job to support the family
- Is not able to spend enough time with children

Possible responses of girls group (positive)

“We like our gender role as girls”, because a girl;

- Can spend hours at the salon
- Is protected by the family
- Can have a lot of influence at home

Exercise 3: Prioritizing negative gender related adolescent sexual behaviours

Purpose: Participants are enabled to identify and rank gender based sexual imbalances

Method: Large group work

Tools: Ranking, a large piece of paper

Duration: 20 minutes

The facilitator will:

1. Ask participants to prioritize the negative sexual relationships identified above.
2. The identified problems are displayed on a flip chart in the middle of the whole group on a table or on the ground.
3. Arrange in descending order the gender related sexual problems identified.
4. Summarize the problems prioritized and ask for feedback. Has the ranking exercise helped to identify and create awareness of the major gender related behaviour of adolescents?

Exercise 4: Display gender roles using a role-play (Optional)

Purpose: Through a role-play, participants will become more aware of negative gender related sexual behaviours

Method: Large group discussion, analysis questions

Tools: Role-play

Duration: 20 minutes

The facilitator will:

1. Ask participants to form two groups, one of boys and one of girls.
2. Have them prepare a role-play of one of the first two situations prioritized during the previous exercise (5–10 minutes).
3. Have the group watch the role plays.
4. After each presentation, analyze the role plays.
 - What were the messages the girls conveyed?
 - What were the messages the boys conveyed?
 - Which were the socially constructed biases or myths about girls?
 - Which were the socially constructed myths or biases about boys?
 - Does the group understand where these biases came from?
5. Summarize the main misconceptions and biases and ask for feedback: Has the exercise made it clear that gender imbalances can be corrected?

Exercise 5: Planning actions to resolve adolescents' gender related sexual imbalances

Purpose: Participants take action to solve negative adolescent gender related sexual behaviours

Method: Small and large group work

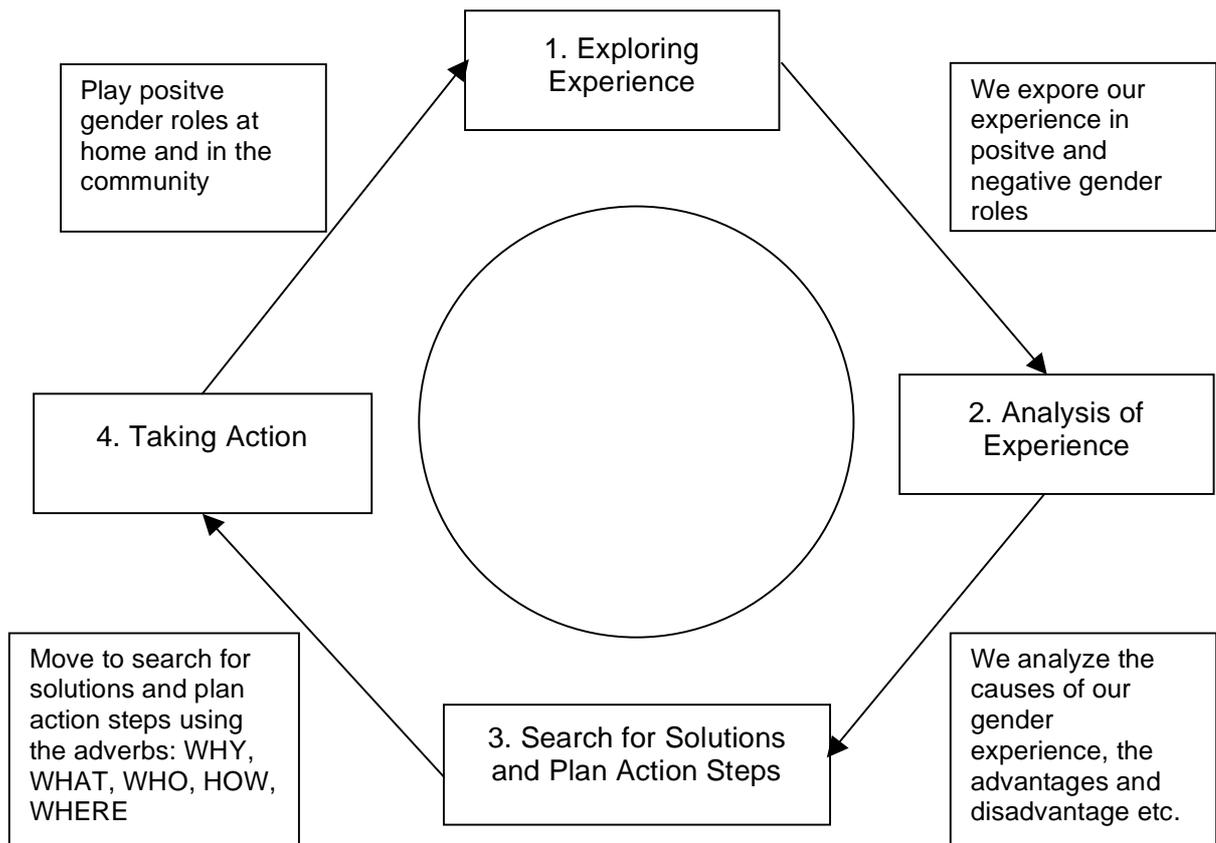
Tools: The six tools of planning

Duration: 45 minutes

The facilitator will:

1. Stress that unlike biologically determined sexual behaviours, gender related roles and behaviours of boys and girls can change - if boys and girls decide to change those behaviours. The facilitator will ask participants whether they agree to undertake an action plan to change undesirable gender imbalances that relate to sexual practices.
2. Ask participants to form two mixed sex planning groups.
3. Ask participants to follow the six tools of planning (explain the process).
4. Ask them to make action plans to change undesirable gender related behaviours among themselves and with their peers (see example below). Allow 25 minutes.
5. When the allotted time is up, bring participants together.
6. Ask one of the two groups to present.

7. Allow the other group members to comment and add points if necessary.
8. Ask the second group to present.
9. Screen repeats and merge overlapping statements to form an action plan for the whole group.
10. Summarize the accepted version of the plan and ask for feedback; will the participants put the plan into action? How will they do that and maintain those behaviours? What will be the consequences of that plan?



The planning process – an example

1. Why? Are we committed to take action? Why? How serious is the gender imbalance among young people in the community? How serious is the need to change the situation, e.g. boys harassing, forcing or raping girls or girls being afraid to speak out against these kinds of behaviours.
2. How do we go about it? Do we confront the boys who are harassing, forcing, or raping girls? Do boys vow to accept girls as equal partners and decide to take peer group action to protect girls from harassment? Do we establish peer-learning groups and strengthen participation in adolescent reproductive health clubs? Do we agitate in the community and call for change? What steps do we take?
3. Where do we take action? At home, in the neighbourhood, in the school, etc.



4. What resources and materials do we need? Who should we collaborate with? What constraints/obstacles need to be overcome?
5. Who should do what? What roles do girls and boys take as a group and as individuals?
6. When do we start our action(s)? How long do they go on? When do we know we have achieved our purpose?

The six tools of planning

WHY?	The reason for the plan or action to be taken
WHO?	The person(s) carrying out the plan
HOW?	The specific steps or tasks required
WHERE?	The location where the action(s) takes place
WHEN?	The time at which each step will be carried out
WHAT?	The resources needed to execute the plan

Unit 5. Adolescent sexuality

Section 1. Adolescence and sexuality

Basic information: Handout

Adolescence

Though adolescence is a developmental phase, there is no universally accepted definition for adolescence. However, the World Health Organization defines adolescents as those between 10–19 years of age, and young people as those in the age bracket of 10–24 years of age. Young people under 25 years of age now comprise over half of the world's population. Adolescents alone make up 20%, with some 85% of these living in developing countries. 60% of Africa's population is under the age of 24 years, and quite a significant number become sexually active at a very early age.

Adolescence is a transitional period from childhood to adulthood. It is a time when dynamic physical, emotional and social changes take place. Along with the rapid physical changes at the onset of puberty also come emotional changes, such as a greater desire to love and be loved, as well as sexual desires. All of this is normal.

Sexuality

Sexuality is an important part of being human. It is a complex and interacting group of inborn biological characteristics and acquired behaviours people learn in the course of growing up in a particular family, community and society (Insel, et. al., 1994).

Because of the important role sexuality plays in human life, communication about sexuality is emotionally charged. Sexual expression is usually regulated by both written and unwritten laws specifying what is acceptable and "normal" and what is unacceptable and "abnormal". Today young people are being bombarded with conflicting messages about sexuality from parents, educators, radio, movies, magazines and popular music.

Unfortunately, parents do not usually talk to their children openly about love, sex, sexuality and contraception because they fear it would encourage them to be sexually active – and because of their own lack of information. Because parents are mostly silent, adolescents rely on their peers as well as on sources like videos and magazines for information for sexual matters and very often this information is inaccurate, confusing, misleading and sometimes completely false. Decisions about sex have far-reaching consequences. Understanding the basic facts about sex, pregnancy and childbirth will help young people make intelligent decisions that are right for them.

A healthy sexual life for a young person requires many things. Among them are having the necessary information to know the difference between fact and fiction with regard to sexual behaviour; knowing how to express sexual feelings in ways that are not harmful to oneself or to anyone else; knowing how to ignore pressure from others; knowing how to say "No, I am not ready for sex"; knowing the potential consequences of unprotected sexual intercourse and how to avoid those outcomes before acting on sexual feelings.

However, many young people become sexually active without sufficient knowledge about sex, reproduction and contraception or their rights and responsibilities as a sexually active person. Even though a lot of information is available, a great deal of ignorance and misinformation on sexual matters continues to exist among young people. The result for many young people is:

- The early onset of sexual activity
- Having multiple sexual partners
- Sexually transmitted diseases, including HIV/AIDS
- Unwanted pregnancy
- Low use of contraceptives
- A greater risk of violence within a sexual relationship
- A limited ability to negotiate for safer sexual practices
- A greater use of harmful practices, such as a self-induced abortion
- Having sex for financial/material gain

This makes the role of peer educators even more crucial. The level of awareness of adolescents of the above listed reproductive health conditions may differ depending on their age and exposure. Four different levels of awareness might be identified (see the following box).

Awareness levels of adolescents

Level 1 – No awareness

Many adolescents are either ignorant or have a “who cares” attitude towards high-risk sexual behaviour. They are not yet aware enough to change their behaviour and are exposed to high risks as a result. This type of adolescent may be classified at Level 1 of awareness.

Level 2 – Some awareness

Young people at level two are those who have some self-knowledge of risky situations and behaviours but are not ready to take action. Thus, they are exposed to unwanted pregnancy and infections.

Level 3 – Relatively aware

Young people at level three are conscious of their risky sexual behaviours and are ready to take action, but do not do so because of factors like peer pressure.

Level 4 – Fully aware

Young people in this stage have a high level of knowledge and awareness and have also undergone attitudinal and behavioural changes. Such young people are actively involved in fighting risky sexual behaviours and gender imbalances.

Process facilitation: Adolescent sexuality

1. Before starting the exercise, make a brief recap of the previous session (3 minutes).
2. Then briefly introduce the Unit: Adolescent sexuality (7–10 minutes).
3. Show participants the illustration of the River Code of Life (See box below)
4. Ask participants to explain or interpret the illustration.
5. Summarize by explaining the River Code.

River Code of Life

In our life, most of us find sex enjoyable. Yet, almost all of us at some time in our lives can have difficulties or dangers related to sex. Adolescents crossing this river of life face many more dangers and need to be aware of them. Adolescents on Level 1 and 2 especially need the necessary knowledge and skills as their life is in real risk.

Exercise 1: Exploring the sexual experiences of adolescents

Purpose: To enable participants to identify both the potential benefits and risks of being sexually active

Method: Small and large group work

Tools: Ranking and Brainstorming

Duration: 45 minutes

The facilitator will:

1. Ask participants to form small groups of 4, 5, or 6.
2. Ask participants to list down positive (enjoyable) and risky sexual behaviours or practices that are common among adolescents (see the example below). Limit the list to 5 positive and 5 risky experiences or behaviours.
3. Ask participants to rank according to the importance of the benefit or seriousness of the risks (Allow 15 minutes).
4. Explain to participants that they are not to discuss the causes, effects or solutions of the risks at this stage. These will be handled later. When the allotted time is over, get together as a whole group.
5. Ask presenters of each group to list the first three major positive aspects and risks identified. Write on a flip chart under two columns.
6. At the end of the brainstorming, screen repeats and merge overlapping statements along with participants.
7. Summarize the main positive and risky behaviours. For feedback, ask the participants whether the exercise has enabled them to identify positive and risky sides of adolescent sexuality or not?
8. Keep for future use the chart with the prioritized risks posted on the wall for future use.
9. Before closing this exercise, explain where some of the prioritized problems, such as unwanted pregnancy, abortion, STDs, will be handled during the training.

Adolescent sexual activity (an example)

Benefits	Risks
<ul style="list-style-type: none"> • A normal expression of love • Feels good • Emotional connection with another person • Can raise self-esteem • A fulfillment of marriage vows • To have a child 	<ul style="list-style-type: none"> • STIs, including HIV/AIDS • Unwanted pregnancy • Emotional distress • Can lower self-esteem • Can cause problems with parents/ community

Exercise 2: The four levels of awareness of behaviour

Purpose: To enable participants to understand awareness levels of behaviour

Method: Brief introduction, small group and large group discussions

Tools: Role-play

Duration: 30 minutes

Activities: The facilitator will explain the four levels of awareness that could be identified among the youth (5 minutes) on a flip chart. Therefore he/she will:

1. Cluster participants into four small groups.
2. Assign one level of awareness demonstrated by a role-play to each group (see the cases below; see also the “four levels of awareness” in the handout). Allow 10 minutes for preparation.
3. When the allotted time is up, pull the groups together.
4. Ask each group to present its role-play. (5–7 minutes each)
5. After each role-play, ask the actors what they have demonstrated.
6. Ask the large group whether the role-play portrayed the levels correctly and what was missing.
7. Summarize the main lessons learned about the levels of awareness.
8. Ask for feedback on whether the exercise was helpful or not?

Case studies on four levels of awareness

Level 1

Group one demonstrates Level 1 by the action of a group of girls who are discussing the death of another girl. Though they know the girl was infected with HIV/AIDS, they are not worried about the cause of death but accept it as her fate and the will of God. Such youth have little knowledge about reproductive health issues.

Level 2

Group two plays the role of boys and girls who are discussing the importance of avoiding risky sexual behaviours. They wish to behave accordingly but are not ready to take action.

Level 3

Group three portrays a group of club members who talk a lot about behavioural change in meetings, but are not willing to go all the way with club members and take action. They are not fully free from risks.

Level 4

Group four demonstrates club members, who are free from risky behaviours, gender imbalances, and have undergone attitudinal changes. They are prepared to fight risky behaviours. They actively participate in youth clubs to improve the sexual health of their peers and the gender relationship between boys and girls.

What have we learnt from the role-play?

- They have shown us that there are different stages of awareness among young people,
- Awareness alone will not protect us from risks,
- To avoid risk we need to make decisions and stay firm with our decisions,
- There is a need for more knowledge to reach Level 4.

Section 2: How pregnancy occurs

Basic information: Handout

Reproductive maturation

Although human beings are fully sexually differentiated at birth, the differences between males and females are accentuated at puberty. This is when the reproductive system matures, secondary sexual characteristics develop, and the bodies of males and females come to appear more distinctive.

Female puberty usually begins at about 8–13 years of age; the reproduction maturation of boys lags about two years behind that of girls. The physical changes of female puberty include breast development, rounding of the hips and buttocks, growth of the hair in the pubic region and the underarm, and the start of menstruation.

For boys, physical changes include enlargement of the testes, development of pubic hair, growth of the penis, the onset of wet dreams (usually at about 11 or 12 years of age), deepening of the voice, the appearance of facial hair, and a period of rapid growth. Estrogens and progesterone bring the physical changes of puberty from the ovaries, testosterone from the testes, and androgens from the adrenal glands.

Terms

Androgens	Male sex hormones produced by the testes in the males and by the adrenal glands in both sexes.
Estrogens	A class of female sex hormones, produced by the ovaries, that brings about sexual maturation at puberty and maintains reproductive functions.
Progestines	A class of female sex hormones, produced by the ovaries that sustain reproductive functions.
Adrenal glands	Endocrine glands, located over the kidneys that produce androgens (among other hormones).
Pituitary glands	An endocrine gland at the base of the brain that produces gonadotropic and other hormones.
Puberty	The period of biological maturation during adolescence.
Menstrual cycle	Monthly ovarian cycle controlled by pituitary and ovarian hormones; in the absence of pregnancy menstruation occurs.
Gonadotropin releasing hormones	Follicle-stimulating hormones (FSH) and luteinizing hormones (LH), produced by the pituitary gland in both sexes.
Follicle-stimulating hormones (FSH)	The pituitary hormones that stimulate maturation of the ovum in the female and sperm production in the male.
Luteinizing hormone (LH)	The pituitary hormones that cause ovulation and stimulate the production of progestins in the female and androgens in the male.

Source: Insel, et. al., 1994

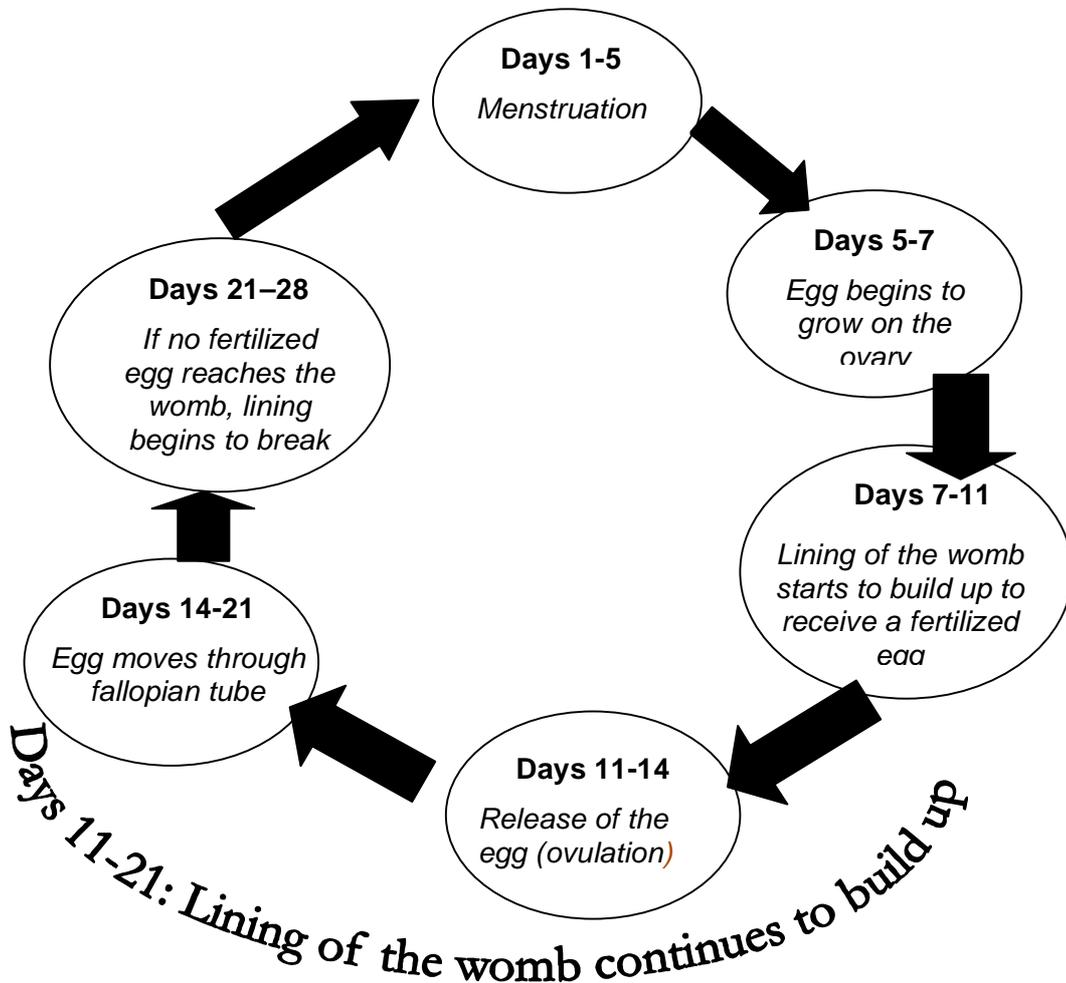
The menstrual cycle (Menstruation or “period”)

The major landmark of puberty among females is the onset of the menstrual cycle, the monthly ovulation cycle that leads to menstruation (loss of blood and tissues lining the uterus) in the absence of pregnancy.

The first menstrual cycle, or menarche, occurs at the average of 12.8 years but it may start earlier or several years later. After the menstrual period the lining of the womb starts to build up and prepare itself to receive a fertilized egg. If no fertilized egg reaches the womb within 2–3 weeks, the lining of the womb breaks down, and bits of tissues leave the womb during the menstrual period about a week later

This is called menstruation and is often referred to as “having a period”. The bleeding can last from 2–8 days; 4–6 days is the average. Menstruation continues throughout women’s reproductive life; menarche. Periods usually stop altogether between the ages of 40 and 50 years; this is known as menopause. However, the age at which menstrual periods begin or end can vary. The length of the menstrual cycle is the interval from the beginning of one period to the beginning of the next period (see figure on next page). It is usually about 28

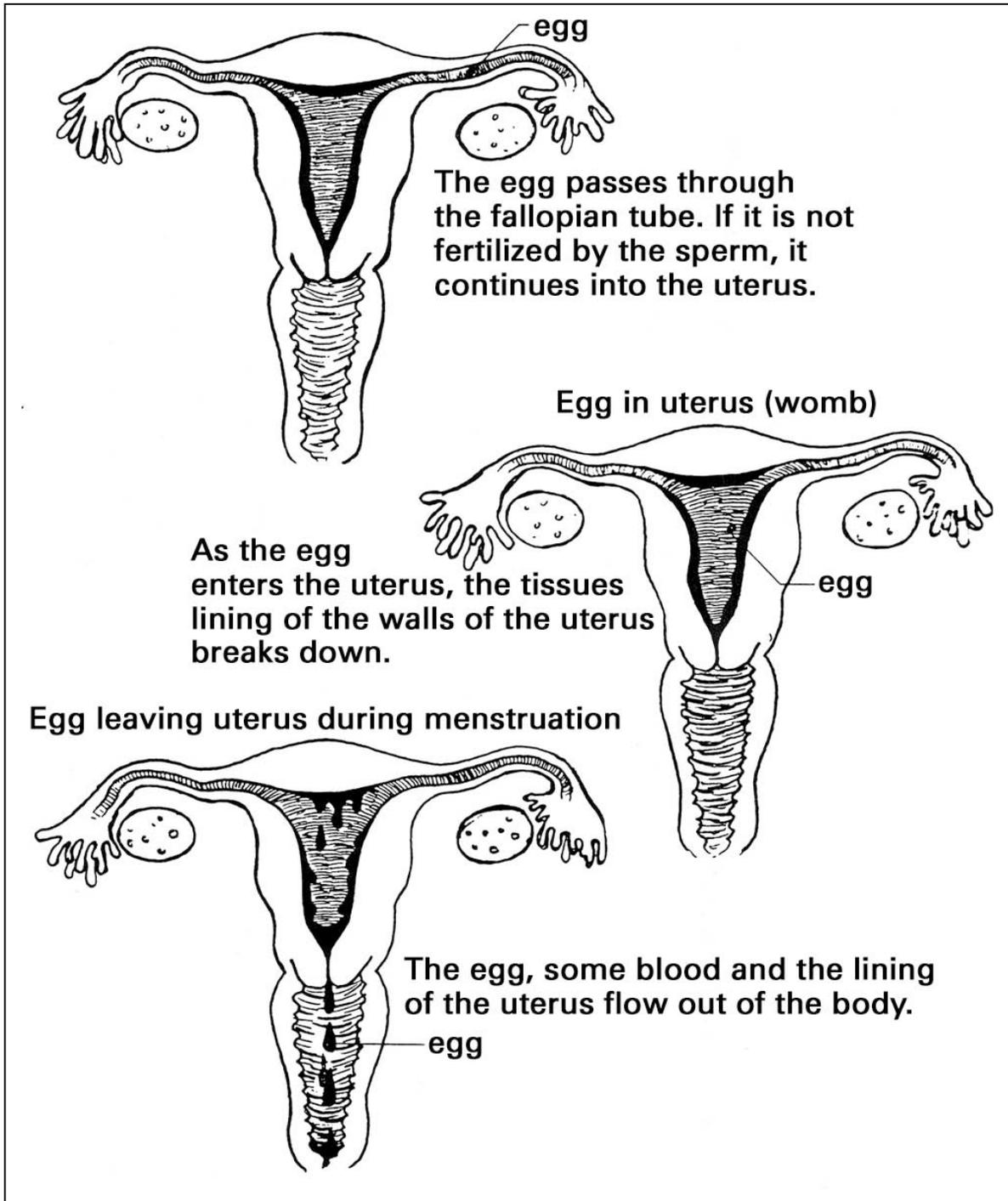
days but can vary between 21 and 35 days, or even more. The first day of the menstrual period is counted as “Day 1” of the cycle. The length of each period, as well as the amount of bleeding, varies from woman to woman. A woman can get pregnant only if she has sexual intercourse with a sexually mature male just before ovulation, or the day she ovulates. In an average 28-day cycle, a woman can get pregnant if she has intercourse on days 11–14.



The menstrual cycle

The process of menstruation

An unfertilized egg leaves the womb through the process of menstruation.





Menstruation related problems

Menstruation is a normal biological process, but it may cause distressing physical or psychological symptoms in some women. Two common problems are dysmenorrhea and premenstrual tensions.

Dysmenorrhea (painful menstruation) is characterized by cramps in the lower abdomen, backache, a bloated feeling, nausea, vomiting, diarrhea, and loss of appetite. Any drug such as aspirin or ibuprofen that blocks the effects of prostaglandins will usually be effective in alleviating some of the symptoms of dysmenorrhea.

Premenstrual tension involves negative mood changes and physical symptoms associated with the time immediately preceding the onset of menses, (hence the name premenstrual). A more serious condition known as Premenstrual Syndrome (PMS) is experienced by a smaller number of women.

Ovulation

Each month, a mature egg (ovum) is released from one or two of the ovaries and moves to the fallopian tube; this is called ovulation (the release of the egg). The egg can survive for only about one day (24 hours) in the fallopian tube. If a sperm does not fertilize it within that time, it dissolves or flows out of the body.

Remember, ovulation occurs in the middle of the menstrual cycle, or about halfway between periods (depending on the length of the menstrual cycle). However, it is often difficult to know when ovulation is taking place if women have irregular menstrual cycles.

Conception

The process of conception involves the fusion of an egg (ovum) from a woman's ovary with a sperm from a man. Every month during a woman's fertile years, her body prepares itself for conception and pregnancy. In one of her ovaries an egg ripens and is released from its follicle.

The egg – about the size of a pinpoint, 1/250 inch in diameter – is then drawn into the fallopian tube through which it travels to the uterus. The journey takes three to four days. The lining of the uterus has already thickened to assist the implantation of a fertilized egg, or zygote. If the egg is not fertilized, it lasts 24 hours and then disintegrates. It is expelled along with the uterine lining during menstruation.

Sperm cells are produced in the man's testes and ejaculated from his penis into the woman's vagina during sexual intercourse. Sperm cells are much smaller than eggs (1/1800 inch in diameter). A typical ejaculation contains millions of sperm, but only a few complete the long journey through the uterus and up the fallopian tube to the egg. Of those that reach the egg, only one will be allowed to penetrate the hard outer layer of the egg. As the sperms approach the egg, they release enzymes that soften the outer layer of the egg. The first sperm cell that bumps into a spot that is soft enough can swim into the cell. It then merges with the nucleus of the egg and fertilization occurs.

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

The ovum (egg) carries the hereditary characteristics of the mother and her ancestors; sperm cells carry the hereditary characteristics of the father and his ancestors. Together they

contain the genetic code, a set of instructions for development. Each sperm cell, egg or sperm, contains 23 chromosomes, and each of these chromosomes contains genes, so small that they cannot be seen through microscope. These genes are packages of chemical instructions for designing every part of a baby. They specify that the infant will be human; what the sex will be; whether it will tend to be (depending also on its environment) short, tall, thin, fat, healthy, or sickly; and hundreds of other characteristics. Together, they provide the blueprint for a new and unique person.

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

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

Terms

Conception	The formation of a zygote (fertilized egg); the cell resulting from the fusion of ovum and sperm, and under normal conditions, capable of surviving and maturing in the uterus.
Follicles	The thousands of protected, enclosed spherical bubbles in the ovaries in which ova mature. Each follicle contains liquid supplied with estrogen.
Fertilized egg	The egg after it has been penetrated by a sperm; a zygote.
Fertilization	The initiation of biological reproduction, as, for example, when the sperm and egg unite to form a zygote (fertilized egg).
Genetic code	Master blueprint messages directing the body's growth and cell differentiation, contained in genetic material.
Fraternal twins	Twins who develop from separate fertilized eggs; not generally identical.
Identical twins	Twins who develop from the division of a single zygote; generally identical.

Source: Insel, et. al., 1994

Process facilitation: How pregnancy happens

Getting started: (25 minutes) You will probably start this session in the morning. Then

1. Ask the person assigned to conduct check-in (3–5 minutes)
2. Ask also the other person assigned to conduct energizer or warm up. This will reactivate participants for the learning.
3. Remind the others assigned for the day as timekeeper, recap, evaluation, etc to be alert.
4. Then, make a brief recap (or ask the person assigned) of what has been covered so far (3–5 minutes).
5. Finally, introduce the process of conception, using the illustrations (7–10 minutes).

6. Then, lead the group to carry out the following exercises:

Exercise 1: Exploring experiences on how pregnancy occurs

Purpose: By the end of the exercise, participants have explored and improved their knowledge on how pregnancy occurs

Method: Large and small group work

Tools: Buzzing, brainstorming, and illustrations

Duration: 45 minutes

The facilitator will:

1. Ask the participants to remain seated and form buzz groups of 3 people each.
2. Ask them to assess: their knowledge, beliefs, and misconceptions from their experience, observation, and reading, including the handout on how pregnancy occurs.
3. Tell participants to concentrate on how pregnancy occurs. Please, do not spend time discussing problems of pregnant women, unwanted pregnancy, and abortion. These will be dealt with later. (Allow 7minutes)
4. When the allotted time is up, ask presenters of each group to share their experience by brainstorming only.
5. Record the main points on a flip chart or large pieces of paper.
6. Add missing facts, using the handout and clarify misconceptions.
7. Summarize (3 minutes) the main points learned about
 - Pregnancy
 - Process of menstruation
 - Ovulation and
 - Conception
8. Ask for feedback. **Has** the exercise helped them to explore how pregnancy happens? Were there any difficulties with the exercise?

Exercise 2: Exercise on and analysis of the menstrual cycle

Purpose: To enable participants get clear understanding of menstrual cycle

Method: Small and large group work, analysis questions

Tools: Drawing

Duration: 45 minutes

Note: A clear knowledge of the menstrual cycle is crucial for a good understanding of pregnancy and its management, or control of conception. Participants should take some time to analyze and do the exercises on the menstrual cycle.

The facilitator will:

1. Ask participants to form groups of 4, 5 or 6.
2. Give them flip charts or large pieces of paper and markers.
3. Ask them to draw the menstrual cycle (5–7 minutes).

4. After 7–10 minutes, bring participants together, and ask one group to present their drawings of menstrual cycle (5 minutes).
5. Ask for comments and improvement of the drawing.
6. Ask them the following questions:
 - What causes menstruation?
 - Describe the role of menstruation in pregnancy.
 - Identify the age when a girl can get pregnant and a boy can impregnate.
 - What are the body elements required for pregnancy to take place?
 - What makes it difficult for a girl to know the exact time when she ovulates?
7. Record the main points on a flip chart.
8. Write each of the 6 steps of menstrual cycle on separate sheets of paper (ask for help from participants).
9. Invite 6 volunteers to stand in front of the trainees forming a circle.
10. Randomly, give the prepared sheet to each one.
11. Ask them to read the text on the sheet of paper and line up according to the menstrual cycle.
12. Ask each to explain what he/she represents.
13. Summarize the main lessons learned and ask for feedback. Was the exercise helpful? What difficulties did they face with the exercise? How should it be improved?

Section 3: Unwanted pregnancy

Basic information: Handout

What is unwanted pregnancy?

Unwanted pregnancy is a pregnancy that occurs which is not wanted, mostly by the woman or her partner. Of course their friends, families and others may also have an opinion on the pregnancy but that is different. An unwanted pregnancy is different from an unplanned pregnancy. A pregnancy can be unplanned, or unexpected, and the woman or her partner are very happy about it. And of course a pregnancy can also be both unplanned and unwanted. Lastly, an unwanted pregnancy is different from an early pregnancy, a pregnancy which takes place in a young girl whose body is not mature enough to handle it well, and who is also not emotionally ready to be a mother. An early pregnancy can be wanted or unwanted, planned or unplanned – but it is still a danger to the girl and her baby.

Causes of unwanted pregnancy

The following are possible factors leading to unwanted pregnancy:

- Early marriage
- Peer pressure
- Sexual experimentation
- Unavailability of family planning services



- Misinformation or myths on male/female sexuality
- Fear or myths about contraceptive use
- Not using contraceptives
- Lack of knowledge or information
- Failure to use contraceptive methods properly
- Violence, such as rape and defilement
- Lack of ability to negotiate contraceptive use or safer sex

Health effects of early pregnancy

Serious health risks are associated with early pregnancy because a young woman's body is not mature enough to handle bearing a child. When a woman is under 20, the pelvic area (the bone surrounding the birth canal) is still growing and may not be large enough to allow the baby to easily pass through the birth canal. This can result in what is called an "obstructed labor". Obstructed labor is dangerous to both mother and child, and requires the help of trained medical professionals. Under the best circumstances, the young woman will have an operation called a "caesarean section" in which a cut is made in the abdomen and the baby is removed directly from the uterus. A major contributor to high maternal mortality rates is adolescent pregnancy.

If a young woman is not physically mature, the uterus may tear during the birth process and she may die because of blood loss. If she is lucky and survives the delivery, she might face fistula due to prolonged labor. A baby's head can also tear the vagina causing a hole between the vagina and bladder or between the vagina and the rectum, resulting in what is known as a fistula. Unless she has an operation to fix her problem, for the rest of her life she will not be able to hold her urine or faeces and this will make her a social outcast.

In addition, younger women who become pregnant face a higher risk than older women in developing a number of other complications such as

- Excessive vomiting
- Severe anaemia
- Hypertension
- Convulsions
- Difficulty in breast feeding (if the girl is too young to produce milk)
- Premature and low birth weight babies
- Infection
- Prolonged labour
- High maternal mortality or death

The risk of having serious complications during pregnancy or childbirth is much higher for girls in their early teens than for older women. Ages of 20–30 years are the safest period of women's life for child bearing. The major difference between girls in their early teens and older women is that girls aged 12–16 years are still growing. The pelvis or bony birth canal of a girl can grow wider by as much as 20% between the time she begins menstruating and the time she is 16 years old. This widening of the pelvis can make the crucial difference between a safe delivery and obstructed labour.

It is not surprising, therefore, to find that obstructed labor, due to disproportion between the size of the infant's head and the mother's pelvis, is most common among very young mothers. The consequences of such obstructed labor may be death due to numerous complications or lifetime crippling conditions of vesico vaginal fistula.

What is obstetric fistula?

Obstetric fistula is a childbearing injury that is usually caused by several days of obstructed labour, without timely medical intervention - typically a Caesarean section - to relieve the pressure. Unattended obstructed labour can last for up to six or seven days, although the foetus usually dies after two or three days. During the prolonged labour, the soft tissues of the pelvis are compressed between the descending baby's head and the mother's pelvic bone. The lack of blood flow causes tissue to die, creating a hole between the mother's vagina and bladder (known as a vesico vaginal fistula), or between the vagina and rectum (causing a recto vaginal fistula) or both. The result is a leaking of urine or faeces or both (UNFPA 2004).

The consequences of fistula are often life shattering: In about 95 % of cases, the baby dies. The woman is left with chronic incontinence. Because of her inability to control her flow of urine or faeces, she is often abandoned or neglected by her husband and family and ostracized by her community. Without treatment, her prospects for work and family life are greatly diminished, and she is often left to rely on charity (UNFPA 2004).

What causes a fistula to occur?

Fistula occurs when emergency obstetric care is not available to women who develop complications during childbirth. Poverty, malnutrition, poor health services, early marriage and gender discrimination are interlinked root causes of obstetric fistula. Poverty is the main social risk factor because it is associated with early marriage and malnutrition and because poverty reduces a woman's chances of getting timely obstetric care.

Because of their low status in many communities, women often lack the power to choose when to start bearing children or where to give birth. Childbearing before the pelvis is fully developed, as well as malnutrition, small stature and general poor health, are contributing physiological factors to obstructed labour. Older women who have delivered many children are at risk as well.

How can fistula be prevented?

According to UNFPA, prevention, rather than treatment, is the key to eradicate fistula. Making family planning available to all who want to use it would reduce maternal disability and death by at least 20%.

Complementing that with skilled attendance at all births and emergency obstetric care for those women who develop complications during delivery would make fistula as rare in the South as it is in the North. Addressing social issues that contribute to the problem - such as early pregnancy, girls' education, poverty and women's empowerment - are important areas of intervention as well.

Yes, fistula is treatable as well as preventable. Reconstructive surgery can mend the injury, and success rates are as high as 90% for uncomplicated cases (for complicated cases, the success rate is closer to 60%). Two weeks or more of post-operative care is needed to ensure a successful outcome. Counseling and support are also important to address emotional damage and facilitate social reintegration. When surgery cannot correct the problem, women undergo a procedure called a urostomy, and they wear a bag to collect their urine. If the surgery is successful, women can resume full and productive lives. They can



usually have more children, but caesarean sections are recommended to prevent a recurrence of fistula.

Sadly, most fistula sufferers are either unaware that treatment is available or cannot access or afford it. In addition, treatment capacity in most areas where fistula is common cannot meet the demand. The key to ending fistula is preventing it from occurring so this backlog of cases will not continue to grow.

Social consequences of unwanted adolescent pregnancy

The social consequences of unwanted pregnancy are equally devastating. For a young girl, an unwanted pregnancy can be a disaster; she may be far from being emotionally ready to have a baby. Most adolescents who become pregnant are forced to drop out of school and may never return, affecting their future life negatively. Several of them may not even get married and establish a family. Besides, they may be shamed in families and communities. This may entail unstable and distressing emotional turmoil where the young girl may be tempted to illicitly terminate the pregnancy or resort to suicide. Quite a number of young girls in this situation may run away from home and end up as sex workers and/or living in poverty with their children.

The girl's partner often denies his responsibility for her condition. Child abandonment or neglect is also a common consequence of unwanted pregnancy.

A boy bears equal responsibility for pregnancy

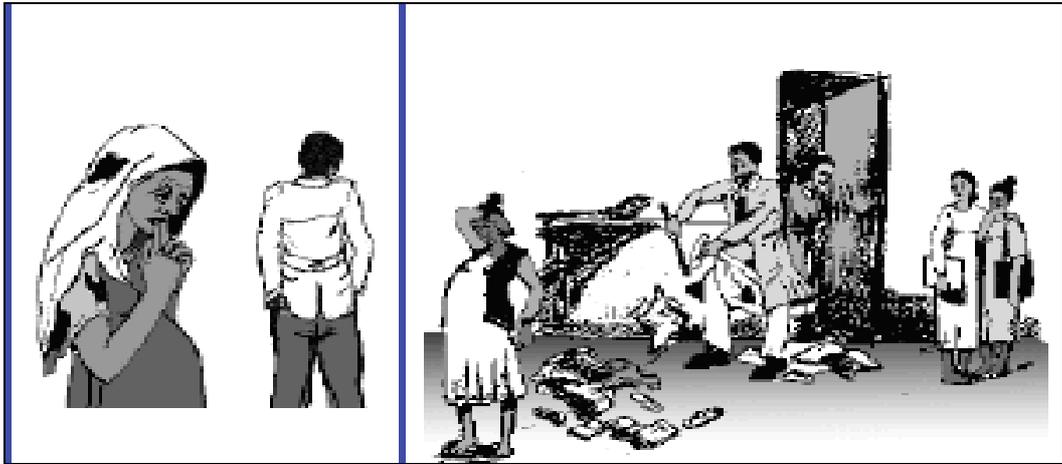
Remember, the boy/man bears **equal responsibility** for each and every pregnancy.

If a boy/man is sexually active, he should be extremely responsible and careful. There are no safe days for adolescent girls and an early pregnancy could be dangerous for her health. It could be even worse for her future and for the future of the boy because both might have to **end their studies** to look after and support the baby.

Therefore, do not take risks. Practice safer sex and make sure that you use contraception each and every time.

If you do become a father, **accept responsibility for your actions**. Talk to your girlfriend about how the two of you can raise the child. Ask her how you can help her with her pregnancy (taking her to the doctor etc.). Even if you and her don't have a close relationship, don't run away - talk to her about how you can be involved in the child's life.

Source: Watson, E. and Brazier, E.



Prevention of unwanted pregnancy

The following prevention strategies are suggested for clubs conducting peer education programs:

1. Increasing knowledge on reproductive systems
2. You should have adequate information about male and female reproductive systems, since poor knowledge about human sexuality is one of the causes of unwanted pregnancy (see Unit 3).
3. Increasing the contraceptive knowledge.
4. Young people with poor knowledge about family planning practices run high risks of unwanted pregnancies. Even those with some rudimentary knowledge have fears and misconceptions about using contraceptive methods. Therefore, sufficient knowledge about contraception needs to be imparted to these high-risk groups (see Unit 9).
5. Once the youth acquires adequate knowledge about family planning, the contraceptive methods should be made available to avoid unwanted pregnancy.
6. Use of emergency oral contraception.
7. Oral contraceptives taken in certain dosages and within a certain period of time after unprotected sex can help avoid pregnancy. Emergency contraception will have no effect if implantation of a fertilized egg in the uterus has already taken place. But, it should not be used if you are not certain if you are already pregnant or not, as it may interfere with fetal development. This method is less effective than other family planning methods and it should not be relied on routinely. For emergency contraceptives, young girls should consult health professionals.
8. Developing essential life skills.
9. Being young is wonderful but can be dangerous, and developing the essential life skills for the prevention of risky behaviour should be underlined (see Unit 6).
10. In the following sections, the facilitator should lead the participants to learn, explore and analyze the causes and effects of unwanted pregnancy; then have them seek solutions for preventing unwanted pregnancy.

Process facilitation: Causes and effects of unwanted pregnancy

Getting started: (15 minutes) Before starting this section, ask the person assigned to conduct energizer (3–5 minutes).

1. Briefly recap (3 minutes) what has been covered in the previous session.
2. Briefly introduce the main content of the handout (5–7 minutes).
3. Tell participants that we are now going to analyze together unwanted pregnancy in depth and conduct exercises.

Exercise 1: Identifying causes and consequences of unwanted pregnancy

Purpose: To enable participants to identify causes and consequences of unwanted pregnancy

Method: Small group work

Tools: Brainstorming

Duration: 30 minutes

The facilitator will:

1. Arrange participants in small groups of 3, 4 or 5 persons and identify the causes and consequences of unwanted pregnancy. They may not have personal experience about unwanted pregnancy, but they might know of other boys and girls who are confronted with it or they might have heard and read about it. They should not mention names of persons known.
2. Ask each group to come up with 3 causes and 3 consequences (10 minutes). Tell them not to deal with the prevention steps at this stage.
3. After 10 minutes, bring participants together as a group. Ask presenters to share by brainstorming the findings of their small group.
4. Record the main points under separate headings: causes and consequences.
5. Screen repeats and overlaps and then merge similar ideas.
6. Add missing ideas from your reading of the basic information.
7. Summarize and ask for feedback from participants whether participants are able to identify causes and effects of unwanted pregnancy or not?
8. At this stage, you also need to think very carefully about how you run the next sessions. It is important that evaluation feedback be incorporated into the upcoming sessions by the facilitator.

Section 4: Abortion

Basic information: Handout

What is abortion?

Abortion is the expulsion of the fetus from the uterus before it is sufficiently developed. The most common time for abortion to occur is between 8 and 13 weeks into the pregnancy.

Types of abortion

Spontaneous abortion

Spontaneous abortion (also called a “miscarriage”) occurs without any deliberate or external manipulation to terminate the pregnancy.

Induced abortion

This is a deliberate termination of the pregnancy by mechanical or chemical means. Depending on the country, such acts of deliberately terminating a pregnancy can be illegal.

Therapeutic abortion

This is a deliberate termination of a pregnancy, which is a serious threat to the life of the mother. Even in many countries where induced abortion is illegal, exceptions are made to allow therapeutic abortions.

Unsafe abortion

An unsafe abortion is any abortion (legal or illegal) performed under conditions that represent a threat to the health of the pregnant woman. Generally an abortion is considered unsafe when it is performed by an untrained (or poorly trained) person or using dirty instruments in unclean surroundings. An unsafe abortion carries with it a number of risks, which are discussed in greater detail below.

Reasons for choosing an abortion

A young woman may decide to terminate the pregnancy because,

- She wants to continue with her education.
 - In many countries where abortion laws are restrictive, girls can be expelled from school as soon as the pregnancy is discovered. (It is worth noting that the man or boy responsible for the pregnancy usually goes unpunished).
- She does not want to bring shame to her family.
 - In many communities in Africa, pregnancy before marriage is treated with shame and as evidence of poor parenting - a judgment many mothers and fathers cannot live with.
- She may be abandoned by her husband, boyfriend or partner
- She is a victim of rape or defilement or incest and does not want to prolong her agony by bringing the pregnancy to term.
- She lacks support during pregnancy.

Source adopted from: The National Training Curriculum for health workers on Adolescent Health

Consequences of unsafe abortion

The consequences of and complications arising from unsafe abortion are multiple and may occur immediately or later. They can be categorized as medical, psychological, social and economic.

Risks associated with an unsafe abortion

1. Medical

Medical complications include,

- Infection (like sepsis)
- Hemorrhage (heavy bleeding)
- Injuries to tissues and organs
- Generalized infection in the blood stream (septicemia)
- Anaemia (due to loss of blood)
- Death

2. Psychological

Psychological consequences arising from unsafe abortion include,

- Depression
- Withdrawal and
- Sexual dysfunction

Note: Sometimes psychological problems may linger and require specialized care usually not available to adolescents because of the stigma attached to unmarried pregnancy.

3. Social

Social complication of unsafe abortion include,

- Dropping out of school
- Stigmatization (disgrace and dishonour)
- Rejection by the community
- Being forced to leave home
- Early marriage (often forced by parents)
- Poverty
- End of the relationship with the father of the child

4. Economic

Unsafe abortion has also economical impact including,

- Hospital costs (which may be enormous) and
- Impact of not being able to work or attend school

Process Facilitation

Abortion, its causes and potential consequences

Getting started: (25 minutes) You will probably start this session in the morning. In this case, ask the person assigned to conduct check-in (3–5 minutes). Ask also the other person assigned to conduct energizer or warm up by telling jokes or performing songs or games. This will reactivate participants for the learning. Remind the others assigned for the day as time-keeper, recap, evaluation, etc., to be alert.

Then, make a brief recap (or ask the person assigned) of lessons learned from the previous section on unwanted pregnancy and its relation to abortion (3 minutes), and then briefly introduce the background information on abortion (5–7 minutes). Finally, facilitate the exercises.

Exercise 1: Exploring experiences of abortion

Purpose: Participants will learn about the nature, causes and potential dangers of abortion

Method: Whole group and small group discussions

Tools: Body language, role-play, brainstorming, ranking

Duration: 45 minutes

The facilitator will:

1. Ask participants to form small groups of 4, 5 or 6.
2. Ask them to explore their knowledge about abortion (10 minutes).
3. Remind the groups not to spend time discussing prevention at this stage but concentrate on the incidences, causes and consequences. The following are examples of questions they could work on:
 - What is the abortion rate among our peers?
 - What is the level of awareness among the peers?
 - What do we know about the causes of abortion?
 - What do we know about the consequences of abortion?
4. Ask them to identify 3 potential causes and 3 potential consequences.
5. Ask them to prioritize them in order of their frequency and severity. When the allotted time is up, bring the groups together for experience sharing.
6. Ask presenters of each group to brainstorm, the first two causes and effects from the prioritized list.
7. Record findings of each group on a flip chart in separate columns. First, the causes in one column and then the consequences in another (see the example below).
8. After presentations, screen and merge repeats and overlaps along with participants.

9. Ask participants in the large group to rank the causes first (what do they see as the most likely, or common reasons) and then the potential consequences.

Potential causes and consequences of abortion (an example)

Causes	Consequences
Miscarriage	Medical, health complications
Unwanted pregnancy	Social isolation
Risks to the mother	Expenses
Unable to raise a child	Relief
Pressure from sexual partner involved	
Pressure from family or friends	

Section 5: Harmful practices affecting young people's sexual and reproductive health

Basic information: Handout

Harmful practices

Culture and tradition play a significant role in shaping the way young people and adolescents behave and lead their lives. However, young people have become victims of some harmful traditional practices, which affect their human and reproductive rights. These practices differ from place to place but primarily affect women. Among the most widely practiced are: female genital mutilation/cutting; early marriage; wife (widow) inheritance; and sexual violence.

Female Genital Mutilation (FGM)/ Female Genital Cutting (FGC)

Increasingly, FGM/FGC is seen as a violation of basic rights and a form of sexual discrimination. FGM/FGC refers to the removal of all or part of the female external genitalia. It is practiced in more than 30 African, 7 Middle Eastern and 4 Asian countries and even in Western Europe, the UK and the US where certain ethnic groups from these countries have migrated.

Types of FGM/FGC

FGM/FGC is practiced in many forms; the most common ones are :

Sunna: in which the tip of the clitoris and/ or its covering (prepuce) are removed.

Clitorodectomy: where the entire clitoris, the prepuce and adjacent labia are removed.

Infibulation: also known as **Pharonic Circumcision**, which is the clitorodectomy followed by sewing up of the vulva. A small opening is left to allow urine and menstrual blood to pass. In some cultures the woman is cut open by her husband or elderly women on her wedding night. She may be sewn up again if her husband leaves on long trip.

Consequences of FGM/FGC

FGM/FGC doubles the risk of women's death in childbirth and increases the risk of a child being stillborn (dead before delivery from the uterus) by up to four times. There are also

more immediate consequences for women or girls who undergo the practice and these can include,

- Hemorrhage
- Chronic urinary and pelvic infections
- Keloid formation
- Labial adhesences
- Clitoral cysts
- Pain-induced shock (since no anaesthetics is used)
- Urine and menstrual blood retention
- Damage to urethra and anus
- Painful scars resulting in painful sexual intercourse
- Sexual dysfunction
- Risk of STIs including HIV/AIDS
- Obstructed labour
- Psychological trauma
- Sterility, and
- Different gynaecological and obstetric problems

Early marriage

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

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

Wife (widow) inheritance

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

Sexual violence

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

Sexual abuse

Sexual abuse is defined as “Violation perpetrated by a person who holds, or is perceived to hold, power over someone who is vulnerable” (Shanler 1998:1).

The abuse may have physical, verbal and emotional components. It includes such sexual violations as rape, sexual assault, sexual harassment, incest, and sexual molestation.

Sexual harassment

Sexual pressuring of someone in a vulnerable or dependent position - a youth, employee, or student for example - is termed as sexual harassment. Employers, teachers, or other people in authority may use their ability to control or influence jobs or grades to coerce people into sexual relations or punish them if they refuse. In extreme cases, a person may be threatened with being fired or being given bad grades if she or he will not submit to the demand.

Sexual harassment can take a variety of forms, including verbal sexual remarks about clothing or appearance, unnecessary touching or pinching, and demands for sexual favours.

Sexual assault: Rape

Sexual coercion that relies on the threat or use of physical force or takes advantage of circumstances that render a person incapable of giving consent to sexual intercourse (such as when drunk) constitute sexual assault or rape.

When the victim is younger than the legally defined “age of consent,” the age at which a young person is said to be capable of fully understanding and consenting/agreeing to sexual intercourse, the act constitutes statutory rape (often referred to as “defilement”), whether or not coercion is involved. Many countries set 16 as the legal age of consent.

Rape victims suffer both physical and psychological injury. For most, physical wounds are not severe and heal within a few weeks. Psychological pain lasts longer and is often considered to be worse than the physical suffering.

Terms

Sexual Coercion	Use of physical or psychological force or intimidation to force a person to submit to sexual demands.
Sexual Harassment	Sexual pressuring of someone in a vulnerable or dependent position, such as a youth, student, employee.
Sexual assault	Use of force to gain sexual access to someone.
Rape	Coercing a person into sexual relations by threats or use of force.
Statutory Rape	Sexual interaction with someone below the age of consent.

Section 6: Drugs and drug abuse

Basic information: Handout

The use and – more dangerously – the abuse of drugs is increasing among young people around the world.

Drugs are defined as chemicals other than food intended to affect the structure or function of the body. They include prescription medicines, such as antibiotics or tranquilizers; over the counter remedies, such as alcohol, tobacco and caffeine products; and illegal substances such as cocaine, marijuana, and heroin. Here, we will deal with psychoactive drugs and chemicals that can alter a person’s consciousness, mood, behaviour or perceptions.

In most cases young people start using drugs without knowledge of the consequences that can arise from such a habit. Drugs change the way a person feels, thinks, sees, tastes, smells, hears, walks or behaves. Drugs can make people feel temporarily better about themselves, more sociable and smarter, better looking and more fun to be around. But these

positive feelings do not last long and are often replaced by behaviours and attitudes that are very damaging to a person's health, family and community life.

Drug abuse

Drug abuse is a maladaptive pattern of use of any substance that persists despite adverse social, psychological, or medical consequences.

Drug abuse can lead to unsafe behaviours because a person under the influence of drugs can and will make dangerous choices that can lead to pregnancy and STDs, including HIV/AIDS. The most widely consumed drug worldwide is cannabis. Three-quarters of all countries report heroin abuse and two-thirds report cocaine abuse.

Drug-related problems include increased rates of crime and violence, susceptibility to HIV/AIDS and hepatitis, demand for treatment and emergency room visits; and a breakdown in social behaviour.

Besides the side effects and risks (including being arrested) that come with taking illegal drugs, there is also the risk that the drugs you buy are not necessarily the drugs you end up taking. Heroin, cocaine, ecstasy and even Marijuana are often mixed with other drugs and strange chemicals. This unknown combination can permanently damage health.

Drug dependence

Drug abuse can develop into drug dependence, also known as addiction. A person is dependent on a drug if he or she takes it compulsively, neglects constructive activities because of it, and experiences adverse social effects resulting from its use. Drug dependence can be physical and/or psychological.

Physical dependence

The hallmarks of physical dependence on a drug are tolerance and withdrawal. Tolerance occurs when the body adapts to the repeated effects of a drug so that higher doses are required to achieve the same effect. Physical addiction occurs if a withdrawal syndrome follows interruption of use of the drug. Withdrawals occur because the user's body gradually becomes accustomed to high levels of the drug, and when the drug is withdrawn, the body must rapidly adjust to the sudden drop in the concentration of the drug. Withdrawal symptoms begin as soon as blood levels of the drug user begin to fall and may last several days or longer. Symptoms can be mild or potentially fatal, depending on the type of drug and on the degree of physical dependence.

Psychological dependence

Psychological dependence involves an intense repetitive need or craving for the changes in feelings and mood that a particular drug provides. Physical changes contribute to these cravings, so psychological dependence has a physical component, but it can develop independently of physical dependence.

Psychological dependence can develop more rapidly than physical dependence, particularly for drugs that have strong, immediate effects. It is strongly affected by social factors. Particular situations, times of day or people may trigger the compulsive craving for a drug.

Terms

Drug abuse	A maladaptive pattern of uses of any substance that persists despite adverse social, psychological, or medical consequences. The pattern may be intermittent, with or without tolerance and physical dependence.
Dependence (dependency)	The compulsive use of a drug that results in neglect of constructive activities and adverse social consequences. Tolerance and physical dependence are often present.
Physical dependence	The result of physiological adaptations that occur in response to the frequent presence of a drug; interruption of drug use is followed by withdrawal syndrome. Also known as physical addiction.
Tolerance	Lower sensitivity to a drug so that a given dose no longer exerts the usual effect and larger doses are needed.
Withdrawal syndrome	The cluster of physical and psychological symptoms that follow.

Common drugs abused by young people and their effects

1. Marijuana (also known as Cannabis, Grass, Joint, Splif, Hashish, Pot, Weed)

Marijuana is a plant grown and used worldwide. Usually people smoke the leaves but the leaves and the stem can be made into tea or even cookies. The effects vary. You can stay under the influence for about two or three hours. Some people become relaxed and happy while others feel panic or fear. Users' eyes usually become red and their throats and mouths will become dry. Appetite may increase.

Effects

Marijuana causes increases in heart rate and dilation of certain blood vessels in the eyes, which creates the characteristics of blood-shot eyes. Chronic bronchial irritation is one of the long-term effects of chronic marijuana use.

Other potential adverse effects include; impairment of long term memory, gum disease, increased risk of cancers of the mouth, jaw, tongue and lung; and impairment of the immune system. Some studies have suggested that long-term marijuana use may result in decreased testosterone levels, decreased sperm counts, and increased sperm abnormalities in male users.

Heavy marijuana use during pregnancy may cause impaired fetal growth and development.

2. Mairungi (also known as Khat, Qat, and Mirraa)

Mairungi is the common name for a stimulant leaf that is chewed in much of East Africa. Chewing Mairungi can help someone feel more awake, confident and energetic and can also reduce hunger. In fact, many students use it when "cramming" for exams.

Effects

Negative effects include sleeplessness, anxiety, aggressive behaviour and hallucinations. Some men are unable to get an erection after they have been chewing.

3. Alcohol

Alcohol is the most common drug and is used worldwide. Because it is legal, often kept in the home, and comes in extremely cheap local brews, alcohol is extremely easy to find and consume. At first, alcohol causes relaxation and people feel less self-conscious. After more alcohol is drunk, reaction time slows down and thinking becomes confused. (This is why people who are drinking are often involved in car accidents).

Effects

Further drinking can cause slurred speech and aggressive behaviour that can lead to fights, rape or other kinds of violence. People who consume too much alcohol can end up vomiting, become unconscious or even dying.

Because both young men and women often lose their inhibitions when drinking, a girl might have unsafe sex with someone she doesn't know and a boy might decide to force someone to have sex. Of course, the consequences of these alcohol-based decisions can be very dangerous, even life threatening.

Remember: when people drink, their ability to make healthy and safe decisions is impaired.

4. Cigarettes (tobacco, cigars)

Many young people start smoking tobacco products for different reasons including: influence of friends, seductive advertisements, and older role models like siblings' or celebrities to mention a few. Young people find smoking a 'cool' thing to do but they become addicted to one of the most addictive and dangerous substances, Nicotine, which is an active ingredient in tobacco.

Effects

According to WHO (2006), tobacco is the second major cause of death in the world. Nicotine, which is found in tobacco products including cigarettes, is highly addictive. The tar in cigarettes increases a smoker's risk of lung cancer, emphysema and bronchial disorders. The carbon monoxide in smoke increases the chance of cardiovascular diseases. Inhaling smoke passively causes lung cancer in adults and greatly increases the risk of respiratory illness in children.

5. Cocaine (also known as Crack, Coke, C, Charlie, Nose candy, Toot, Bazooka, Big C, Cake, Lady, Stardust, Coco, Flake, Mister coffee)

Cocaine is prepared from coca leaves, which are greenish-yellow leaves of different size and appearance. Cocaine is often called the "champagne of drugs" because of its high cost. It makes one feel like his/her body is going very fast. His/her heart races and the "highs" and "lows" are sudden. Crack, which is smoked, is a much stronger form of cocaine. Cocaine usually comes in a white powdered form and crack looks like hard white rocks. It is usually snorted up the nose. It can also be injected or smoked.

Effects

A small amount of cocaine will raise body temperature, make the heart beat faster, increase the breathing rate, make you feel over confident and make you more alert with extra energy. When crack is smoked, all of these feelings are intensified. Excessive doses may lead to convulsions, seizures, strokes, cerebral hemorrhage or heart failure. Long term effects of cocaine/crack use will lead to strong psychological dependence, and other health problems like destroying nose tissues, reportorial problems and weight loss.

6. Heroin (also known as Hammer, Horse, H, Junk, Nod, Smack, Skag, White, beige, White lady, White stuff, Joy powder boy, Hairy, Harry, Joy powder)

Heroin is a drug obtained from morphine and comes from the opium poppy plant. Heroin is a drug that slows down the user's body and mind. It is a very strong painkiller and can be one of the most dangerous things to mix with other drugs. Heroin usually comes in a rock or powdered form, which is generally white or pink/beige in color and could also come in dark grey/medium brown. Heroin can be injected, snorted, smoked, or inhaled. This last method is often called "chasing the dragon".

Effects

When injected, heroin provides an extremely powerful rush and a high that usually last for between 4 to 6 hours. The effects of heroin include a feeling of well-being, relief from pain, fast physical and psychological dependence, sometimes nausea and vomiting, sleepiness, loss of balance, loss of concentration and loss of appetite. An overdose can result in death. One of the most dangerous effects of injecting heroin is the increased possibility of contracting AIDS. A lot of the time, people who inject heroin use each other's needles and this is the main source of infection.

Studies have also shown that people who are "high" on drugs tend to have unprotected sex. This too puts the person at risk of getting HIV.

7. Amphetamines (also known as Speed, Ice, Browns, Footballs, Hearts, Oranges, Wake ups, Black beauties, Crystal meth, Crack meth, Cat, Jeff amp, Dexies, Rippers, Bennies, Browns, Greenies, Pep pills)

Amphetamines are stimulants that affect a person's system by speeding up the activity of the brain and giving energy. Ice is a strong type of amphetamine, and is very similar to crack.

Amphetamines are man-made drugs and relatively easy to make. Usually, they are white or light brown powder and can also come the form of a pill. "Ice" usually comes as colourless crystals or as a colourless liquid when used for injecting. It can be swallowed, snorted, injected or smoked.

Effects

Amphetamines can cause an increase in heart beat, faster breathing, increase blood pressure and body temperature, sweating, make the person more confident and alert, give him/her extra energy, reduce appetite, make it difficult to sleep and might make the abuser talk more. The person using amphetamines may also feel anxious, irritable, and suffer from panic attacks.

Frequent use can produce strong psychological dependence. Large doses can be lethal.

8. Ecstasy (also know as Ecstasy, Adam, Essence, MDM, MDMA, XTC, Eve, MDE, MDEA)

Ecstasy belongs to the same group of chemicals as the above category that is stimulants, and is most often used in the form of tablets at rave parties. Ecstasy is a drug that speeds up the users system by increasing his/her physical and emotional energy. Like amphetamines, ecstasy is also a synthetic (or man-made) drug.

Ecstasy is usually a small, coloured tablet. These pills can come in many different colours. Some ecstasy tablets have pictures on them, such as doves, rabbits or champagne bottles. The colour or the "brand" of the tablet is usually unrelated to the effects of the drug. Ecstasy tablets are usually swallowed.

Effects

A person using ecstasy will probably feel happy, warm, loving and more energetic. He/she would feel emotionally close to others, and might say or do things that he/she usually would not. Nausea and vomiting, rise in blood pressure and heart rate, possibly even death due to overheating of the body and dehydration or loss of water are some effects of ecstasy. Feelings of depression and tiredness are common after stopping the drug. There is mounting evidence that prolonged ecstasy use can lead to brain and liver damage.

9. Inhalants and solvents

Inhalants and solvents are chemicals that can be inhaled, such as glue, gasoline, aerosol sprays, lighter fluid etc. These are not drugs as such and are, in fact, legally available from a large number of shops. However, they are abused widely by the poorer sections of society, particularly street youth. Inhalants can look like almost anything (glue, paint thinner, gasoline, lighter fuel, cleaning fluids, etc). They usually come in tubes or bottles.

Often, the chemical is placed in the bottom of a cup or container and then placed over the nose and mouth. Other methods include: soaking a rag in inhalant; placing the rag in bag or sack and then placing the bag over the face and inhaling the vapors.

Effects

Inhalants may give the user a „high“ for a very brief period of time. They make him/her feel numb for a short period of time, dizzy, confused, and drowsy. They can also cause headaches, nausea, fainting, accelerated heartbeat, disorientation, and hallucinations. They can damage the lungs, kidney and liver in the long term. They can also cause suffocation, convulsions, and comas.

Staying off drugs

In order to stay off drugs young people need to remember a number of things.

- You don't need to take drugs to be liked by other people.
- You don't need to take drugs to feel brave or courageous.
- You don't need drugs to cope with sorrow or disappointments.
- You have, inside you, the strength and inner resources to deal with any situation and any problem.
- Whatever problem you are facing; there are people available to help you. You can talk to a friend, a teacher, a parent, or a trusted person at your church or mosque.

Here are a few other ways to avoid getting involved with drugs:

- **Get active:** Get involved in activities at your church/ mosque and in sport groups. These things will fill your time and will help you feel good about yourself. You won't be bored and you won't need to look to drugs for entertainment.
- **Respect Yourself:** Don't take drugs or alcohol to impress other people or to find the courage to do something. Respect yourself and other people will respect you, you will find the courage to do whatever you want to do.
- **Seek positive acceptance:** There are many ways to feel accepted and liked by other people - and they are more beneficial than taking drugs or alcohol. Join groups of people who are focused on doing something like singing, playing sports, acting, studying, or helping people in the neighborhood. Find people who will like you for who you are and what you can do, people who aren't wasting their time with drugs.
- **Have your own values:** Look at yourself. What are your values? What's right for you? Stand up to yourself and what you believe in.
- **Have goals:** What are your dreams? Look into the future, see where you want to go and then go there!
- **Get help:** If you are feeling under pressure to take drugs, talk to a youth counselor. Get help! If you think you have a drug problem, try to find counseling and treatment. It is never too late.

Source adopted from Watson, C. and Brazier, E.

Process facilitation: Drugs and behaviour

Getting started: (15 minutes) Before starting the exercise, make a brief recap of the previous session (3 minutes) then, briefly introduce

Exercise 1: Exploring the different kinds of drugs and their risks

- Purpose: To enable participants to identify different kinds of drugs and the risks involved in using them
- Method: Small and large group work
- Tools: Brainstorming
- Duration: 45 minutes

The facilitator will:

1. Ask participants to form small groups of 4–6 people.
2. Ask the groups to brainstorm the various kinds of drugs and the risks involved in using them (using the handout if necessary). Encourage groups to name risks that are not listed in the handout.
3. When the allotted time (15 minutes) is over, bring the participants back together.
4. Ask presenters from each group to list the various drugs and the risks involved. Merge overlapping statements
5. Summarize the points made and ask for feedback from the participants. Has the exercise enabled them to identify the various drugs and the risks involved in taking them?
6. Keep the chart with the drug risks posted on the wall for future use.

Kinds of drug and their Effects (an example)

Kind of Drug	Risk
Marijuana	Panic, fear, lung damage, loss of concentration and memory
Mairungi	Anxiety, hallucination, inability to sleep
Alcohol	Vomiting, unsafe sex, aggression, death
Tobacco	Cancer, stroke, heart attack
Petrol, paint thinner, solvents, glue	Brain damage, suffocation, nausea
Ecstasy	Dehydration, depression, blood clotting, death
Cocaine	Anxiety, paranoia, aggression, sleeplessness, HIV infection
Crack	Aggression, increased heart rate, paranoia, madness
Heroin	Nausea, mental health issues, HIV infection
Hallucinogens	Anxiety, violent behaviour, madness, death
Tranquilizers	Depression, anxiety, death

Exercise 2: Signs that someone is taking drugs

Purpose: To enable participants to recognize the signs of drug abuse

Method: Small group discussion, larger group discussion

Tools: Brainstorming

Duration: 30 minutes

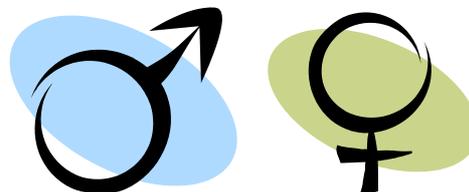
The facilitator will:

1. Ask participants to form small groups (4–6 people).
2. Ask them to brainstorm the signs indicating that someone has a drug problem on the basis of their experience and based on the handout (15 minutes) and list five of each on a flipchart.



3. Bring the group back together.
4. Ask presenters from each group to present the five signs.
5. Screen repeats and merge overlapping statements.
6. Summarize the results and ask for feedback from the participants. Has the exercise enabled them to identify the signs of drug abuse?
7. Keep the chart with the prioritized signs posted on the wall for future use.

Unit 6. Life skills in developing positive sexual behaviours



Basic information: Handout

What are life skills?

Life skills have been defined in various ways including:

- “Abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of everyday life” (WHO 1994).
- “Personal and social skills required for young people to function confidently in the community” (Ugandan, Life Skill Initiative, P.6).
- “Skills required for positive living and survival”.
- “Life skills provide a link between motivating factors and behaviour by translating knowledge of ‘what to do’ and the attitudes and values of what ‘one should do’, into abilities for ‘how to do’.

For the purpose of this guide the following working definition will be used:

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

Aim of sexual and reproductive health life skills

The main aim of the following life skill exercises is to promote abilities in:

1. Making positive sexual health choices,
2. Making informed decisions on sexual matters,
3. Practicing healthy sexual behaviours,
4. Recognizing and avoiding situations and behaviours that are likely to pose risks to sexual health.

Benefits of life skills

Life skills promote health behaviours that may reduce early sexual involvement, early pregnancy and the risk of STIs, including HIV transmission.

They are designed to empower young people to act positively and effectively when confronted with difficult situations. Furthermore, life skills enable young people to protect their own sexual health as well as that of others.

Types of life skills

Life skills are numerous and it is difficult to limit their type and number. However, for the purpose of this guide, the following core life skills have been identified:



Core life skills

- | | | | |
|---|----------------------------|---|-------------------------|
| 1 | Assertiveness | 2 | Effective communication |
| 3 | Interpersonal relationship | 4 | Self-esteem |
| 5 | Problem solving | 6 | Peer resistance |
| 7 | Critical thinking | 8 | Decision making |
| 9 | Self awareness | | |

Assertiveness

Assertiveness refers to the ability or competence to express one's feelings, needs or desires openly and directly but in a respectful manner.

The following are examples of abilities:

- To stand firmly by your beliefs without putting down others in the process.
- The ability not to be exploited or used against your will.
- The ability to reject undesirable behaviour.
- The ability used to reject unequal treatment.
- The ability to overcome submissiveness and uphold one's decisions, e.g. saying „No“ to unwanted sexual activity.

Effective communication

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

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

The following are examples of abilities in effective communication:

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



- The ability to use body language and smiling, a facial expression that inspires trust and friendliness.
- The ability to provide facts and raise awareness.

Interpersonal relationship

“Interpersonal relationships” refer to the abilities to:

- Coexist amicably with other people and construct meaningful and healthy associations with them.
- Understand, form and develop mutually beneficial friendship.

To understand that people form deep one-to-one relationships with those they love and are committed to. It is only in the context of these loving and respectful relationships that our sexuality can be expressed in a healthy and full way.

Examples of interpersonal skills are:

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

Self-esteem

Self-esteem, the basis of all life skills is the way an individual feels about her/ himself and how they believe others feel about them. It has been described as an awareness of one’s worth as a unique and special person endowed with various attributes and great potential. A person’s self-esteem can be either damaged or enhanced through relationships with others. High self-esteem tends to encourage and reinforce healthy behaviour. Low self-esteem tends to encourage unhealthy behaviour.

Examples of self-esteem are abilities to:

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

Problem solving

Problem solving is the ability to identify, cope with and find solutions to difficult or challenging situations. Problem solving is related to decision-making and the two may often overlap. It is



only through practice in making decisions and solving problems that young people can develop the skills necessary to make healthy choices for themselves.

Examples of sexual and reproductive health related problem solving abilities are:

- What to do when faced with an STI, unwanted pregnancy, etc.
- How to access appropriate health services, including VCT.
- Identifying where to go for additional SRH information.
- What to do when your partner does not want to use a condom.
- What to do when your partner does not want to use contraception for birth spacing.
- What to do if you, or someone you know, are in an abusive relationship.

This training guide uses the problem solving approach. During the sessions, participants explore their experiences, analyze causes and effects, identify solutions, and then implement them.

Peer resistance

Peer resistance is the ability to consciously resist the desire “to go along with the crowd”. It means not taking part in undesirable/unsafe activities without feeling obliged to make explanations to peers who may have conflicting ideas and threaten you with exclusion from the group for not participating. If the group is engaging in negative influences and habits, peer resistance is a very important skill for young people.

Examples of abilities in resisting peer pressure:

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

Critical thinking

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

Examples in critical thinking are abilities to:

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

Self-awareness

Self-awareness is an individual's ability to appreciate the strong and weak points of one's own character. This realization enables one to take actions, make choices and decisions, which are consistent with one's abilities.

Examples of self-awareness skills are abilities to:

- Recognize the weak and strong sides of one's own behaviour.
- Recognize the weak and strong sides of one's own thoughts and abilities
- Differentiate what one can do or can't do by her/himself.
- Recognize things which cannot be changed, and accept them (example: height, type of hair, size of breasts, etc.).
- Whatever people may say, each person is different and should value themselves.
- Recognize one's own unique talents.

Decision-making

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

Examples of abilities in decision-making:

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

Process facilitation: Life skills

Getting started: (30 minutes) Before embarking to deal with life skills the facilitator will conduct an energizer (3–5 minutes). Then, he/she will recap (3–5 minutes) the lessons learned about adolescent sexuality up to this point and link them with the session on life skills.

1. Refer participants to the handout they received and read the day before.
2. Explain briefly (10–15 minutes) the meanings of the nine core life skills presented in the handout and give examples. Inform participants that we use these life skills in our daily relationships to cope with various situations and we

either use them well or we use them poorly. For the sake of this workshop, we want to use good life skills to promote sexual health.

3. Distribute the following statements matching life skill with behaviour to illustrate your presentation (5–7 minutes).

Matching life skills with behaviour (examples)

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

Exercise 1: Exploring one's own knowledge of life skills

Purpose: To enable participants to identify life skills

Method: Large group discussion

Tools: Buzzing, cards

Duration: 40 minutes

The facilitator will:

1. Ask participants to form a buzz group with their neighbours.
2. Write the nine essential life skills on a piece of paper or card (with help from participants).
3. Distribute one card to each of the buzz groups.
4. Ask the buzz groups to discuss the meaning of the life skill on their card using examples (5 minutes).
5. When the time is up, ask one of the buzz group members to explain very briefly the life skill on the card, giving an example of how it could be used.
6. Ask other participants to supplement or improve on what was said.
7. Take an average of 3 minutes for discussion on each card.



8. Using a flip chart, write the key points under each life skill.
9. Summarize the main lessons learned from the card activity and ask for feedback from participants.
 - Did the exercise help you understand life skills?
 - How should the exercise be improved, say for peer educators or peer learning groups?
10. Put the list of essential life skills on the wall.

Exercise 2: Practicing the application of life skills

Purpose: To enable participants to practice applying life skills

Method: Story

Tools: Role-play

Duration: 45 minutes

The facilitator will:

1. Ask for volunteers to put on a role-play on the story of Sara and David (see the case next page).
2. Tell them to apply the life skills that have been discussed.
3. Allow 10 minutes for preparation (if the role-play was not assigned earlier).
4. Allow 5–7 minutes for the presentation.
5. At the end of the role-play, analyze what happened:
 - What do the participants think of this scene? Is it accurate?
 - What skills did David use to try to get what he wanted?
 - What skills did Sara use?
 - How effective were each of these? (Very effective, medium, low)
 - Where there skills that either David or Sara could have used, but did not? What were they?
 - Who was more effective in the use of life skills – David or Sara? How? Why?
6. Write the main life skills that are identified on a flip chart.
7. Summarize the lessons learned and ask for feedback. Is the exercise useful for learning life skills?

The story of Sara and David

David was a married college graduate whose wife was studying abroad. He was a good family friend of a girl called Sara. Sara is poor but an attractive young woman who had just completed her high school. David would make jokes and sometimes he would hug her. Sara knew he was attracted to her.

One afternoon, David met Sara on her way home and drove her back to town. He invited her for a drink and she accepted a soda at a restaurant. He said he would drive her home but instead he took her to a hotel.

David insisted that she join him in the hotel room to eat supper but knowing his intentions, Sara refused. David took her hand and pulled her to go along with him. He told Sara he would beat her if she refused or started to scream. Scared, she went with him into the hotel room where he ordered supper.

After a while David started to pull her on the bed. She wept, she begged him to let her go but she didn't want to scream very loudly because of David's threats. After more than one hour of struggling, she finally found the courage to threaten him.

"If you do anything to me, I will tell your wife and my family and you will be put in prison for rape." David was so angry he pushed her out of the room.

Lessons learnt (Note for the facilitator)

- Sara was able to decide not to have sex (Decision Making Skills).
- She was able to maintain her decision to say „No“ to David's demands (Assertiveness Skill).
- She did not fully assess and foresee the possible dangers of driving alone with David even though she knew he was attracted to her (Critical Thinking).
- Like many young women, Sara was threatened with violence if she expressed herself in front of other people. Because of that fear, she had to go into the hotel room and risk being raped (Communication)
- In the end, Sara successfully resisted David. (Self-esteem/Awareness).



Exercise 3: Practicing life skills

Purpose: To enable participants to internalize the use of life skills

Method: Group acting and presentations

Tools: Miming drama and sculpture

Duration: 40 minutes

The facilitator will:

1. Divide participants into three small groups.
2. Inform the groups to refer to the handout for the following assignment.
3. Ask group 1 to demonstrate Effective Communication using verbal skills.
4. Ask group 2 to demonstrate Assertiveness through miming (body language without speech).
5. Ask group 3 to demonstrate Decision Making Skills through sculpture (body language without movement and speech).
6. Allow 10 minutes for preparation and 3–5 minutes for each presentation.
7. Bring the group together and ask each group to present.
8. After each presentation analyze what was learned.
 - Why is the skill necessary?
 - What type of skill is it?
 - How effectively was the skill used?
 - How would you do it differently?
9. Summarize the key points learned from the exercise and ask for feedback. Was the exercise effective?



Effective communication using verbal and body language



Unit 7. Sexually Transmitted Infections (STIs)

Basic information: Handout

General

Sexually transmitted infections, or STIs, (which were once more commonly referred to as sexually transmitted diseases or STDs) are infections spread from man to woman, from woman to man and between two people of the same sex through body fluids including semen, vaginal fluids and blood through sexual intercourse. They can also be spread from mother to child.

A person may have more than one STI at a time. STIs may or may not have any particular signs or symptoms. When there is no clear indication of an infection, a person is referred to as being asymptomatic. Usually however an STI is indicated by open sores, bumps, blisters, itching of the external sex organs and change in vaginal discharge for girls/women. Some STIs can cause very serious complications and even death.

It is very important to be aware of how STIs are acquired as well as the signs and symptoms. If they are detected and treated early, they do not cause serious problems, but when not detected or treated, the infection may spread and cause complications such as sterility (infertility).

It is possible to become infected even after only one act of sexual intercourse with an infected person. Remember, anyone can get an STI; not just commercial sex workers or people with “loose morals”. Most men can tell when they have an STI because there are usually clear signs. Women, however, often have an STI without knowing it because there are often no signs of infection.

STIs are relatively easy to contract, and so it is important to know what they are, what they look like and what you need to do to get them treated. The following includes the basic information you need to know about STIs.

Gonorrhea

Gonorrhea is the most common STI. In males, the disease usually causes pain or a burning sensation when passing urine and is accompanied by a thick discharge from the penis. These symptoms begin within approximately one week of being infected. Some females have the same symptoms – pain with urination and discharge from the vagina – but about 80% of the infected females have no symptoms at all. Therefore, it is very important for males to inform their female sexual partners if they have Gonorrhea.

Gonorrhea can be a serious disease. If the infection is not detected and treated, then it will spread to the internal reproductive organs. If a female has gonorrhea repeatedly or does not seek treatment, she may develop pelvic inflammatory disease (PID), an infection of the internal reproductive organs. PID is a very serious disease. Its signs are constant lower abdominal pain, painful menstruation and menstrual disorders, fever and bad smelling vaginal discharge. Sometimes the symptoms of PID go away without treatment, but this does not mean that the disease has been cured. If a female with PID does not get treatment, the fallopian tubes can become blocked from scarring, and she can become infertile.

Chlamydia

Chlamydia is an infection of the tissues lining the urethra, throat, rectum and the opening of the uterus. It is becoming increasingly common in Africa. The signs of Chlamydia are similar to those of Gonorrhoea, except they are usually less severe. Up to 75% of people with Chlamydia have no symptoms at all. The disease can be easily treated. However, if not treated correctly, Chlamydia can lead to the same complication as Gonorrhoea, such as PID and infertility.

Syphilis

Syphilis has been around for thousands of years. The initial symptom only consists of a soft, small painless sore in the genital area, penis or vagina that will heal by itself in 3–4 weeks. If Syphilis remains untreated the second stage is marked by fever, headaches, pain in the bones (rheumatic pains) and muscles, usually 6–8 weeks after infection. An itchy rash may also appear on the body (particularly in babies). Eventually the disease will progress into ulcers forming on the genitals, mouth or rectum, hair loss, blindness and mental illness. Syphilis can infect a baby while it is still in the uterus and it can die in the womb or it can be born with the disease.

Chancroid (genital sores)

This disease causes shallow, painful sores or ulcers around the genital area and inside the vagina. The sores are accompanied by painful swelling in the genital area. Without treatment, the sores take 2–3 months to heal. Females often have the disease without developing any symptoms, but they can still transmit the disease during sexual intercourse.

Genital herpes

Herpes is a viral disease that causes painful or itching, swollen blisters or sores on the penis, vulva and vagina, the pubic area or also at the entrance of the anus. The sores usually last between 4 to 15 days and then heal and disappear. They may recur repeatedly. The disease can be transmitted when the sores are actually present, or just before the sores come back. It is possible to tell the sores are returning if there is a feeling of burning or itching at the site where the sore will appear. Sex should be avoided or a condom should be used from the time the itching is felt until the sore has completely disappeared and the skin has mended. Note that the open sores can make a person much more likely to catch other STIs/STDs especially HIV.

Genital warts

Genital warts usually appear as small, hard painless bumps in the vaginal area, around the penis or around the anus. If untreated, they may grow and develop a fleshy cauliflower-like appearance. They are easily transmitted from person to person by sexual contact. The warts can be removed, but they are likely to grow again. There are many types of viruses that can cause genital warts. Some of these viruses have been linked to an increased risk of getting cancer of the cervix. A woman who has genital warts should have check up with a trained health professional every year.

Trichomonas

Trichomonas is an infection caused by bacteria. The signs are an increased discharge from the vagina, and fluid that looks frothy. Itching and pain with urination may also be signs of a



Trichomonas infection. Symptoms start 2–3 days after infection. Males usually have no symptoms at all. Both partners need to be treated. No sexual intercourse should take place until the treatment has been completed.

Granuloma inguinale

Granuloma inguinale is also caused by bacteria. It is a chronic infection of the skin and lymph glands in the genital area of the body. Granuloma inguinale is a relatively rare disease which affects people living in tropical and subtropical areas. It is seen more frequently in males. It is spread through sexual contact with an infected individual. More specifically, this contact involves exposure to bacteria from the open sores or lesions in the genital area. Symptoms may be noticed 1 to 16 weeks after exposure. The disease begins with the appearance of lumps or blisters in the genital area that become slowly enlarging open sores. Granuloma inguinale can be effectively treated with antibiotics but without treatment, it can result in serious damage to the sex organs and the disease may also spread to other parts of the body.

Candidiasis

This is an infection caused by a fungus. It is characterized by a thick, whitish discharge resembling curdled milk. It is extremely itchy and may be associated with swelling of the labia in females. Men can be carriers without showing any symptoms. It is therefore important to treat both partners even though the male partner may have no symptoms.

Relationship between STIs and HIV/AIDS

Human Immuno Deficiency Virus (HIV) is an STI. Although there are several modes of infection, the main mode of transmission is through sexual intercourse. Other ways of getting HIV/AIDS include use of contaminated sharp instruments, blood transfusion with infected blood and mother to child transmission (read Unit 8 for more information).

A person with other STIs has a higher risk of becoming infected with HIV if he/she has sexual intercourse with a person infected with HIV. This is because many of the open wounds and sores associated with STIs allow easier entry of the HIV virus into the body.

Also, a person with HIV whose body's natural immunity has been reduced, has a higher risk of also contracting other STIs as a result of unprotected sexual intercourse with a partner who has an STI. When an individual has both HIV and another STI, the presence of the HIV infection worsens the signs and symptoms of STIs. The person may also not respond to treatment quickly.

Note: Because there are serious health risks posed by having a STI for many years, it is particularly important for young people to avoid them – especially HIV.

How to avoid STIs

It is possible to prevent transmission of STIs by:

- Abstaining from sexual intercourse, or
- Only having one sexual partner, or
- Proper and consistent use of a condom in all sexual relationships

You should always go immediately for a medical check up and get proper treatment if you believe you are at risk of or could already have contracted an STI.



What to do if one thinks he/she has an STI?

The moment you suspect or think that you might have an STI, you should go to the nearest health unit or see a qualified health worker for an immediate check up and treatment. All the medication prescribed by the health worker must be taken correctly and completely, in accordance with given instructions. If the symptoms do not go away within a week of treatment, you should go back to the health unit and get help.

Note: All STIs - except HIV/AIDS - can be cured as long as they are identified early enough. If an STI is not treated, it can have very serious consequences including blindness, infertility and death.

Summary: Sexually Transmitted Infections

The following are the most common signs of an STI. But often, people can have an STI that will not show any signs/symptoms.

Signs in girls/women

- Sores, wounds, ulcers, rash or blisters on the vulva, inside the vagina or around the entrance to the anus.
- A discharge from the vagina that is thick, itching has a bad smell, an altered colour or is much more abundant than normal.
- Pain or burning sensation when passing urine.
- Pain during sexual intercourse.
- Pain in the lower abdomen.
- Abnormal swelling or growth on the genitals.
- Itching in the genital area.
- Abnormal irregular bleeding from the vagina.

Signs in boys/men

- Sores, wounds, ulcers, rash or blisters on or around the penis or around the entrance to the anus.
- Discharge (fluid), like pus from the penis.
- Abnormal swelling or growth on the genitals.
- Pain during sexual intercourse.
- Pain and swelling of the testicles.
- Pain or burning sensation when passing urine.

Source: Arkutu, A. A., 1995

Do you know why girls are more at risk of becoming infected by STIs including HIV/AIDS than boys?

Although both boys and girls can become infected with STIs, girls become infected more easily. These are some of the reasons why:

- The boy's or man's penis goes inside the female and his sexual fluids, which may carry infection, stay inside her body. This increases her chances of getting an infection in the uterus, fallopian tubes or ovaries.
- Girls are especially at risk of STIs because the cervix and the vagina of an adolescent girl are more delicate than those of an older woman. The vagina can tear during intercourse, which increases the risk of getting a STI.
- Many girls and women are thought to be submissive to men. They lack the skills and confidence to persuade their partners to use condoms for protection. Many adolescent girls have partners who are older than them and it can be very difficult for her to ask him to use a condom. Also, in many cultures, it is very difficult for a woman to refuse to have sex with her husband or ask him to wear a condom even if she thinks he has been with other women.
- Girls are more at risk of sexual violence (incest, defilement, rape). The force used by a male in these circumstances increases the risk of tearing the vagina (or anus).
- Many cultural practices such as dry sex and putting herbs, cloth and other objects into the vagina to "clean" or "tighten" it increase women's risk of being infected with an STI/STD. Drying the vagina before sex makes it more likely that there will be tears and cuts during sexual intercourse.

Source adapted from: Watson, C. and Brazier, E.

Process Facilitation

Section 1: Common STIs/STDs and their symptoms

Getting started: If you are starting this session in the morning, you conduct the following activities to get started (20 minutes).

- Introduce the person assigned for the check-in of the day (3 minutes) and show concern about the well-being of the participants; ask them how they spent the night, whether they had any problems, or encountered something nice, etc.
- Ask the person assigned to perform the energizer (5 minutes).
- Recap briefly the lessons learnt from previous sessions (5 minutes). Do not forget to remind the time-keeper to be alert.
- Introduce the program of the day.
- Finally, briefly introduce the handout on common STIs/STDs (5–7 minutes), which was distributed the day before and has been read.
- Then conduct the following exercises.

Exercise 1: Identifying common STIs

Purpose: By the end of the session, participants should be able to identify common STIs

Method: Exercise

Tools: Buzzing, Brainstorming

Duration: 15 minutes

The facilitator will:

1. Explain to participants that our behaviours are determined by our knowledge, beliefs and influences surrounding us. It is important to examine our own knowledge and attitudes towards STIs, before we see what we can do to prevent them.
2. Ask participants to form a buzz group of 3 with their neighbours.
3. Ask the buzz group to identify and list the commonly known STIs that they have heard of, read about and fear (5 minutes).
4. Ask the participants to identify the local names of the commonly known STIs.
5. Ask one member from each buzz group to present the identified STIs.
6. Write these down on a flip chart without comments.
7. Improve the list using the facts in the basic information.
8. Now that you have a complete list of STIs, read quickly through the list.
9. Tell participants that we use this list for the card game in the next exercise.

Exercise 2: Enhancing knowledge of STIs

Purpose: By the end of the exercise, participants' knowledge of both the causes and symptoms of STIs will have increased.

Method: Exercise

Tools: Card game

Duration: 45 minutes

The facilitator will:

Prepare the card activity in advance. Write the names of STIs and one or two of their symptoms on separate cards or slips of paper (see chart below).

1. Ask participants to stay in the whole group and distribute the cards.
2. Ask any participant to read a card loudly and show it to the group.
3. Ask for the person who has the corresponding card (symptom or STI name) to read it out loudly and show it to the group.
4. Ask participants if the cards correspond with one another.
5. Ask if they have any questions or need clarification (do not take more than 3 minutes per card). Ask how that STI can be transmitted and how one can identify it; explain only if not known to participants. Do not discuss prevention at this stage.
6. Every time, add any missing information. Use the basic information.

7. Continue with the exercise until all cards are exhausted.
8. At the end, summarize and ask for feedback from the participants. How difficult was the exercise? Can they use the exercise with their peers later?

Common STIs STDs and their Symptoms

Names of the STI	The symptom(s)
Gonorrhea	<ul style="list-style-type: none"> • Burning when passing urine. • A thick yellow/cream discharge from the penis. • 80% of women have no symptoms. • Lower abdominal pain. • Painful menstruation. • Fever. • Bad smelling discharge from the vagina. • Painful sexual intercourse. • Infertility (because the fallopian tubes are blocked).
Chlamydia	<ul style="list-style-type: none"> • Symptoms are similar to Gonorrhea. • 75% of people with Chlamydia have no symptom.
Syphilis	<ul style="list-style-type: none"> • Small and painless sores in the genital area, vagina or penis or in the mouth. • Painless swellings in genital area. • Baby may be born dead. • Baby may have rash or blisters on the feet. • Symptoms are easy to overlook.
Chancroid	<ul style="list-style-type: none"> • Abnormal vaginal or penile discharge. • Sores or ulcers around genital area. • Painful swelling around genitalia.
Genital herpes	<ul style="list-style-type: none"> • Swelling and itching of vagina. • Painful swollen blisters on penis, vagina, anus. • Burning or itching around the genital area. • Cannot be cured. • The open sores increase the risk of catching HIV/AIDS.
Trichomonas	<ul style="list-style-type: none"> • Increased fluid from the vagina or penis. • Frothy vaginal/penile discharge. • Itching and pain during urination.
Genital warts	<ul style="list-style-type: none"> • Fleshy growth in the genital area caused by a virus.
AIDS	<ul style="list-style-type: none"> • Diarrhoea for at least 4 weeks. • Cough for more than 3 weeks. • Severe weight loss. • Persistent skin rash. • Loss of appetite.
Candidiasis	<ul style="list-style-type: none"> • Thick white discharge, itching.
Granuloma inguinale	<ul style="list-style-type: none"> • Open sores or wounds on the vulva or vagina, penis or genital area. • Enlarged genital lymph nodes.



Exercise 3: Analysis of attitudes and behaviours leading to STIs

Purpose: At the end of the session participants will be able to identify risky attitudes and behaviours

Method: Small and whole group discussion, exercises

Tools: Brainstorming, ranking

Duration: 40 minutes

The facilitator will:

1. Ask participants to get into small groups of 4–6.
2. Ask each group to identify and list 3 common beliefs and behaviours of their peers (mostly at Level 1 of Awareness) leading towards contracting STIs (see example). Allow 5–7 minutes for this exercise.
3. When the allotted time is up, bring them together and ask one person from each group to present the behaviours and attitudes identified.
4. Write the list on the flip chart without comments.
5. Screen and merge overlaps, repeats and those not relevant.
6. Now you have a long list of behaviours that affect the youth of the community.
7. Rank (as in Unit 4, Exercise 4) your final list of behaviours in order of the risks they pose to health.
8. Summarize by comparing with the facts on the basic information.
9. Ask for feedback: Will participants be able to identify the risky attitudes and behaviours of their peers?
10. Keep the list on the flip chart hanging on the wall for future use.

Analysis of attitudes and behaviour which increase the risk of contracting STIs (an example)

- Unprotected sex with multiple partners, including commercial sex workers.
- Violence or force during sex
- Believing that when a girl says “No”, she means “Yes”
- The belief of being protected by a patron saint or God.
- Being ashamed or afraid to tell your partner that you have an STI.
- Failure to get treatment on time.
- Having sex during a high-risk period even if you are being treated for an STI.
- The belief that having sexual intercourse only once cannot be dangerous.
- Believing that having sex with a virgin will cure an STI
- Believing that you can “give” your infection to someone else, and be cured yourself
- The belief that using herbs cures an STI.
- Not understanding how an STI is transmitted (e.g. the belief that urinating against the moonshine, on hot stone or where a dog has urinated can give you an STI).
- Drinking alcohol and taking drugs, which affects your ability to think clearly and logically, reduces the chances of proper condom use.
- Not using condoms because of believing that condoms have “holes” in them which allow viruses to pass through.

Exercise 4: The consequences of STIs

Purpose: To increase participants' awareness of the danger of STIs

Method: Large group

Tools: Video, pictures or slides

Duration: 40 minutes

The facilitator will:

1. Ask the whole class to sit and watch the video.
2. Divide the participants into small groups of 4–6 people.
3. Allow 5-7 minutes for the participants to discuss what they observed.
4. When the allotted time is up, bring the participants together and ask presenters of each group to explain their observations (3 minutes).
5. Summarize the main consequences and ask for feedback: Are they clear about the consequences of the STIs? Can they use the tools or techniques to facilitate among their peers?



Unit 8. Acquired Immuno Deficiency Syndrome (AIDS)

Basic information: Handout

What is AIDS? What is the difference between HIV and AIDS?

HIV/AIDS: these two commonly used acronyms refer to a very serious STI.

HIV stands for **H**uman **I**mmuno **D**eficiency **V**irus.

AIDS stands for **A**cquired **I**mmuno **D**eficiency **S**yndrome

HIV is the virus responsible for AIDS. AIDS is the most advanced stage of a HIV disease. AIDS is now considered a major worldwide epidemic. By killing or damaging cells of the body's immune system HIV progressively destroys the body's natural ability to fight infections and certain cancers. People diagnosed with AIDS may get life-threatening diseases called opportunistic infections, which are caused by viruses or bacteria that usually do not make healthy people sick. No one dies from AIDS itself, but from diseases which result from AIDS.

If you get infected with HIV, your body will try to fight the infection. It will make "antibodies" – special molecules to fight HIV. For HIV to trigger an infection, the virus has to enter the body and attach itself to host cells. HIV attacks a particular set of cells called the CD4 positive T-cells. These are white blood cells. They co-ordinate the body's overall immune system which is responsible for attacking foreign bodies and fighting off infections. Within an infected person then commences a battle between the virus and the immune system.

There is an initial burst of activity during which many cells are infected, but the immune system still has the power to fight back by producing a high number of antibodies. This is unseen and unfelt by the individual and the person's status cannot be detected using standard test kits. This is called the 'Window Period'. This period can last from three to six months and during this time the infected person is extremely contagious. At the end of this period, the infected person usually becomes very ill (colds, coughs, fever, sneezing) and still it will not resemble a prominent HIV marker.

The 'Window Period' is followed by the 'Incubation Period'. During this phase, the HIV and the CD4 cells that it is attacking are being produced and destroyed as rapidly as possible by each other. Up to 5% of the body's CD4 cells (2,000 million cells) may be destroyed each day by the billions of HIV particles (Barnett, T. and Whiteside, A., 1999).

Eventually the immune cells get depleted, more quickly than they can be replaced, and the body's immune system is significantly weakened. As the CD4 cell count falls, opportunistic infections are caught. The person is said to have AIDS. These infections will increase in length, severity and regularity until they become too much for the body to handle and the person dies.

AIDS

AIDS has no cure and everyone infected with HIV will eventually develop AIDS. Once the person is infected, the virus can remain in the body for many years without any sign that something is wrong. This phase can last for as little as a few months, or as long as ten years.



During this phase, an infected person appears healthy and may not even know he or she has the virus, but the disease can be transmitted to others.

Once AIDS actually develops, the infected person begins to get sick often because the body is less able to fight off diseases. The most common symptoms are fever, diarrhea that will not go away, severe weight loss, persistent cough, tiredness, loss of appetite and skin diseases. The most common diseases developed by people with AIDS are tuberculosis, cancer, meningitis, pneumonia and in women, gynecological infections.

Signs and symptoms of HIV/AIDS

Only a professional can confirm whether a person has HIV/AIDS and only they can accurately inform the person of his/her status. A person is said to be HIV “positive” (or simply referred to as “positive” or +ve) when the blood tests show a presence of HIV antibodies. A person is said to be HIV “negative” (or just “negative” or –ve) when there is no evidence of the HIV antibodies.

During the initial stages of HIV especially the “Window Period”, a HIV +ve person may begin by having flu like symptoms only. This could be followed by a period of witnessing or feeling no signs or symptoms at all.

However, as HIV continues to attack the body’s immune system, the following signs/symptoms take effect or are felt:

- Fever
- Fatigue
- Diarrhea
- Skin rashes and lesions
- Night sweats
- Loss of appetite
- Gynecological infections
- Swollen lymph glands
- Significant weight loss
- Memory loss
- Depression
- Movement problems and shortness of breath
- White spots in the mouth/tongue
- Vaginal discharge (yeast infection)
- Easy bruising and bruises that last and remain painful for a long time. These sometimes result in subcutaneous (under the skin) infections
- Weakness and numbness (especially in the hands and feet)
- Sinus infections (head feels congested and pressured)
- Trouble with certain body organs (lungs, liver, kidneys, intestines and heart)
- Lipodystrophy: though not a direct sign of HIV/AIDS, it is a side effect of the medication combinations used during HIV care. Though medication is gradually enabling persons living with HIV to live longer, it comes with side effects constituting fat redistribution syndrome or lipodystrophy

Persons infected with HIV are more prone to suffer from various opportunistic infections such as: Tuberculosis, Pneumonia, Malaria, Meningitis, and Candidiasis.

They are also at much greater risk of certain types of cancer, including:

- Invasive cervical cancer in women
- Kaposi’s sarcoma
- Lymphoma



As mentioned previously, the culmination of all these diseases eventually results into full blown AIDS: the syndrome. Each individual person infected with HIV has a distinct set of signs and symptoms respective to his/her body's system.

It is important to note the following points:

- Some of the above mentioned signs/symptoms can develop as late as 10 years or more after the infection, and yet some studies have revealed signs/symptoms can appear in some people as early as 5 hours after the person has been infected with HIV.
- Even if a person may look and feel healthy, all HIV+ve people (even those on combination therapy) should realize they are able to infect others with HIV.
- If a person engages in risky sexual practices (does not use condoms, has multiple partners, etc.), is an intravenous drug user, or works in a situation where he/she is exposed to body fluids, he/she is at increased risk of HIV infection and may decide to get HIV tests done regularly.
- If a person is HIV+ve, he/she should note that there are various treatments and support/care services available and the sooner he/she registers or starts with one of them the better his/her chances will be for living a much longer and positive life (see later notes for this).

How does one get infected?

HIV is entirely preventable and avoidable. Unlike flu, cold or a cough it cannot be transmitted so easily. It can only be transmitted through contaminated body fluids. For a person to be infected the virus has to enter the body in sufficient quantities and it must pass through an entry point in the skin and/or mucous membranes in the bloodstream. The main modes of transmission in order of the risk are: sexual intercourse; mother to child; blood and blood products; and sharing of needles or other sharp instruments, such as with intravenous drug use.

Sexual transmission

Sexual transmission is the most common way in which HIV can be transmitted. The virus is usually passed from one infected person to another through sexual intercourse. About 80–85% of the people in Africa who have HIV were infected through sexual transmission. The virus is present in the semen or vaginal fluids of an infected person and he/she can easily pass it to his/her sexual partner during intercourse. It only takes one act of sexual intercourse with an infected person to become infected.

To help protect themselves against the virus, young people should:

- Use latex (rubber) condoms every time they have intercourse.
- Avoid sexual intercourse if they or their sexual partners have a sexually transmitted disease. If one person has an STI and another person also has HIV, the chance of getting HIV is very high.
- Avoid having a sexual relationship with different people. In fact the best way to avoid getting AIDS is to stay with one person who does not have the HIV virus and who does not have sexual relations with other people.
- Avoid causing scrapes, cuts or scratches in the genital area when having sexual intercourse. Women who have been circumcised may be at increased



risk of catching the virus, since sexual intercourse is more likely to cause bleeding and cuts.

Mother to child transmission (MTCT)

An estimated 15–30% of mothers with HIV infection will transmit the infection to their child during pregnancy and delivery, and 10–20% through breast milk (WHO 2005). HIV infected infants usually become seriously ill by the age of six months, and many die before their first birthday.

The child can be infected with HIV prenatally – that is, during the pregnancy itself; at the time of delivery (the most common mode of transmission) when the risk of exposure to the infected mother's blood is the highest; or post-natally through breast-feeding (Barnett and Whiteside, 2002).

Because there are drugs that can be given to the woman which reduce the risk of transmission during pregnancy, and to both the mother and child at the time of delivery, it is extremely important that pregnant woman know their HIV status.

HIV can be present in the breast milk of an infected mother and can be transmitted to the baby through breastfeeding. However, breast feeding is extremely beneficial to both mother and baby and even though using artificial breast milk or “formula” reduces the risk of MTCT, it comes with its own risks, which need to be carefully considered and discussed with a trained professional.

One thing to keep in mind is that given the right nutritional, physical and emotional care, a baby born with HIV or who tests positive after birth has good chances of testing negative after 18–24 months.

Transmission through blood or blood products

Blood to blood contamination is the most effective way of passing on the virus as HIV is introduced to the bloodstream directly. Since the virus is present in the blood of an infected person, it is possible to catch it if infected blood enters another body.

This can happen through:

1. Blood transfusion when using unscreened and infected blood products.
2. The use of injections and needles that have not been sterilized.

For example, women sometimes need a blood transfusion during pregnancy and childbirth, if they are bleeding heavily or have a serious bout of anaemia. They are most vulnerable to catch HIV through transfusions if infected blood and medical equipment like needles are used.

Blood banks and donors in some poor settings are notorious for using unscreened blood for transfusions and market sale. In many countries this has proved to be the initial factor causing HIV/AIDS.

Practices such as Female Genital Mutilation (FGM) and scarifications (tribal markings) also increase the risk of contracting HIV. This is because these harmful and very painful practices are often performed in unhygienic settings and involve sharing sharp instruments such as razors, blades and knives. If the same tool is used on more than one person, it is very easy to spread the infection.

The best way to avoid transmission through blood is to:

- Make sure that needles and surgical instruments are always sterilized.



- Only use blood that has been tested for blood transfusions.
- Never share needles, knives, razors or other sharp instruments.

Health workers should wear gloves when there is the risk of being exposed to infected blood, for example during delivery.

In addition, communities should be encouraged to avoid rituals that involve cutting the skin or make sure that the instruments are sterilized.

Intravenous drug use

Drug users who share needles during drug abuse are at a greater risk of being infected with HIV. If the equipment is contaminated, the virus can directly enter the body.

Note: HIV is not transmitted in any of the following ways:

- By sitting on toilet seats.
- Sharing drinking cups or utensils.
- Touching or other casual physical contact with an infected person (such as hugging or shaking hands).
- Mosquito bites.

How does one avoid infection?

Infection of HIV can be easily avoided by following the given advice:

- Never engage in sexual intercourse without using a condom.
- If you do decide to have sex without a condom (to get pregnant, for example) always ensure that you and your partner both go for an HIV test first.
- Remain faithful to one sexual partner.
- Do not share needles or other sharp instruments.
- Avoid harmful practices such as FGM.

Note to remember: Having HIV does not mean that a person is “bad” or has done something “wrong.” There can be lots of ways of becoming infected even when precautions are taken: a girl may be defiled, a health worker may be accidentally infected, a man may be circumcised as an adult with an unclean knife. Stigmatizing people with HIV and isolating them from others is discriminatory and a violation of basic human rights and dignity.

Doing so makes it harder to help individuals and families in need, and to prevent future transmission. Communities must come together to help each other in curbing the spread of infection and supporting those who are HIV+ve. HIV/AIDS infected persons should be encouraged and helped to live positively, to eat healthy foods, get regular medical care and should get more care and support from his/her friends, family and members of the community at large.

Voluntary counseling and testing (VCT)

Information on where to go (or refer people) for Voluntary Counseling and Testing (VCT) can be obtained from local health clinics, medical professionals, health workers and NGOs. VCT services/centers offer the best means to find out one’s status. This is whether one is HIV+ve or HIV-ve. VCT centers have helped:



- To reduce HIV transmission.
- HIV+ve people learn to lead healthier and more positive lives.
- Be the focal points in initiating support/care groups.
- Employ more pro-active measures to deal with stigmatization/ostracisation.
- Act as a prime motivational and educational service to ensure that people who have been tested negative remain so.

Who will benefit from VCT information and referral?

- A person who is serious about behaviour change.
- A person who is planning marriage, or venturing into a new relationship.
- An individual or a couple considering pregnancy (or a woman who is already pregnant).
- A person with more than one sexual partner (now or in the past).
- A person whose partner has more than one sexual partner.
- A person with an STI.
- A person working and living away from his/her spouse and family.
- A person who has had a blood transfusion.
- A person who is constantly feeling unnaturally sick (with one or more of the signs or symptoms of HIV/AIDS).

Many people, especially youth are afraid of going to visit a VCT centre primarily because they are thought of as 'scary' places to visit and because of the stigma associated with going to visit one; people may think you have a problem. This is a huge misconception as in fact they can go a long way in helping people live positively with HIV/AIDS; help people stay negative and offer care/support services for those infected and affected, for those who have been tested -ve and those who have been tested +ve.

VCT benefits for HIV-ve persons:

- Clients learn how to stay -ve.
- Couples can marry without having doubts.
- Couples can plan for future pregnancies without having doubts.
- Reduce anxiety over past risky behaviour.
- Testing -ve creates powerful motivation to be more aware about behavioural standards and remain uninfected.

VCT benefits for HIV+ve persons:

- Counseling services offered help clients avoid passing the virus to anyone else.
- Clients learn to take better care of themselves to lead a longer, healthier life.
- Clients learn early about TB and STI treatment, prevention of mother to child transmission (PMTCT), family planning and social support.

Medical check ups

Going for a regular medical examination is the direct means of knowing your status. Regularity will also ensure that you are aware of the changes that may be taking place in your body and that you are informed about how to deal with these or how these may actually be signs and symptoms of HIV/AIDS.

Note: Getting tested during the 'Window Period' of infection (for those who have already contracted the virus) will not enable one to know their status as the virus is undetectable at this stage (see previous notes on what is HIV/AIDS). Therefore, a person who tests negative is asked to get a second test within 6 months just to be certain.

Indirect, but unconfirmed means of detecting whether a person may be HIV +ve could be determined as a result of constant and prolonged occurrence of any of the signs and symptoms of HIV/AIDS. A medical/health professional would be able to validate this.

HIV/AIDS intervention

If I have HIV, how can AIDS be prevented?

As we discussed above, the first principle of prevention is to ensure that people are not exposed to HIV/AIDS in the first place. Once exposure has taken place, the second step in prevention is to try to avoid infection. For many diseases, a vaccine has been developed that prevents infection even when a person has been exposed. This is the reason for childhood immunizations such as polio, measles, and TB. Even though scientists are working on this, no vaccine has been developed for HIV/AIDS. Certain medicines, like anti-retroviral drugs (ARVs) can help further delay the time between becoming infected with HIV to the onset of full-blown AIDS, however these medicines are still quite expensive and can be difficult to access. Some governments and NGOs are trying to make ARVs available for free, especially for pregnant women.

Intervention measures to seek prevention of HIV/AIDS can be best put in effect by altering sexual behaviour: these are commonly referred to as Knowledge, Attitude, Practices and Behaviour (KAPB) interventions and/or the Behavioural Change and Communication (BCC) methods of tackling HIV/AIDS. People need to have the **knowledge** first though:

This entails mechanisms to make one aware, concerned and better equipped with information on HIV/AIDS. This could be done using mass and group media and through interpersonal communication provided through government organizations, NGOs, training programmes, health and social workers, resource materials and the World Wide Web (www...) etc.

From this, hopefully one will be able to change his/her **attitude**:

Knowing all the relevant information, individuals should seriously begin to think about the need to protect themselves and their loved ones from AIDS. This is when motivation sets in and a decision is made to stick to one partner, buy condoms or get oneself tested. Moreover, it should promote receptiveness of peers to those infected and affected by HIV/AIDS.

Finally altering one's practices and **behaviour**:

At this stage, condoms and other popular contraceptive methods need to be easily accessible and individuals need to feel capable of using them and negotiating safer sex. Mass and targeted campaigning and advocacy can help provide a supportive environment by showing role models and promoting a positive view of safer sexual behaviour. Peer role models are especially useful here.



Support groups should be set up at this point for infected and affected peers and to bring about general positive change in community behaviour and response to HIV/AIDS.

The classic ABC message

Young people are encouraged to:

A: Abstain or Delay first sexual intercourse: The best way to avoid getting infected with HIV is not to have sexual relationships at all, or to have relations only with someone who is not infected.

B: Be Faithful to one sexual partner.

C: Condom use: When used every time, and used correctly, condoms can prevent sexual transmission of HIV, can prevent other STIs and can prevent pregnancy.

However, even if people have the knowledge on all the above, they may not have the resources or even the power to change their behaviour. For HIV/AIDS intervention strategies to address prevention by tackling broader issues like this, we must look at: socio-economic circumstances of individuals that sometimes limit them to access commodities like contraceptives; their accessibility to VCT services and information points; ingrained traditional beliefs of having large families; poor living conditions that have accelerated the spread of the disease and the like.

Other basic preventive methods are:

1. Always ensure that needles, syringes and other medical equipment are sterilized and disinfected before a blood transfusion, surgery, or, if one is taking drugs, (stay away from drug abuse altogether!)
2. If one is to get a blood transfusion, always ensure that one knows which blood bank that the blood is coming from and that the blood has been tested for infection beforehand.
3. According to epidemiological and ecological studies, male circumcision has been associated with a reduced risk of acquiring sexually transmitted HIV infection.

What do I do if I am HIV+ve?

Once a person knows that he/she is HIV+ve, they must understand the full nature of the disease and not get depressed. Depression will only embolden the virus to attack the body more aggressively.

An HIV+ve person should employ the necessary steps to elongate the period of his life and delay the onset of full-blown AIDS. Moreover, he/she should make the best of his/her life by living positively and even more enthusiastically.

They can do this by:

1. Accessing the nearest VCT to get ongoing counseling and support to deal with HIV.
2. Get proper medical advice on the best treatment depending on the level of infection.
3. Take proper care of yourself through e.g. nutritional care, join support groups and always ensure that you are never idle; always keep your mind occupied.
4. Have many friends and family members around you.

How can you help somebody who is HIV+ve or has AIDS?

1. Attitude and approach towards people living with HIV:
 - Treat them like any other person.
 - Do not discriminate/stigmatize them by either ignoring them completely or giving them too much attention.
 - Involve them in your life and surrounding activities like you would any other person.
 - Be patient and understanding: HIV+ve people already have a lot to deal with, just by knowing they are positive. They are prone to getting upset, depressed, sensitive and moody; however you should be patient with them and actually help them through it.
 - Ensure them that there is nothing wrong in being open about it and not to let others' opinions matter or affect them.
 - Encourage them to go for regular counseling and medical check ups.
 - Encourage them to develop a POSITIVE attitude (if they haven't done so already) and if they have, encourage them to always remain that way, as it is encouraging and motivational for others to see.
2. Caring for people with HIV:
 - If you know someone with HIV, a friend, family member or a colleague, ensure that you keep a regular check on their weight and diet and advice/help them to undertake better nutritional standards (if they are not already doing so).
 - Discuss issues with them: those that are affecting them directly or indirectly (i.e. be there for them whenever they may need you).
 - Show them that there are people out there who really love and care for them: take an active interest in their lives.
 - Encourage other friends and community members to go visit them and be supportive towards a person who may be HIV+ve.
3. Taking care of yourself: Advice for the person living with HIV/AIDS:
 - Your body needs extra rest: sleep for at least 8 hours every night and rest whenever you feel tired.
 - Try not to worry about things too much as this only aggravates the illness.
 - Be positive and strong. Being positive about your illness is so important in fighting the disease and helping you cope with living with it for a stronger and healthier way of life. It would also help your fellow peers realize that one can live happily even if infected.
 - HIV+ve persons can serve as true humanitarian ambassadors in fighting the AIDS epidemic and ensuring that the spread is contained.
 - Do things you really enjoy.
 - Exercise regularly.
 - Find good care and support groups.



- Do not feel ashamed, intimidated or shy to ever ask for help or accept it when offered.
- Stop smoking, drug abuse and taking alcohol.
- Avoid taking unnecessary medicine, as these can have unwanted side effects. Only take medication prescribed by a qualified medical doctor.

Medical treatment for HIV/AIDS

As mentioned previously a huge amount of resources have gone into trying to find a vaccine to contain the virus, but as yet none has been developed. Nevertheless, there have been major advances in clinical treatment. In clinical terms there are three key components to treatment:

1. The first component is 'positive living': staying healthy, eating the correct food: fresh fruits and vegetables, drinking lots of clean water, and getting plenty of rest. An infected person must ensure that he/she eats balanced diets. This means a balance of proteins which can be found in milk products, eggs, fish and meat; carbohydrates which can be found in rice, maize, millet, sorghum, wheat, barley, potatoes, sweet potatoes, cassava and yams; and fats which are important for maintaining weight and enhancing energy. That can be found in butter, margarine, cream, avocados, curds and cheese.
2. The second component is to get prompt medical treatment for opportunistic diseases like TB.
3. The third component is the use of ARVs, which help the body to fight HIV directly, can improve the quality of life, and can significantly delay the onset of AIDS.

Note: Knowing when to introduce ARV treatment is something that should be medically determined by a health professional. Effective treatment of HIV/AIDS involves more than just prescribing drugs: Patients need regular consultations, testing of their viral loads and CD4 counts. If treatments fail, they need regular testing for drug resistance.



Key facts about HIV/AIDS

HIV/AIDS is an STI for which there is no cure. HIV is the leading virus that gradually destroys the body's immune system by reducing the number of CD4 cells. This makes the body very weak and vulnerable to opportunistic diseases like Tuberculosis, Malaria and Pneumonia. It also makes the body easily succumb to various types of cancers. The combination of all these complications leads to the onset of what is called AIDS, the syndrome. Eventually the infected person's body will no longer be able to handle the constant infections and will die.

How AIDS is transmitted:	Ways to avoid it:
<p>Sexually: Due to the exchange of body fluids during sexual intercourse.</p>	<ul style="list-style-type: none"> • Abstain from sex. • Always use a condom. • Don't have intercourse with more than one partner: Be faithful to your partner. • Don't have intercourse that causes cuts or scrapes in the genital area, or don't have intercourse with people who have cuts and bruises in these areas. • Avoid having intercourse with people who already have HIV or other STDs.
<p>Through blood: By contact with HIV-infected blood, such as from a needle, a blood transfusion or a cut.</p> <p>By intravenous drug abuse: When persons share dirty and infected needles.</p>	<ul style="list-style-type: none"> • Only use sterile needles. • Use surgical gloves. • Test blood used for transfusions, and use only non-infected blood. • Avoid FGM practices and rituals that cause bleeding.
<p>From mother to child: A pregnant woman who has HIV can pass it to her infant.</p>	<ul style="list-style-type: none"> • A woman should know her HIV status before becoming pregnant and make an informed choice about pregnancy. A woman who is already pregnant should be tested and work with health professionals to reduce the risk of transmission to her child before, during and after delivery.

Source: Arkutu, A. A., 1995

Process facilitation: The nature of AIDS and its mode of transmission

Getting started: (20 minutes) If you are starting this session in the morning, you can conduct the following activities:

1. Introduce the person assigned for the check-in of the day (3 minutes).
2. Next ask the person assigned for energizer to perform the warm up (5 minutes).
3. Also ask the person assigned for recap to briefly summarize the lessons learned the previous day (5 minutes).
4. Do not forget to remind the time-keeper of his responsibility.
5. Introduce the program of the day (2 minutes).



6. Introduce this session by briefly explaining the content of the handout or background information. Do not spend too much time here. Participants will have more chance to learn during the next exercises.

Exercise 1: Exploring the experience of peers on HIV/AIDS

Purpose: To enable participants to explore their level of awareness of HIV/AIDS

Method: Reflection, analysis questions

Tools: Sketch

Duration: 30 minutes

The facilitator will:

1. Divide participants into small groups of 4, 5 or 6.
2. Ask participants to review the previous exercise and the handout they have read.
3. Instead of lecturing on this topic, ask participants to form buzz group of 2 or 3 with those sitting next to them.
4. Ask the groups to discuss the following questions (5–7 minutes):
 - What do the abbreviations HIV and AIDS mean? What is the difference between the two?
 - Where in the body of the infected person do we exactly find the virus?
 - How does a person infected with HIV develop the disease AIDS?
 - Give three main symptoms of AIDS.
 - Give three main diseases developed by AIDS.
 - Give three major ways that the HIV virus is transmitted.
5. Take turns and ask buzz groups to briefly respond.
6. Write the short answers on the flip chart.
7. Improve the responses, if necessary; explain briefly (use fact on basic information).
8. Summarize the major points and ask for feedback. Does the exercise help participants have a clear knowledge of the disease?

Exercise 2: Learning how AIDS is transmitted – Risk analysis

Purpose: Will be able to identify high risk behaviours

Method: Comparison

Tools: Card game, flip charts/large pieces of paper on the ground

Duration: 35 minutes

The facilitator will:

1. Ask one of the participants to review the last exercise before continuing with this exercise (3 minutes).
2. Allow participants to remain in the circle.



3. Use the card game (see following pages for card game) to help participants analyze and identify the causes of transmission from non-causes.
4. Distribute high risk, low risk or no risk statement cards to each participant.
5. Join two flip charts (or used cement sack) and put it in the middle of the circle.
6. Write on cards or pieces of paper the titles “HIGHLY RISKY”, “LOW RISK”, “NOT RISKY” and “NOT SURE”. Put these cards in a row on the floor.
7. Ask participants to read the cards they possess carefully and put each under the appropriate card of their choice on the floor.
8. Ask for a brief explanation as to why that title is chosen. This may generate discussion.
9. Summarize the lesson learned on the causes and non-causes and ask for feedback. How useful was the card game in this learning process?
10. Hang the flip chart paper on the wall with the final list of risk analysis.

Risk analysis game

Highly risky	Low risk	Not risky
<ul style="list-style-type: none"> • Transfusion of infected blood 	<ul style="list-style-type: none"> • Non-penetrative sexual activities (kissing, stroking, fondling, massage, masturbation, oral sex, etc.) 	<ul style="list-style-type: none"> • Kissing
<ul style="list-style-type: none"> • Sharing sharp instruments (needle, razor, blade, etc.) 	<ul style="list-style-type: none"> • Sexual intercourse with a condom 	<ul style="list-style-type: none"> • Sweat, tears, sneezing
<ul style="list-style-type: none"> • Violence during sex 	<ul style="list-style-type: none"> • Piercing ears 	<ul style="list-style-type: none"> • Caring for someone with AIDS
<ul style="list-style-type: none"> • Sexual intercourse without a condom 	<ul style="list-style-type: none"> • Nose bleeding 	<ul style="list-style-type: none"> • Playing games or sports
<ul style="list-style-type: none"> • Mother to child transmission before, during and after delivery 	<ul style="list-style-type: none"> • Male circumcision 	<ul style="list-style-type: none"> • Hugging, touching or shaking hands
<ul style="list-style-type: none"> • Sexual intercourse with someone who has a STI 	<ul style="list-style-type: none"> • Blood transfusion with uninfected blood, using sterilized instruments 	<ul style="list-style-type: none"> • Sharing eating utensils
<ul style="list-style-type: none"> • Sharing toothbrush 		<ul style="list-style-type: none"> • Swimming pool, shower • Insects, mosquitoes • Domestic animals, cats, dogs, birds etc. • Donating blood • Being around each other (Sharing bus, taxi, being in class, eating at the same place, using public telephone or toilet, etc.)

Risk analysis card game



- Not Sure
- High risk
- Low risk
- No risk

HIV is not transmitted through the following



Sharing cooking utensils



Sharing toilets



Kissing
Not french kissing!



Shaking hands



Sneezing



Playing together



Socializing



Mosquito bites

Exercise 3: Signs and Symptoms of HIV/AIDS

Purpose: To make participants aware of the signs and symptoms of HIV/AIDS

Method: Small group work, analysis questions

Tools: Sculpture, role play, mime

Duration: 25 minutes

The facilitator will:

1. Briefly recap and explain that once the HIV disease has developed the infected person begins to get sick often because the body is less able to fight off diseases. Now, participants should be able to identify those symptoms of the most common diseases caused by HIV/AIDS.
2. Ask participants to move into four small groups of 3, 4 or 5 and ask them to prepare role-play, or mime on the symptoms of HIV/AIDS (remind them to use their knowledge on effective communication skills).
3. Write one symptom (seen below) on a flip chart or a piece of paper indicating mime, role-play or sculpture.
4. Ask each group to draw one. Ask them to discuss the symptoms very briefly, and then prepare the demonstration as on the flip chart. Allow time for preparation (5–7 minutes).
5. When the allotted time is over, bring all of the groups together and ask each group to present its preparation.
6. After each group's the presentation, ask analysis questions such as:
 - Which symptoms have you identified?
 - What are the causes?
 - Indicate the effective communication skills observed? (Do not spend time discussing prevention at this stage).
7. Write the main symptoms on a flip chart and compare with the list above.
8. Ask for feedback. How did the exercise help participants create awareness of the consequences of HIV/AIDS?

Symptoms and most common diseases of HIV/AIDS

- Unexplained diarrhea that will not go away
- Persistent fever and night sweats
- Severe weight loss
- Persistent cough
- Loss of appetite and difficulties in eating
- Skin disease that itches all over, persistent swelling in lymph nodes in several sites of the body
- Tiredness
- Tuberculosis
- Lesions (open wounds) on the skin
- Pneumonia
- Meningitis
- Gynecological infections

Exercise 4: Social consequences of HIV/AIDS

Purpose: To enable participants to be aware of the social consequences of risky behaviour

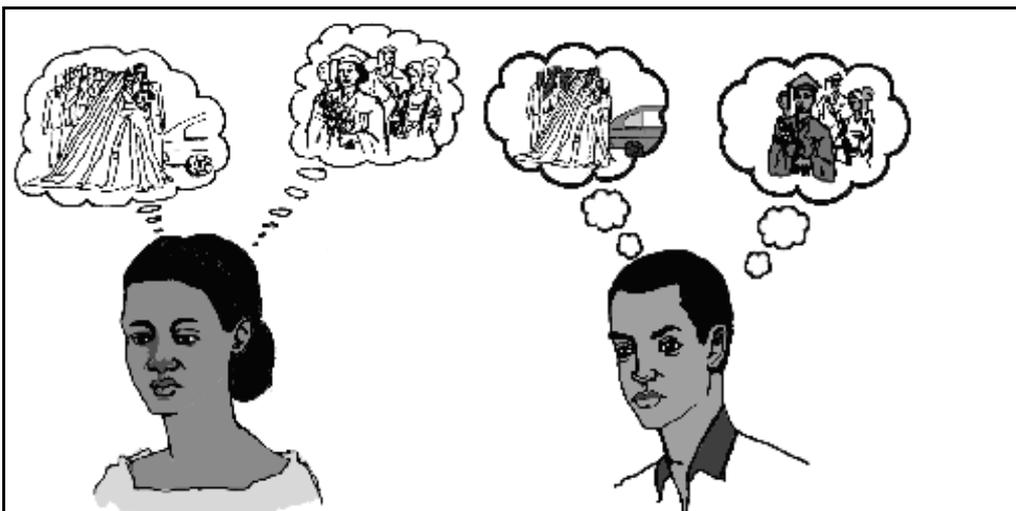
Method: Imagining the dangers ahead

Tools: Brainstorming

Duration: 20 minutes

The facilitator will:

1. Allow participants to stay in the circle.
2. Allow for a song if the need for an energizer arises.
3. Tell the participants that the dangers of contracting HIV/AIDS also have their social consequences.
4. Tell them to think of a brilliant boy and a very lively and beautiful girl of about 19 years. Both of them enjoyed their youth but were at level one of awareness and became suddenly sick having contracted the disease.
5. Imagine what the boy and the girl are going to miss in life that other peers at the Level 4 of awareness would gain?
6. Tell them to write down their ideas on paper (2–3 minutes).
7. Go round and ask each person to brainstorm what he/she has noted as the most important losses.
8. Write the answers on a flip chart.
9. Summarize the lessons learned on social consequences.
10. Ask for feedback: Is this exercise useful?



She imagines what she is going to miss in life.

He imagines what he is going to miss in life.

Section 1: Life skills in preventing HIV/AIDS and other STIs

Getting started: The facilitator should briefly review (3–5 minutes) the lessons learned from the previous session. Refer participants to their handout on life skills for upcoming exercises. Explain that participants have enough knowledge on the nature, causes and the consequences of the STDs including HIV/AIDS. They might have developed awareness about the need for behavioural change. Hopefully, participants have gone through Level 1 to 3 and might even have reached Level 4 of awareness.

However, awareness alone is not enough to prevent risky behaviours. It is necessary to develop the appropriate skills or abilities to overcome risky behaviours and attitudes. Participants should now go over to practice these skills and learn how to handle difficult situations and behaviours using their knowledge to:

- Make informed decisions to protect themselves and others.
- Resist peer pressure for unhealthy behaviour.
- Learn to assert and affirm themselves in their decision.
- Establish and cultivate a good relationship with their partner.
- Exercise skills in communication, i.e. listening to partners and informing and persuading their peers.

Exercise 1: Using life skills in dealing with risky situations and behaviours

Purpose: Participants will be enabled to employ life skills in risky situations

Method: Exercise-matching

Tools: Hand out on life skills, situations and skills sheet

Duration: 35 minutes

The facilitator will:

1. Ask participants to move into small groups of 4, 5 or 6.
2. Distribute a copy of the sheet – situations and life skills – one per group (see below if distributing a copy is impractical, write on a flip chart and post on the wall for the whole group).
3. Suggest that one member of the group acts as a writer and takes on the task of filling in the identified skill, based on the ideas and discussions of the group. Participants should decide on the skills or competencies, which could be used in a given situation.
4. Refer participants to the earlier distributed handouts on essential life skills. (20 minutes).
5. When the allotted time is up, ask the small groups to report back on the skills they have identified to the whole group. Encourage each spokesperson to be brief.
6. Write up the list of the skills on a flip chart.
7. Add any skill that you think has been missed out referring to the handout.
8. The facilitator may refer to the possible responses on the skill sheet below.



9. Summarize the main lessons learned on life skills and ask for feedback.
10. How difficult is the exercise? Do you recommend this approach for developing life skills?

Match situations with skills (possible responses)

Situations	Life skills
The offer of a person who believes sex is completely safe	
The offer to take alcohol and go along with the group	
To deal with the demands of friends to engage in sex like all others	
Being seduced by an attractive person	
I like you, you like me, let's make love	
A person trying to convince you that having sex once is not dangerous	
Know-all person" preaching that abstinence is a sign of impotence	
Your friends telling you that to be a virgin is nonsense	
Visit prostitutes	
Shyness to negotiate on sexual matters	
Not to use a condom	
Afraid or ashamed to tell one's partner about a contracted STD	
Belief that one can be cured by having sex with a virgin	
Belief that having sex with young girls is not dangerous	
Belief that you can rid him/her of infecting others	
Belief that herbs or holy water can cure	
Carelessly having sex with many partners	

Life skills	Explanation
Critical thinking	Ability to differentiate between wrong and right statements or offers.
Decision-making and assertiveness	Ability to differ from others.
Pressure resistance	Ability not to conform to the false behaviours of peers.
Decision-making	Ability to resist temptation and control oneself.
Decision-making with effective communications	Ability to avoid a trap and persuade a partner of his/her dangerous move.
Critical thinking	Ability to assess the advantages of a given act with its disadvantages.
Critical thinking	Ability not to be fooled by false thinking.

Pressure resistance	Ability not to give in to ridiculing.
Self-esteem	Not to be shy, but have confidence and be able to negotiate.
Critical thinking	Awareness of the need to use condoms.
Interpersonal relationship and Self-esteem	Have sense of responsibility to your partner and have courage to tell the truth and get treatment.
Interpersonal relationship	Ability to care for the well-being of others.
Critical thinking	Ability to acquire sound knowledge and be free of myths and misconceptions.
Critical thinking	Ability to raise one's awareness level of risky situations.

Exercise 2: Planning prevention of HIV/AIDS and other STIs

Purpose: At the end of the exercise, participants will know how to prevent an infection

Method: Small and large group discussion

Tools: The six tools of planning

Duration: 40 minutes

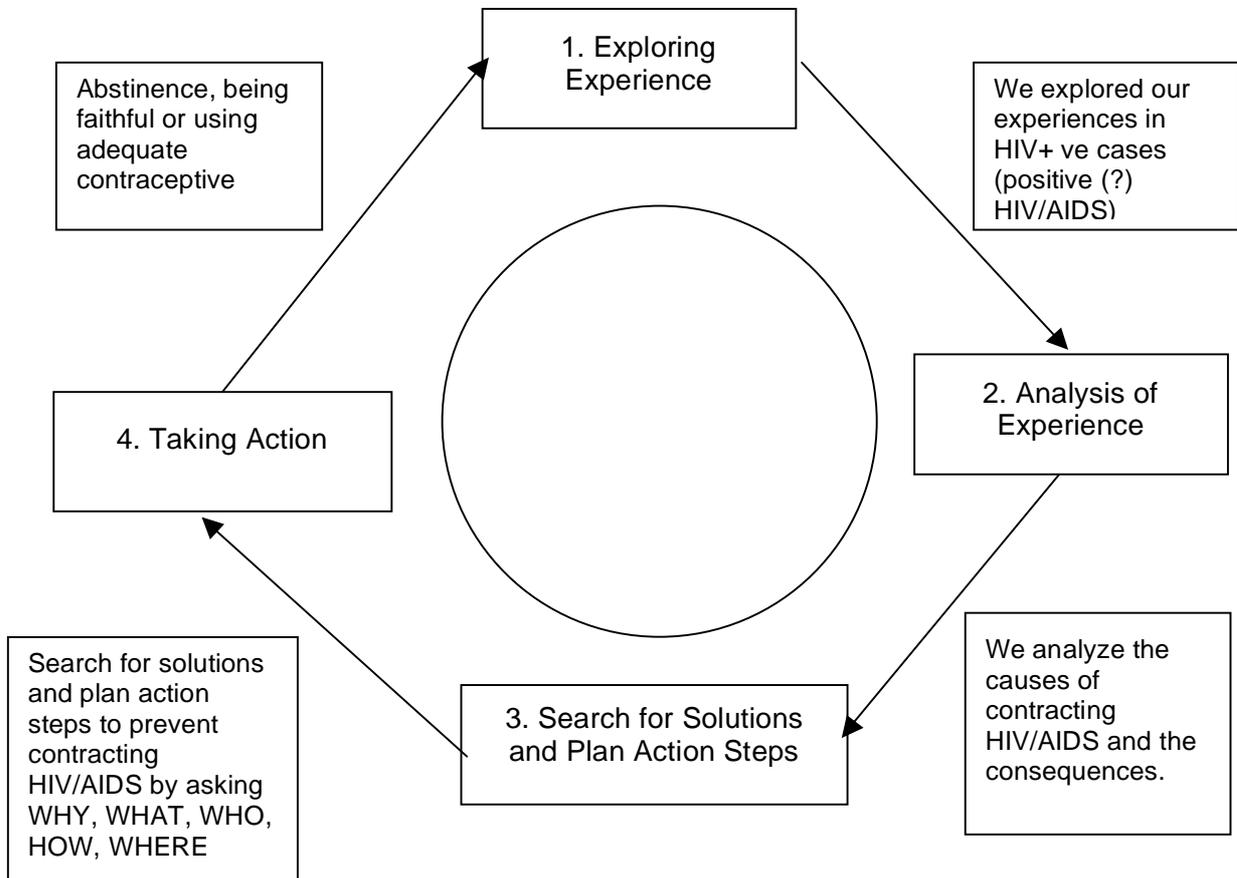
Getting started: Before starting this session, the facilitator has to recap the main points the group has learned so far using the learning cycle (see below). Connect that with this session (3 minutes)

Explain to participants that adolescent learning groups should not stop at the identification of skills. Learning should be followed by action. Learning without action leads to “apathy” and “powerlessness”. At this planning stage we expect that most of the peer learning group members have reached Level 4 of awareness. The facilitator should encourage them to decide, plan and implement the prevention of STIs including HIV/AIDS. In the following, learning groups should discuss and decide, as a group or as an individual, on WHO should do WHAT? WHY? HOW? and WHEN?

The facilitator will:

1. Explain briefly the “six tools of planning” (see below).
2. Ask participants to form small groups and plan (see example below). Allow 20 minutes. When the allotted time is up, bring participants back together.
3. Ask one group presenter to report on the planning of the group. There may not be enough time to go through all the groups, but the members of all the groups may contribute by comparing with their plan.
4. Write the main steps and points on a flip chart.
5. Summarize the decisions and planning steps and ask for feedback. Did you find the planning session useful, difficult etc.? Do you think Peer Learning Groups will make use of this approach?

The learning cycle on HIV/AIDS and STIs



Planning prevention of STIs and HIV/AIDS (an example)

1. **WHY?** Why are you committed to preventing HIV/AIDS? Is there any felt need for prevention among the peers? How high is the suffering among the peers?
2. **WHO?** Who in the learning group should be responsible for the prevention action?
 - Define the role and responsibility of the learning peers as a group.
 - Define the role and responsibility of the male as an individual partner.
 - Define the role and responsibility of the female as an individual partner.
 - The male partner may, for example, vow to be responsible towards female partners to practice safe sex, be faithful to a partner etc. The female partner may, for example, vow to keep her virginity or to practice safe sex, inform her partner in case of disease, or remain faithful to him.
3. **HOW?** The specific tasks or steps required for the action. Which steps should the peer take? Organize oneself in peer education group? Participate in peer



education activities? Actively participate in club activities? Develop codes of behaviour and abide by them? etc.

4. WHEN and WHERE? When and where should the action take place; when should it start and end? Is there any time limit or location for the prevention action? Can you decide now?
5. WHAT? What is needed to execute the plan in terms of place, structure, leadership, money, materials and support groups?

Unit 9. Contraceptive Methods

Basic information: Handout

A contraceptive is a drug or device used to prevent pregnancy. There are many different contraceptive methods – but only the condom can prevent pregnancy and STIs. In this Unit, we will focus on pregnancy prevention. For more information on STIs, please refer to Unit 7.

Most contraceptive methods are reversible; that is a woman will be able to become pregnant again after she has stopped using the method. Some methods, such as surgical sterilization, are permanent, meaning a woman cannot become pregnant ever again or a man cannot make a woman pregnant again. In this Unit we shall discuss a range of contraceptive methods. Even though not all methods may be available where you are (or recommended for young people), it is important that you know about them and how they work. Contraceptive methods are frequently referred to by the way in which they prevent pregnancy:

- Barrier methods,
- Intrauterine methods,
- Hormonal methods,
- Surgical (permanent) methods,
- Natural methods,
- Emergency contraception,
- Traditional methods

1. Barrier methods

Barrier methods are exactly what they sound like: something which prevents the sperm and the egg from uniting, thus preventing fertilization. They comprise:

- The male and female condoms,
- Cervical caps/Diaphragms,
- Spermicides,
- Intrauterine (contraceptive) devices (IUD)

Condoms

The male condom

This is a thin rubber sheath made of latex that is placed on an erect penis before having sexual intercourse to protect against unwanted pregnancy and STIs including HIV/AIDS. Condoms come with different features: they can be smooth, ribbed, studded, lubricated, flavoured, coloured, etc. They should be used only once, and then properly disposed of after use.

How it works

It works by preventing a man's semen from entering the woman's vagina and thus preventing the sperm and egg from uniting.

How to use it

Always put a condom on once the penis is erect and before any contact is made with your partner. Make sure:

1. Get condoms from a reliable source
2. Check if the condom is still okay by
 - Checking the expiry date
 - Pressing the container to check if it is sealed and also feel if pressure is still there
3. Carefully open the package so as not to damage the condom.
4. Penis should be erect (hard) before putting on a condom.
5. Squeeze the tip of condom and put it on the end of the penis (squeezing the tip allows space for semen to collect and reduces the possibility of bursting).
6. While still holding the tip, unroll the condom down to the base of the penis. (Do not put on a condom after it has been unrolled; it is unsafe to put it on after it has been unrolled, for it may tear in the process).
7. Then one is ready for intercourse.
8. After ejaculation (coming), hold the base (ring) of the condom and withdraw (pull out) the penis from your partner before it gets soft (holding the rim keeps the condom from slipping off).
9. Slide the condom off the penis without spilling the semen. (If possible one should use tissue paper, towel, or any thing available when unrolling the condom).
10. If paper is available, wrap the condom in it and throw it in a pit latrine or bury the condom (condoms must only be used once).
11. Wash hands with soap.

Advantages

- Condoms are 97% effective, and they protect against most STIs if used consistently and correctly
- Condoms are the only contraception that can prevent STIs including HIV/AIDS
- Are inexpensive and easy to get
- Are lightweight and disposable
- Do not require a prescription
- Can help relieve premature ejaculation
- May help a man stay erect longer
- Can be put on as part of sex play
- Can be used with other methods



Disadvantages

Some men and women feel that the condom dulls sensation. Others become frustrated and lose some of their sexual excitement when they stop sexual engagement to put on a condom. Some men are self-conscious about using condoms. They feel pressured about having to maintain an erection to keep the condom on. Others feel pressured to ejaculate. Many overcome these pressures and learn to enjoy using condoms by using them during sex play before intercourse.

Side Effects

Condoms have no side effects except for people who are allergic to latex. Some women and men have such allergies. They may use plastic male or female condoms instead.

Effectiveness

A condom is extremely effective when used correctly. The effectiveness is increased when used concurrently with spermicides.

The female condom

This is a barrier contraceptive method with a thin rubber tube with flexible rings at each end; it is inserted into the vagina before sexual intercourse.

How it works

Prevents semen from entering the woman's body and protects male partner from contact with vaginal fluids.

How to use it

Before sexual intercourse begins, it is inserted into the vagina. One of the rings is used to insert the device and hold it in place. The other ring stays outside of the vagina. The female condom must be removed immediately after intercourse and must be thrown away after one use; it should never be reused.

Advantages

- It helps protect you from STDs and HIV.
- The female condom is lubricated to make it easier to use.
- It can be put in any time before sex.
- It is thought to protect against cervical cancer.

Disadvantages and common side effects

- They can be tricky to use at first but practice makes perfect.
- The inner ring is quite uncomfortable and can slide down if you do not fit it properly.
- Like the male condoms, be careful with getting sharp objects (i.e. rings, nails etc.) into contact with the female condom.
- It is possible for the man's penis to enter at the side of the female condom into the vagina.
- They can be quite expensive and not all Family Planning Clinics have them.
- It can slip out if not correctly inserted.



Male Condom

Female condom

Effectiveness

A female condom is extremely effective when used correctly.

Diaphragm/cervical cap

Diaphragm/cervical cap is a shallow rubber cup that is placed inside the vagina before intercourse so that it covers the cervix.

How it works

Diaphragms/cervical caps prevent sperm from mixing with cervical mucus and entering the cervical canal thereby preventing the sperm from fertilizing the egg. In addition, spermicides provide added protection when used with diaphragm.

How to use it

Diaphragms/cervical caps come in three types and a range of sizes. A trained health care provider examines the client and determines the right size for the client. The health care provider will teach the client on how to use it and how to check that it is in the correct position. Back home the woman puts the spermicide inside the cap, then inserts it into the vagina before sexual intercourse. The diaphragm must remain in place for at least six hours and not more than 24 hours after sexual intercourse. After use, it should be washed gently with soap and water, air dried, and stored in a cool place.

Advantages

- The diaphragms/cervical caps are effective if used properly and every time you have intercourse.
- There are no side effects unless you are allergic to rubber or to spermicide.
- The diaphragms/cervical caps are immediately reversible form of contraception.
- The diaphragms/cervical caps are low cost after the initial outlay. A diaphragm lasts several years with care.
- The diaphragm can be inserted anytime and worn more or less all the time so that its use need not interfere with sexual arousal.

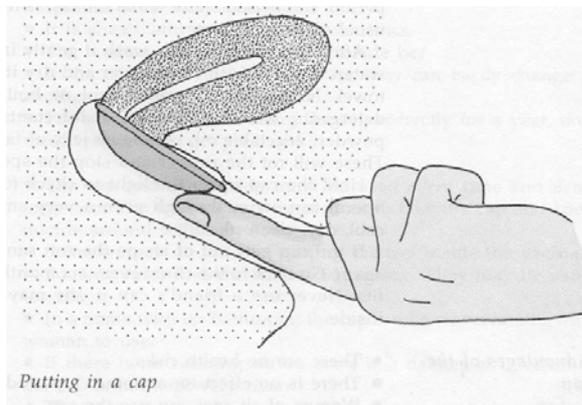
- They are good if you need contraception only occasionally or for short periods now and then. Some women use a diaphragm or cervical cap during their fertile time if they are relying on fertility awareness (natural birth control) for contraception.
- They do offer some protection against those STDs that affect the cervix and upper reproductive tract (Cervical Wart, Virus, Gonorrhoea and Chlamydia).
- Many women wear a diaphragm if they have sex during menstruation to save soiling the sheets. It will hold an hour or two of average menstrual flow without leaking.

Disadvantages and side effects

- Someone trained must fit them.
- Some women don't like putting anything into their vagina.
- Not every woman is anatomically suited to the available range of shapes and sizes.
- Some women have difficulties with inserting the diaphragm themselves.
- Occasionally the suction of the rim may lead to irritation of the vaginal lining.
- Diaphragms in their plastic storage containers are rather too bulky for the average pocket or purse. This is not true for a cap.

Effectiveness

As with the cervical caps, diaphragms are between 92% and 96% effective at preventing pregnancy if used according to instruction.



Spermicides

These can be in the form of vaginal foaming tablets, cream or jelly and are inserted in the vagina before sexual intercourse to prevent pregnancy.

How it works

Makes the sperm unable to move towards the egg and blocks the path of sperm to the uterus. They also kill some of the sperm.

How to use it

The spermicides are inserted into the vagina just before sexual intercourse. After each act of sexual intercourse, you need to insert more before the next act. One should not wash the vagina for at least 6 hours after sexual intercourse.

Advantages

Contraceptive foams, creams, jellies, film, or suppositories can be used by just about any woman who wants to use them but shouldn't be used many times a day. Some people may be sensitive to certain brands - they can try different ones.

Disadvantages

If not used exactly as directed, these products may not form a good barrier over the cervix. Some women complain of messiness or leakage. Spermicide may irritate the penis or vagina. Switching brands may solve this problem.

Side effects

- Must be used before each sex act and may interrupt sex if not inserted beforehand.
- Causes more wetness of the vagina for several hours after intercourse.
- Requires a woman to be willing to touch her vagina.
- May cause irritation to a woman or partner especially when used several times a day.

Effectiveness

They are 79% effective if used alone and correctly. When combined with a condom, their effectiveness increases.



Contraceptive tablet, jell and spermicides

2. Intrauterine Device (IUD)

The IUD is a unique method of birth control – it looks like a barrier method, but is based on a chemical reaction. Intrauterine means “inside the uterus”.

An IUD is a plastic, T-shaped device about 3 cm long, generally coated with copper wire. Some IUDs also contain the hormone progestin. At the bottom of the IUD there are strings which hang inside the vagina, but cannot be seen outside.

IUDs must be inserted and removed by a trained person. They are not recommended for young women who have not yet had children, as there is a risk of infertility, and also for those with multiple or frequently changing sexual partners.

We do not actually know how or why an IUD works so well, but in essence the copper wire changes the chemistry in the uterus which makes it “unfriendly” to eggs, and destroys sperm before it can fertilize an egg. An IUD does not protect against STIs.

How it works

- Copper T emits metallic ions, which kills sperm.
- Makes the sperm unable to swim and meet the egg.

Advantages

IUDs are the most popular form of reversible birth control. There is nothing to put in place before intercourse to protect against pregnancy. Some women say they feel free to be more spontaneous because they do not have to worry about becoming pregnant. Moreover, the ability to become pregnant returns quickly when IUD use is stopped.

Side effects

Possible side effects that usually clear up after the first several weeks to months include

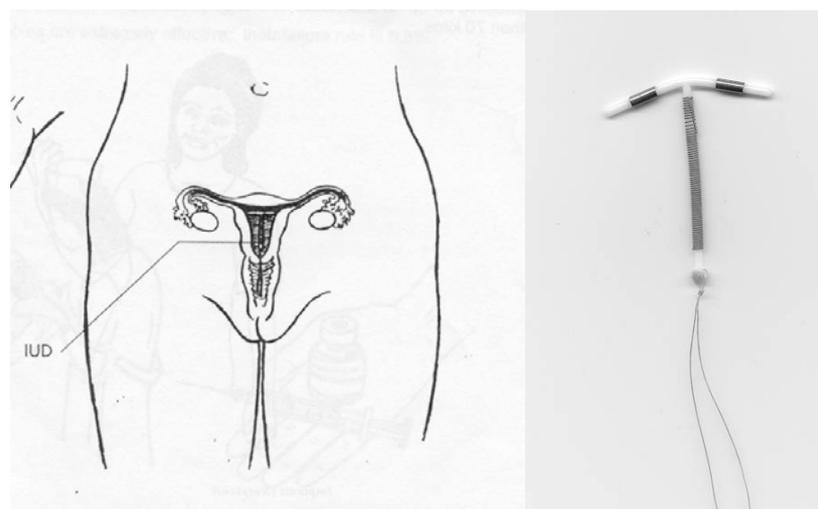
- Changes to menstrual flow (Spotting between periods is common with IUD use)
- Menstrual cramps or backaches

Disadvantages

- Mild pain during the first few days after it is put in.
- Longer and heavier periods in the first 3 months.
- Increased pain during periods.
- Can come out without the user noticing.
- It requires a trained health worker to insert and remove it.

Effectiveness

It is very effective (97%) and protects one for a long time.



IUD: Device that is inserted into the womb through the vagina by a trained health worker

3. Hormonal methods

Hormonal methods of birth control provide very effective protection against unwanted pregnancies. They do not protect against STIs, so should always be used in combination with (male) condoms.

a) Oral contraceptives (the pill)

These are tablets, which are swallowed one every day by a woman, containing artificial forms of hormones (chemicals) similar to those produced by the body to protect her from getting pregnant. Different types of pills contain different levels of the hormones estrogen and progesterin; there are also pills that contain only progesterin. These hormones tell the ovaries not to let any egg cells ripen. The lining of the uterus becomes thinner and the entrance to the uterus is blocked by thick, jelly-like mucus, which makes it hard for sperm to reach the uterus.

Birth control pills are taken every day and it is very important that the pills be taken at the same time every day, whether or not she and her partner have sexual intercourse. Pills should not be shared with anyone else.

If used properly and consistently, birth control pills can be 99.9% effective. If a woman forgets to take the pill for even a few days, it is possible for her to get pregnant. If a woman misses a pill for three or more days in a row, she should use a condom or other barrier method to protect against the risk of pregnancy. Most women do remember to take the pill on a daily basis. If a woman has problems remembering to take the pills, she should seek advice from a Family Planning Clinic about contraceptive options.

How they work

- Suppressing the release of the egg (ovulation).
- Making the inner lining of the womb become thin so that implantation cannot take place.
- Making cervical mucus thick so that sperm cannot pass.

How to use them

The most common is the 21-day system whereby the woman takes a pill daily for 21 days then takes none (or iron containing pills) for 7 days. Women on contraceptives should see a health worker at least once a year to be checked. Some women believe they should only use the pill for a year or two, and then stop. This is not necessary; the method can be used for many years provided the woman has regular check-ups.

Advantages

Taking the pill is simple, safe, and convenient. Many women who take the pill have fewer menstrual cramps and lighter periods. The pill does not interfere with having sex. Many women say it has improved their sex lives. They say it helps them feel more spontaneous. It also regulates the menstrual cycle, reduces menstrual flow, reduces acne, protects against certain cancers, and is totally reversible (once the woman using it is off the pill, her body resumes its normal cycle). When used correctly, the pill is very effective, making it the most reliable contraception available.

Other non-contraceptive benefits

It reduces the amount of blood lost and pain suffered during menstruation. Although this is a concern for some women, they can be reassured that it is not because the blood is staying inside the womb. The menstrual blood is reduced because the lining of the womb builds up less when a woman is taking the pill. When a woman stops taking the pill, she is usually able to get pregnant again quite soon.

Disadvantages

The pill doesn't protect against sexually transmitted infections and it may cause a few side-effects such as irregular bleeding, breast tenderness, weight gain, headaches and nausea. These side-effects usually disappear after a few months, though. If you're on the pill and these side-effects don't go away after a few months, see your doctor. Moreover, it does not protect against sexually transmitted infections (STIs) or HIV.

Side effects

Contraceptives may cause side effects in some women. Usually these side effects go away after the first three months. They may include feeling sick in the stomach, weight gain, headaches, depression, breast tenderness, and irregular menstrual bleeding. If these side effects do not go away, the woman may want to switch to a different kind of pill, or to another method. She should consult a health worker.

The most serious and rare side effect is that some women develop blood clots, especially if the woman

- Smokes cigarettes and is over the age of 35.
- Has ever had any of the following conditions:
 - High blood pressure
 - Blood clots
 - Heart disease
- The pill is not advisable in women who have or are suspected to have
 - Swellings in the breast
 - Any unusual bleeding from the vagina

For healthy women who do not have one of these risk factors, taking the pill is less dangerous than having an unwanted pregnancy.

Effectiveness

If taken regularly and correctly, less than 1 woman per 100 will get pregnant. However, if you miss a pill or are sick or have severe diarrhea, this could affect the performance of the pill and it is recommended that you use additional contraceptives (i.e. condoms) for the next 7 days.



Combined Oral Contraceptive (pill)

b) Injectables

Injectable contraceptives contain progesterone. An injection is given every two or three months, depending on the type, in the woman's arm or buttocks.

How they work

The hormones in injectables prevent pregnancy by causing changes in a woman's body similar to those caused by progesterone-only pills.

How to use it

The woman gets an injection every two or three months, depending on the type of injectable; the injection may be given in the arm or in the buttocks.

Advantages

- You only have to think about it 4 times a year! You do not have to remember to take it every day
- Can be used by women who cannot take estrogens
- Can be used while breast-feeding
- Effective for 12 weeks
- Helps prevent cancer of the lining of the uterus
- No pill to take daily
- Nothing to put in place before vaginal intercourse
- It is reversible

Disadvantages

Injections not appropriate for women who are afraid of shots.

Effectiveness

Injectables are extremely effective (99.7%) in preventing pregnancy.



c) Implants (Norplant)

Norplant consists of a set of six small, thin plastic capsules containing progestogen.

How it works

Norplant prevents pregnancy by slowly releasing a little of the progestogen hormone into the body every day. Norplant contains a smaller dose of progestogen than the pill or the injectable. It therefore works to prevent pregnancy the same way and has the same side effects as other program-only pills and injectable methods, especially the effects on menstruation. But these side effects are usually minimal.

During the first months, bleeding may be irregular. There may be spotting in between periods, or the periods may be longer or more frequent. Usually menstrual periods will resume their normal pattern within 9–12 months. Once Norplant is removed, fertility returns quickly.

How to use

The implant is placed under the skin of the upper arm through a small cut, during a minor operation where the client is not put to sleep. Norplant must be inserted and removed by a trained health worker. Once implanted the tubes cannot be seen easily, although they may be felt if the skin in that area is squeezed.

Advantages

- Can be used by women who cannot take estrogen
- Nothing to put in place before vaginal intercourse
- Can be used while breast-feeding
- Gives continuous long-lasting birth control without sterilization for seven years
- No birth control to take every day
- Ability to become pregnant returns quickly when use is stopped

Disadvantages

The most common side effect of Norplant is not serious. It is irregular bleeding which may include irregular intervals between periods. This includes

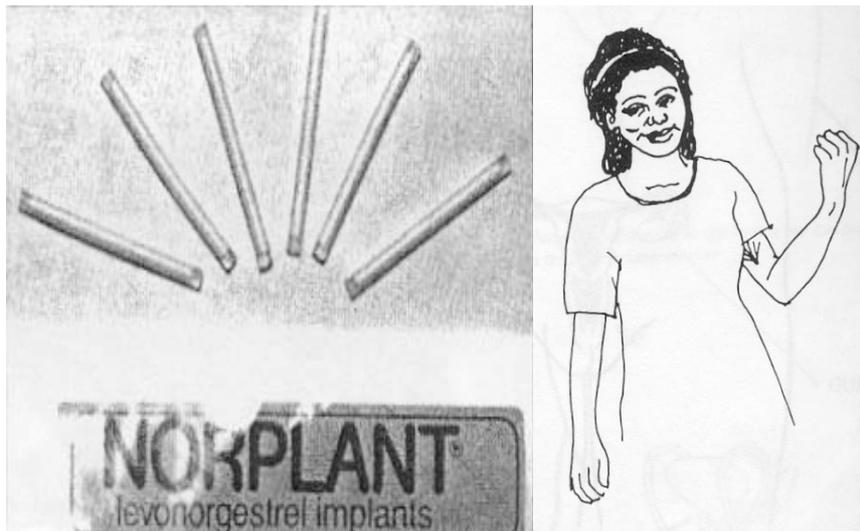
- longer or heavier menstrual flow
- irregular bleeding or spotting between periods
- no menstrual bleeding for months at a time

Bleeding usually becomes more regular after the first two years. Moreover, it does not protect against sexually transmitted infections (STIs) or HIV.

Note: Implants provide no protection against transmitted infections.

Effectiveness

Norplant is highly effective, with a success rate of 99.9%. It remains effective for up to five years. Studies have shown that it is slightly less effective in women with more than 70 kilograms body weight.



d) Birth control patch (Contraceptive patch)

This is a thin 5 cm patch that is worn on the woman's buttocks, abdomen or upper arm. The patch releases estrogen and progestin through the skin into the bloodstream. Patches are worn for one week at a time for 3 consecutive weeks; the fourth week a patch is not worn and menstrual bleeding occurs. A patch is only available through a health professional, and is about 99% effective in preventing a pregnancy when used properly.

The patch can be worn while in water (swimming or bathing). Side effects may include breast tenderness, headache, nausea, upper respiratory infection, menstrual cramps and abdominal pain. There may also be skin irritation where the patch is worn.

Note: The patch does not prevent against STIs, and should always be used together with a (male) condom.

4. Permanent methods

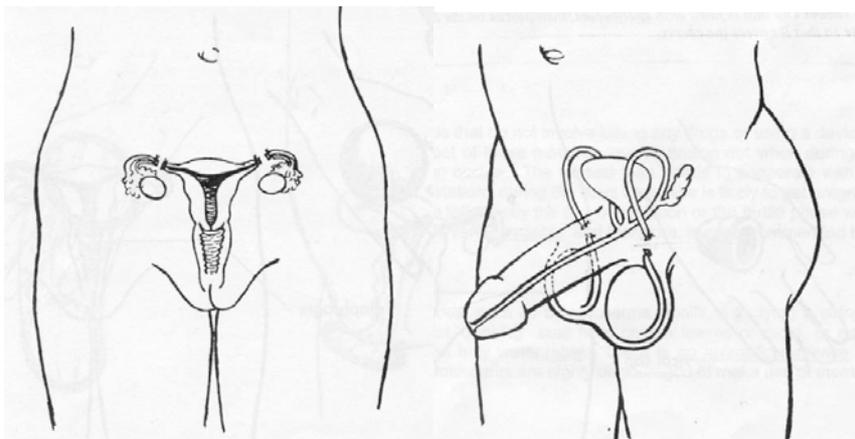
These are sometimes referred to as sterilization or surgical methods. They include Vasectomy for males and Tubal Ligation for females. Once done it is not reversible in developing countries, including those in Africa.

Tubal ligation (female sterilization)

It is a simple operation in which the fallopian tubes that carry the eggs to the womb are cut and sealed. A trained health worker always performs the operation.

Vasectomy (male sterilization)

It is a simple operation during which the vas deferens, the tubes that carry sperm are cut and closed. A trained health worker must perform the operation without sending one to sleep.



Tubal ligation (female sterilization) Vasectomy (male sterilization)

5. Natural methods

These include all methods that do not involve taking any drugs or using a device to prevent pregnancy. Most of these methods involve finding out when ovulation occurs during the menstrual cycle. The woman then needs to cooperate with her partner to avoid sexual relations during the days when she is likely to get pregnant. Since it can be difficult to tell the day of ovulation or the fertile phase when ovulation takes place, it is very unreliable and therefore not recommended here for adolescents. The natural methods include the following:

a) Abstinence

This is where one totally refrains from sexual intercourse. It is 100% effective at preventing pregnancy and has no side effects.

b) Lactational Amenorrhea Method (LAM) (prolonged breast-feeding)

LAM is a family planning method that uses breastfeeding to prevent pregnancy. It is most effective in a woman whose periods have not yet returned and when the baby is less than 6 months old breast-feeding exclusively (at least 10 times every day). The method's effectiveness is reduced when the baby starts eating other foods besides breast-milk and therefore breast-feeding is less frequent. It is not recommended for mothers with babies above 6 months.

c) Cervical Mucus Method

Here one has to observe the change in cervical mucus that takes place during ovulation. During ovulation the cloudy, tacky mucus becomes clear and slippery in the few days before ovulation. It also will stretch between the fingers. The woman has to put her fingers into her vagina to feel and look at this mucus so as to avoid sexual intercourse during this fertile period.

d) Basal Body Temperature

It requires a girl/woman taking her body temperature every morning before getting out of bed. The body temperature rises between 0.2°C and 0.4°C during ovulation. It remains at that level until her next period. Pregnancy may occur during two days before the temperature rise until six days after. This method requires plenty of discipline and knowledge of one's body.

6. Emergency Oral Contraceptives (EOC)

They are oral contraceptives taken within 72 hours after unprotected or forced sex to help avoid pregnancy. They prevent the release of the egg only and do not disrupt existing pregnancy.

How to use emergency contraception

Emergency contraception can be given within 72 hours to women who have had unprotected sex, forced sex or their normal method of birth control cannot be relied upon. For example, the condom may have broken or she may have missed some contraceptive pills. There are two methods commonly used, either high dose hormonal pills (known commonly as the „morning-after-pill“) are given or an IUD can be fitted.

For correct use of emergency contraceptives, adolescent youth should consult health workers. If sex was forced, the girl may need medical care and also special counseling.

Effectiveness

The actual reliability is 95% at preventing unwanted pregnancy. This method is less effective than other family planning methods and should not be relied on routinely.

7. Traditional methods

Cultural traditional methods are contraceptive methods whose effectiveness has not yet been scientifically proven; hence adolescents are not encouraged to use them.

In Africa they include some of the following:

- Using charms
- Spells, e.g. tying a string or amulets around the waist
- Drinking herbs prepared from certain leaves, or roots
- Eating certain foods or taking the holy water
- Jumping with the legs spread out after sexual intercourse for the semen to come out of the vagina
- Using animal waste e.g. zebra dung

Summary of contraceptive methods

Contraceptive methods	Descriptions	Failure rate
Male/Female condom	• Barrier method: rubber sheath	12%
Spermicides	• Chemical contraceptive; creams, jellies, foam, tablets, suppositories	21%
Diaphragm	• Shallow rubber cup with a rim	18%
Cervical and vault caps	• Soft rubber cap covering only cervix	0.3%
The pill: POP	• The pill containing only progesterone	1%
The Pill: COC	• The combined pill containing estrogen and progesterone	0.3%
Long-acting injectables	• Injectables containing progesterone	0.3%

Norplant	• Six plastic tubes with progesterone	0.09%
IUD: Intrauterine devices	• Plastic devices inserted into the womb	0.1–2%
Male sterilization: (Vasectomy)	• Cutting and tying of each vas deferens	0.15%
Female sterilization (Tubal ligation)	• Cutting and tying of each fallopian tube	0.4%
Abstinence	• Avoiding sexual intercourse	0%
Natural methods	• When ovulation occurs in the menstrual cycle	20%
Traditional methods	• Using charms or spells, eating or drinking plants, taking herbs, etc.	Not documented

Process Facilitation

Section 1: Knowledge on contraceptives

Getting started: (25 minutes) If you are starting this session in the morning, you may conduct the following activities:

1. Hand over to the person assigned for the check-in of the day (3 minutes). He/she should ask the group how they spent the night, whether they had any problem, etc. Discuss if one can do something about their difficulties. At least indicate your concern about their well-being. Ask them also to recount something good, which has happened to them since the last session.
2. Next, ask the person assigned for the energizer to perform the warm up (5 minutes).
3. Also ask the person assigned for recap to briefly summarize the lessons learned the previous day (5 minutes).
4. Do not forget to remind the time-keeper of his responsibility.
5. Introduce the program of the day (2 minutes).
6. Explain to the participants (put on a flip chart), in a form of recap and introduction, the choices open for young people in preventing STDs, HIV/ AIDS and unwanted pregnancy, or for proper spacing between births.
 - a) Using life skills
 - Developing healthier and safer sexual behaviours.
 - Avoiding risky sexual behaviours.
 - b) Abstinence
 - Abstain from sexual intercourse.
 - No sex before marriage.
 - Maintain virginity.
 - c) Staying with a faithful partner
 - Avoid unfaithful partners.
 - Avoid multiple partners.
 - d) Using contraceptive methods

7. Briefly explain (7–10 minutes) the content of the handout on contraceptive methods.
8. Finally, explain to participants that they may now explore their (or peers') experiences, knowledge, feelings and attitudes about contraceptives and compare them with the facts provided in the handout in the basic information.

Exercise 1: Exploring and deepening knowledge on contraceptive methods

Purpose: At the end of the exercise participants will have been familiarized with contraceptives and prevention methods appropriate for young people

Method: Matching, analysis question, and large group work

Tools: Buzzing, cards, and handout

Duration: 35 minutes

The facilitator will:

1. Prepare a set of contraceptive method cards and description cards separately. You may take the ideas for the cards from the background information (see next page: Methods of Contraception)
2. Have the group seated in a circle. Ask participants to form a buzz group of 2 or 3 with their neighbours.
3. Mix up the two sets of cards and distribute them to each buzz group equally.
4. Ask every buzz group to take a turn to read aloud what is on their card.
5. Ask for the one who has a matching card to read it out (method card or description card).
6. Show illustrations.
7. Ask buzz groups analysis questions (if necessary allow the buzz groups to discuss briefly).
 - Describe what the method is?
 - How is it used? Be brief.
 - How does it prevent conception, STDs and HIV/AIDS?

Note: Most of your time should be used for methods which are available to young people where you live. These are probably condom, pill, injectable: Norplant and abstinence.

8. Write the important points on a flip chart.
9. Add major facts missed. Use the background information.
10. Summarize the main methods learned and ask for feedback. Can participants use this exercise with peer learning groups?

Methods of Contraception

Contraceptive Methods	Descriptions
Condom	• Barrier method: rubber sheath
Spermicides	• Chemical contraceptive: creams, jellies, foam, tablets, suppositories
Diaphragm	• Shallow rubber cup with a rim
Cervical and vault caps	• Soft rubber cap covering only cervix
Contraceptive sponge	• Round sponge with spermicides
The pill: POP	• The pill containing only progestogen
Norplant	• Six plastic tubes with progestogen
IUD: Intrauterine devices	• Plastic devices inserted into the womb
Male sterilization (Vasectomy)	• Disconnecting the vas deferens
Female sterilization (Tubal Ligation)	• Disconnecting each fallopian tube
Natural methods	• When ovulation occurs in menstrual cycle
Traditional methods	• Using charms or spells, eating or drinking plants, etc.
Abstinence	• Avoiding sexual intercourse

Exercise 2: Ranking contraceptive methods

Purpose: Participants will be enabled to decide on appropriate contraceptive methods

Method: Large group work

Tools: Buzzing, ranking

Duration: 15 minutes

The facilitator will:

1. Collect the method cards and redistribute them to the buzz groups.
2. Ask the same buzz groups to rank the contraceptive methods in order of their unsuccessfulness for the peers in regards to: availability, safety, and easy use.
3. Write on the ground or on the top of a flip chart horizontally: "most useful", "less useful", "not useful at all", "don't know".
4. Ask the buzz groups to place the card where they think it belongs.
5. Ask them to tell why they have put it there.
6. Participants may suggest the following as most useful: condom, oral contraceptives, injectables, implants and abstinence.
7. Explain to participants that the above five are most appropriate for sexually active adolescents.
8. Summarize the main methods and ask for feedback from participants.
9. Has the ranking exercise enabled you to decide on appropriate methods?

Exercise 3: Analysis of advantages and disadvantages of selected contraceptive methods

Purpose: At the end of the section, participants will be able to identify the advantages and disadvantages of selected contraceptive methods

Method: Small group work

Tools: Brainstorming

Duration: 30 minutes

The facilitator will:

1. Ask participants to form four small groups.
2. Write each of the four methods (condom, the pill, injectables/implant and abstinence) on a piece of paper and fold it.
3. Ask each small group to draw one from the four
4. Ask the small groups to brainstorm on the advantages and disadvantages of the method they have drawn.
5. Tell them to place them under two columns (see example below) on a flip chart or a large piece of paper.
6. Allow 10 minutes for small group work.
7. Bring all groups together and ask presenters of each group to report as recorded on the flip chart (3 minutes).
8. Ask for comments. If necessary, make additional suggestions from information provided in the basic information (see example: Basic information).
9. Review the major advantages and disadvantages and ask for feedback. Have there been any difficulties in using this exercise to identify advantages and disadvantages?

Advantages/disadvantages of selected methods (an example)

	Advantages	Disadvantages
Condom use	<ul style="list-style-type: none"> • Prevents STIs/STDs including HIV/AIDS • Prevents pregnancy • Doesn't necessitate going to the clinic • Success rate 97% 	<ul style="list-style-type: none"> • Partner may refuse to wear condom • Takes partner longer time to "come" • The condom could break or slip off • Less lubrication during sex • Less enjoyment due to reduced sensation for the man
The pill	<ul style="list-style-type: none"> • Highly effective in prevention of pregnancy • Reduces blood lost during menstruation • Easy to get 	<ul style="list-style-type: none"> • Swallowed every day • Can be missed • Small temporary side effects • Doesn't prevent STDs
Injectables	<ul style="list-style-type: none"> • Easy to use • Long-acting (2–3 months) • Success rate of 99.7% 	<ul style="list-style-type: none"> • Not easily available • Menstrual period irregular for some time • Fertility returns after 12–14 months • Don't prevent STIs
Norplant	<ul style="list-style-type: none"> • Highly effective • Success rate of 99.9% • Long-acting 5 years • Fertility returns quickly 	<ul style="list-style-type: none"> • Inserted by a trained health worker • Bleeding irregular for a short time • More frequent periods or longer period
Abstinence	<ul style="list-style-type: none"> • Highly effective • No side effects 	<ul style="list-style-type: none"> • Requires decision and discipline • May not persist

Section 2: Condom use

Getting started: (3–5 minutes) Recap the lessons learned from the previous exercises and explain briefly the importance of condom and the pill for sexually active adolescents and that misconceptions and other barriers towards their use should be overcome.

Exercise 1: Identifying barriers in using condoms

Purpose: Participants will be able to identify barriers in using condoms

Method: Large group discussions

Tools: Buzzing, brainstorming

Duration: 25 minutes

The facilitator will:

1. Ask participants to form buzz groups of 2 or 3 with their neighbours.
2. Ask them to briefly discuss and list 4 misconceptions, negative attitudes and behaviours towards the use of condoms (5–7 minutes).
3. Ask them to rank the barriers.
4. Ask one of the buzz group members to share the first two from the list to the whole group by brainstorming (see example below).
5. Record on a flip chart without comments.

6. Then screen and merge repeats and compare with the facts in the handout.
7. Rank the barriers in order of their hindering possibilities.
8. Summarize the important attitudinal and behavioural obstacles in using condoms.
9. Ask for feedback from the participants. Has the exercise helped to identify some of the barriers?

Myths, attitudes and behaviours towards condom use (an example)

- Condoms break a lot and are not reliable
- Condoms fall off and get lost in the vagina
- Condoms are expensive
- There are defective condoms
- It is embarrassing to get condoms
- I do not have knowledge and skill in using a condom
- Condoms make peers more promiscuous
- I can't feel anything when I wear a condom; it diminishes pleasure
- None of my other friends use condoms
- It is embarrassing to be seen with a condom

Exercise 2: Life skills to overcome barriers to condom use

Purpose: To enable participants to identify life skills to overcome barriers in using a condom

Method: Exercises

Tools: Barrier sheet and life skill sheet

Duration: 35 minutes

The facilitator will:

1. Ask participants to form four small groups. Use group-dividing technique.
2. Assign to each group one of the four important barriers identified and ranked earlier.
3. Ask the groups to identify and list the kind of life skills necessary to overcome the barriers to the use of a condom. Different life skills may apply to different behaviours (see example below).
4. Allow 10 minutes for small group work.
5. When the allotted time is up, pull the groups together.
6. Ask the presenter to brainstorm the life skills identified.
7. Write on a flip chart the life skills under the four barriers.
8. Summarize the main life skills learned for overcoming the barriers and ask for feedback. Was the exercise helpful?

Life skills in overcoming barriers in Condom Use

Myth or Barriers	Life skills
<ul style="list-style-type: none"> For those who say the condom is not reliable or it can be damaged easily 	<p>Problem solving</p> <p>Understand condom effectiveness Practice correct condom use, keep condoms away from heat and extreme coldness</p>
<ul style="list-style-type: none"> For those who say condom can get stuck inside the woman 	<p>Critical thinking</p> <p>Condoms which are placed properly on an erect penis cannot come off by themselves and stay inside your partner</p>
<ul style="list-style-type: none"> A condom has virus in it 	<p>Critical Thinking</p> <p>HIV cannot stay outside of human being or fluids of human beings for longer period of time</p>
<ul style="list-style-type: none"> There are defective condoms 	<p>Problem Solving</p> <p>Be able to identify defective condoms when you get them, know about condoms</p>
<ul style="list-style-type: none"> Buying a condom is embarrassing and it is a sign of promiscuity 	<p>Self confidence</p> <p>Be aware of yourself and have the confidence to get a condom. Having AIDS while you can protect yourself is more embarrassing than using a condom</p>
<ul style="list-style-type: none"> Condoms make people more promiscuous 	<p>Self awareness and Self esteem</p> <p>Using condoms and carrying them shows how protective you are</p>
<ul style="list-style-type: none"> Condom decreases sexual pleasure/ satisfaction; It is like eating candy/ banana with its cover 	<p>Effective communication</p> <p>Sexual pleasure does not come only from sexual intercourse, there are other things you can do also. Most people do not experience a loss of feeling with a condom, but if you do you can use a lubricant with spermicide in combination with a condom (NEVER use petroleum jelly!)</p> <p>Condoms protect against STIs, HIV and avoid unwanted pregnancy</p>
<ul style="list-style-type: none"> Not one of my friends uses condoms, why should I? 	<p>Avoiding peer pressure/critical thinking</p> <p>If all of your friends are dying, does this mean you should too? Many people are using condoms. Be who you are and avoid peer pressure.</p>

Exercise 3: Feelings and emotions towards condom use

Purpose: Participants will be able to demonstrate condom use comfortably in public

Method: Fantasizing, analyzing questions

Tools: Flip chart paper

Duration: 25 minutes

Note: Participants may never have tried practicing the use of condoms with others. When peer educators discuss difficult taboo topics, they must be comfortable with the topics so that their peers can benefit from their knowledge without interference. Conduct the following exercise so that participants “get in touch with” their feelings about the taboo.

The facilitator will:

1. Ask participants to relax, close their eyes and imagine how they would react in the following situations and think about their answers (about 5 minutes with the explanation of the situation). Imagine how you would feel when
 - Distributing illustrated brochures to peers that describe how to engage in safer sex using condoms.
 - Demonstrating how to put a condom on a penis model in front of a small group of peers during a training session.
 - Negotiating with peers who refuse to consider condom use.
2. Ask analysis questions:
 - Have you ever demonstrated condom use before?
 - Do you feel comfortable?
 - What information and facts do you need to make you feel comfortable in this situation?
3. After reading the situations and questions, ask participants to share their feelings and fears (10 minutes).
4. Write the responses on a flip chart.
5. Summarize the important feelings and ask for feedback from participants. Does this exercise help you deal comfortably with condoms in public?

Exercise 4: Demonstration on the correct use of condoms

Purpose: To enable each participant to use a condom correctly and safely

Method: Demonstration

Tools: Penis model, banana, or bottles, and male condoms

Duration: 25 minutes

The facilitator will:

1. Using a penis model and condom, demonstrate how to properly remove a condom from the package and place it on a model, following the steps described below. Show the steps to follow when putting on a condom (about 5 minutes).

2. After the demonstration and a brief discussion, distribute penis models and condoms, all the participants should put a condom on a model at least once. You may improvise your own models, e.g. using bottles, banana.
3. Ask the participants to practice putting on and removing a condom using a penis model and a condom (10 minutes).
4. Summarize the main steps and ask for feedback from the participants. Can the exercise help master the use of a condom? What are the problems?

Exercise 5: Practicing the steps in condom use (both male and female condoms)

Purpose: To enable participants use condom correctly

Method: Exercise

Tools: Condom cards

Duration: 30 minutes

The facilitator will:

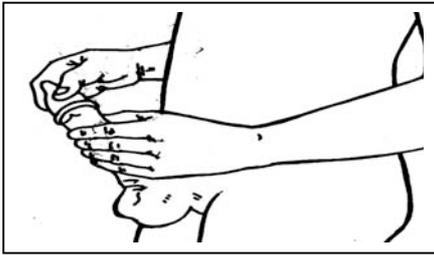
1. Prepare in advance the “How to use a condom” cards (see charts below). The sheets contain both illustrations and words describing the steps. Carefully photocopy them on cards or paper.
2. Select eight volunteers from the group of participants.
3. In random order, distribute the prepared “How to use a condom” cards to the volunteers.
4. Instruct volunteers to look at each other’s cards and line up in correct order across the room (allot about 7 minutes).
5. Instruct the participants remaining in the audience to observe the Problem Solving skills used by members of the “card” group while completing the activity.
6. After the participants with their cards are in the correct order, ask each volunteer to describe the activity illustrated on his/her card. Discuss any questions or comments that participants may have with regard to each (about 15 minutes).
7. Summarize the lessons learned and ask for feedback from the participants. What are the problems faced in performing the exercise? Can Peer Learning Groups use this exercise?

How to use condom cards

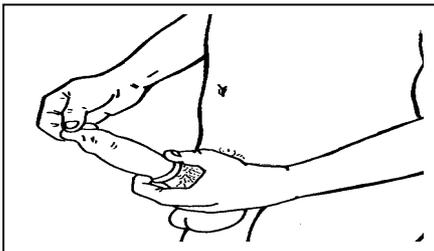
Instructions: Photocopy on heavy paper or cut out the cards on the following pages for use in exercise.



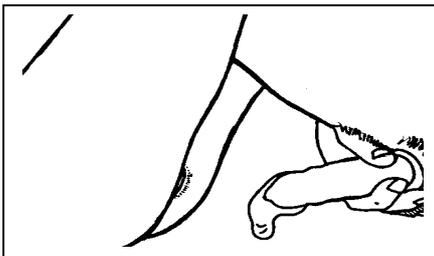
Carefully open the package so that the condom does not tear



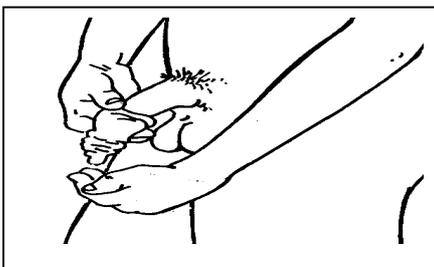
If not circumcised, pull the foreskin back. Squeeze tip of condom and put it on end of hard penis



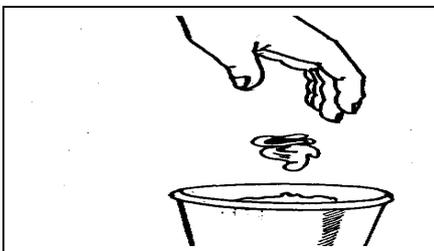
Roll condom onto the penis. It should unroll easily. If it does not, it is inside out and should be discarded



After ejaculation (coming) hold the rim of the condom firmly as you withdraw your penis



Slide condom off without spilling liquid (semen)

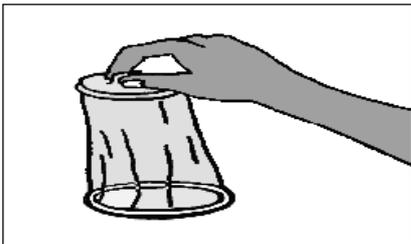


Tie and wrap the condom (in piece of paper if available) then throw it into a dustbin or pit latrine or burn if possible. Wash hands.

How to use a Female Condom



Open the package carefully



Open end consists of the outer ring and covers the area around the opening of the Vagina.

Inner ring used for insertion helps hold the condom in place.



Hold inner ring between the thumb and middle finger. Put index finger on condom between other two fingers.



Squeezing the inner ring insert the condom as far as possible into the vagina. It should cover your cervix and be held in place between the cervix and rear wall of the vagina - like a diaphragm



Make sure the condom is inserted straight, and is not twisted inside the vagina. The outer ring should be outside of the vagina.





The penis should be guided into the condom in order to ensure that the penis does not slip into the vagina outside the condom.



Remove the condom carefully before standing up. Squeeze and twist outer ring and pull out gently keeping the sperm inside.



Dispose: Wrap the condom in the package or in tissues and dispose with trash, not in toilet.

Helpful hints for the use

Use lubricant if:

- The penis doesn't move freely in and out,
- The outer ring is pushed inside,
- There is noise during sex.
- You feel the condom when it is in place.



Section 3: Using the pill correctly

Getting started: (20 minutes) If you are starting this session in the morning, you may conduct the following activities to get started.

1. As usual hand over to the person assigned for the check-in of the day (3 minutes). He/she should ask the group how they spent the night; whether they had any problem, etc. and discuss if one can do something about their difficulties. At least indicate your concern about their well being. Ask them also to recount something good, which has happened to them since the last session.
2. Next, ask the person assigned for the energizer to perform warm up (5 minutes).
3. Also ask the person assigned for recap to briefly summarize the lessons learned the previous day (5 minutes).
4. Do not forget to remind the time-keeper of his responsibility.
5. Introduce the program of the day (2 minutes).
6. Explain to participants (put on a flip chart), in a form of recap and introduction, the choices open to adolescents in preventing STDs, HIV/AIDS and unwanted pregnancy (3 minutes).
 - a) Use of the life skills
 - In avoiding risky behaviours.
 - Developing safe sexual behaviours.
 - b) Abstinence
 - Abstain from sexual intercourse.
 - No sex before marriage,
 - Maintain virginity.
 - c) Stay with a faithful partner
 - Avoid multiple partners.
 - Avoid unfaithful partners.
 - d) Use the condom, and
 - e) Use the pill

Exercise 1: Exploring experiences about the pill

Purpose: At the end of the session participants will have learned to identify beliefs and misconception affecting the use of the pill

Method: Large group discussions

Tools: Buzzing

Duration: 20 minutes

The facilitator will:

1. Ask the participants to form buzz groups with their neighbours mixing male and female participants.
2. Ask them to discuss their experience with the pill: their beliefs, fears, misconceptions and what they expect from the pills (see the example below) (5 minutes).

3. Ask each buzz group to take turns and share two of the fears or misconceptions identified.
4. Record on a flip chart, screen repeats and compare the beliefs with the facts in the handout.
5. Summarize the important misconceptions learned and ask for feedback from the participants. Does the exercise help to identify misconceptions?

The pill: beliefs, misconceptions and expectations (an example)

- | | |
|-----------------------------------|-------------------------------------|
| • The pill prevents pregnancy | • The pill makes you weak |
| • The pill is unreliable | • The pill is uncomfortable |
| • The pill causes deformed babies | • The pills collect in your stomach |
| • The pill causes sickness | • The pill prevents STIs |

Exercise 2: Advantages and disadvantages of the pill

Purpose: At the end of the session participants will be able to understand the advantages and disadvantages of the pill

Method: Large group discussions

Tools: Buzzing

Duration: 20 minutes

The facilitator will:

1. Ask the participants to form a buzz group with their neighbours (you may change neighbours regularly) and discuss the advantages and disadvantages of the pill (allow 5 minutes).
2. After 5 minutes ask one member of each buzz group to share two of the identified advantages and two disadvantages of the pill.
3. Record the ideas on a flip chart under two columns: advantages and disadvantages.
4. Screen for repeats and compare with the facts from the handout.
5. Review the important lessons learned about advantages and disadvantages of the pill and ask for feedback from the participants. How useful was the exercise?

Advantages and disadvantages of the pill (an example)

Advantages	Disadvantages
<ul style="list-style-type: none"> • Very effective in preventing pregnancy • Nothing to insert/take care of at the time of sex • Feels safer and more secure • When stopped, fertility returns quickly • Availability • Less menstrual bleeding and pain, and more regular periods • Easy to stop if one wants to get pregnant 	<ul style="list-style-type: none"> • Sometimes nausea, headaches, dizziness or sore breasts (not dangerous) • Sometimes weight gain • Medical check up is advisable • Does not protect one against STIs including HIV/AIDS. • Illness such as blood pressure and blood clots in a few women, especially older women who smoke • Must be taken daily

Exercise 3: How to use the pill correctly

Purpose: At the end of the exercise participants will have learned the correct use of the pill

Method: Large group discussions, analysis questions

Tools: Buzzing, quiz, the packet of the pill, question

Duration: 30 minutes

The facilitator will:

1. Give one pill packet (if possible) to each participant, or at least one per group.
2. Explain the steps of using the pill following the arrow on the package.
3. Ask participants to form a buzz group and discuss your input briefly. Write the questions on a flip chart or a large piece of paper (Allow 7–10 minutes).
 - Where will you get the pill?
 - When do you take the pill?
 - In what order will you take the pill?
 - How will you remember to take a pill a day?
 - What happens if you miss two days? Or three days?
4. Go round and conduct a quiz using the same questions.
5. Summarize the correct steps of using the pill and ask for feedback. Has the exercise clarified the correct use of the pill?

Exercise 4: Using the pill correctly

Purpose: At the end of this exercise the participants will understand how to take pills correctly

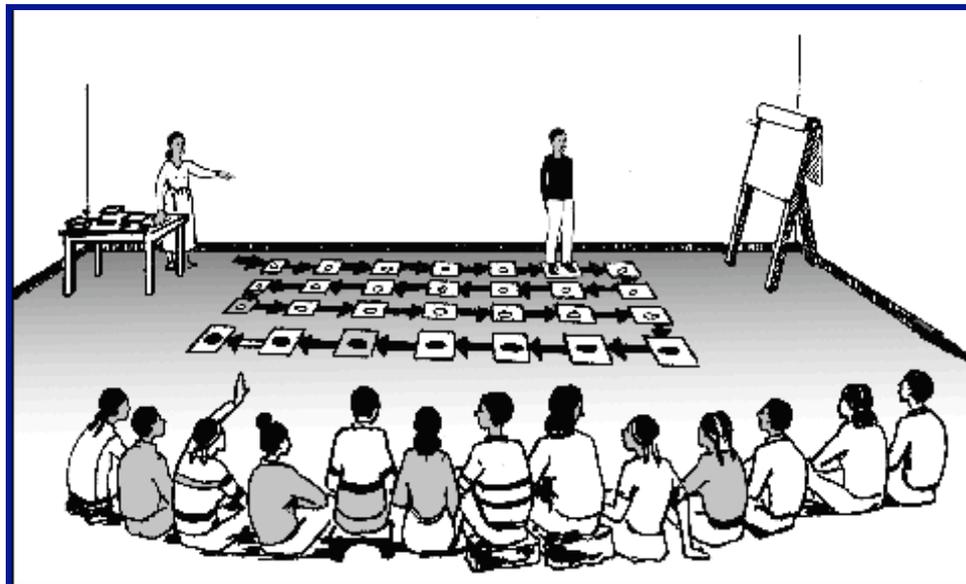
Method: Taking pills in relation to ovulation and menstrual cycle

Tools: Role-play, marker, 28 sheets of A4 paper with a flow chart and drawing of a menstrual cycle

Duration: 50 minutes

The facilitator will:

1. Stick the drawing of the menstrual cycle on the wall. (You will get this drawing from Unit 5, Section 2).
2. Draw arrows on each of the 28 sheets of A4 paper using a marker.
3. Put the arrow and the A4 size papers on the ground, like the pills (as seen in the picture below).
4. Each day represents each tablet to be taken every day. The average day for the menstrual cycle will be 28 days.
5. Ask a volunteer, male or female, to walk on the pills using the direction. Each step represents taking one pill.
6. Participants will ask the volunteer to stop when he/she steps on one arrow.
7. She/he will be asked to answer the following questions:
 - Where exactly is the stage of the menstrual cycle at this particular day?
 - What is the development of the egg at this day in the ovulation stage? (Use the drawing).
 - What exactly will the woman feel at this particular day?
 - What is the chance of the woman getting pregnant at this day? Is she safe? How safe?
 - What will happen if she forgets to take the pill on this particular day? How worrying it is for the chance of getting pregnant when she is on the last pills?
 - Why are these pills different? What are they for?
 - What will happen if a woman forgets to take it?
8. If the volunteer fails to answer the questions, please ask the trainees.
9. Ask as many volunteers as possible to walk on the papers representing pills.
10. Finalize the correct use of pills mentioned on the next page.
11. Ask for feedback from participants regarding this exercise. Has this exercise managed to equip you with the skill for correct usage of pills?



How to use the pill correctly:

1. Know that there are many different kinds of pills.
2. Know that there are many different packets of pills.
3. Identify where you can get the pills regularly.
4. Follow the arrow direction on the pill.
5. Take your first pill on the first menstrual bleeding day or on any of the next 4 bleeding days (for the 28 pills packet).
6. Take one pill at the same time everyday as per the arrow directions.
7. Take the pill at the same time every day.
8. When you finish one packet, take the first pill of a new packet of the same kind/brand the very next day and follow the arrow direction.
9. If you forget one pill, take it as soon as you remember.
10. If you miss two or three pills one after the other, throw away the rest of the packet and start a new packet until the next period is over.
11. Design means of remembering to take the pill everyday.



Unit 10. Peer Counseling Service

Basic information: Handout

What is counseling?

Counseling is a two-way communication whereby the service provider and the client are engaged in open discussions, understanding and exchanging ideas and learning from each other. In this process the client is given detailed information and an explanation of the options to help them make an informed choice. In the context of sexual and reproductive health, this might be to choose appropriate contraceptive methods that suit his/her individual situations; options to protect herself/himself from unwanted pregnancy, HIV/AIDS etc. and to develop safer sexual behaviour and/or decide to take an HIV/AIDS test voluntarily without any external influence.

Counseling is not providing advice to a person or just giving information. It is not about telling people what measures to take or not. It is neither about influencing the client to take this or that type of contraception nor about awareness creation or knowledge transfer; nor is it about a service which judges and accuses the client for whatever he/she has done. Counseling is rather about giving options to the client so that he/she is able to make informed decisions on their own sexual life to protect him/herself from unwanted pregnancy, HIV/AIDS, STIs, or to develop options which lead the client to make informed decisions to overcome an existing problem related to one's sexual and reproductive health.

Counseling knowledge and skills are important instruments that help solve different sexual and reproductive health (SRH) related problems. The most important thing is the need to be well informed about the issues, which are raised in the course of the counseling session.

Counseling is helping someone to understand their options, and to effectively assess the potential risks and benefits, so that he/she is able to make informed decisions about their sexual and reproductive health life.

Why is peer counseling important?

If you remember (or look back at) the very first unit in this guide, you will recall that peer groups and peer-to-peer communication is one of the most common and most effective ways for young people to get information. The sudden – and sometimes rather extreme – body changes that take place during adolescence make this a time when young people turn to their peers more than ever. Since many young people do not get accurate information and skills from their parents, other family members or from school which answer their worries about what exactly is going on in their body and the associated feelings, they start their sexual adventures based on the information they get from their peers. Therefore it is very important that the information young people give one another is complete and accurate. A large number of young people are engaged in sexual activities without having the knowledge and skills that will help them make informed decisions affecting their sexual and reproductive health life.

Many young people worry about a number of things including unwanted pregnancy, HIV/AIDS, being loved or not, the size of their penis and time of menstruation. They need



and request more information and advice but they do not know where to get it. Besides, there are not enough places where young people could get youth-friendly services without being judged and feeling embarrassed. Peer counseling is therefore meant to fill this gap and help young people get the necessary services from a trained peer counselor who will support them.

Who provides peer counseling?

Trained professionals usually give counseling. However, young people who have been trained in SRH issues and communication skills and been involved in peer education programs as peer educators, youth leaders that have experience working with young people as well as young people willing to serve as peer counselors can also be trained in peer counseling and provide this service for their peers.

Role of peer counselors

The main roles and responsibilities of peer counselors include:

- Assisting the client/peer to make informed decisions by assessing his/her own personal behaviour and attitude, which will make her/him vulnerable to unwanted pregnancy, HIV/AIDS and STIs,
- Identifying myths and facts about SRH issues with the client,
- Providing priority consideration to the needs and feelings of the client,
- Preparing and making supportive educational materials available to his/her service such as penis model for condom demonstration, different types of contraceptives, IEC materials, etc.
- Keeping simple records,
- Keeping the secrets of the client and assuring confidentiality, and
- Referring clients to SRH clinics/centres for further services if needed.

The Peer counselor should **NOT**

- Assume he/she knows what is best for the person he/she is speaking to.
- Pressurize the client to accept his/her decision, but should help ensure that he/she has accurate and complete information and understands his/her rights in order to make his/her own decisions.

Knowledge of peer counselors

The peer counselor should have full knowledge about and the skills to explain:

- Reproductive organs and their functions,
- Sexuality and gender,
- Drug and drug abuse,
- STIs including HIV/AIDS,
- Contraceptive methods,
- Life skills and
- How to refer clients to SRH services and the referral system.



- The peer counselor needs to update her/himself with current issues and developments in the field.

Note: It is not possible for the peer counselor to provide answers to each and every question that young people may raise. Therefore, when and if the counselor faces questions for which he/she does not have any answer or with which he/she is not familiar with, he/she should either refer the client to a health professional where the client will be able to get answers to his/her questions or make an appointment to come up with the answers by asking professionals or by consulting references.

THE PEER COUNSELOR MUST NEVER GIVE ANSWERS HE/SHE IS NOT COMPLETELY SURE ABOUT.

Characteristics and skills of an effective peer counselor

An effective peer counselor should have the following main characteristics and skills, among others:

- Have effective communication skills, (ability to communicate clearly and in ways that include body language) and adequate knowledge of his/her key message,
- Respect for peers' feelings, sympathy for their problems and the ability to be supportive,
- Belief in family planning services,
- Respect for one's belief system and feelings,
- Respect for the SRH rights of young people,
- Ability to keep the secrets of peers,
- Knowledge of his/her role and responsibilities as peer counselor,
- Ability to listen and give attention to the client,
- Ability to ask questions that will help the client to openly reveal his/her feelings and needs,
- Ability to speak in the language of the client, and
- Ability to help the client to assess his/her own behaviours and identify components that lead to vulnerability of the client to SRH problems.

Process of peer counseling

The counseling service has its own procedures and skills. Accordingly, the counselor needs to be well trained to acquire these skills. As the service needs a conducive environment to be properly provided, one needs to prepare all the necessary materials well in advance.

Give the options in different stages, which will address the clients' issues and let her/him decide or choose the appropriate option for his/her situation. We will discuss these stages in the following sections.

Creating an appropriate atmosphere for peer counseling

Since peer counseling deals with individuals' personal issues, it needs to be carried out in a quite and conducive atmosphere, where the conversation cannot be listened to by others next door. Sit face to face with the client, with a fair distance in between you. Allow the client to feel comfortable and ask questions. If you are conducting the counseling outdoors, make



sure you chose a place where you can sit and there is no noise and movement of people to distract your attention and the process.

Ensure the confidentiality of your conversation with the client. The peer counselor should ask her/himself the following questions to make sure that he/she is ready to provide the service,

- Am I ready to provide the service? (Knowledge and feeling wise)
- Have I managed to create a conducive environment?
- Can I provide enough attention without distraction?
- Is the place I chose conducive enough for discussion?
- Is the place clean and free of other people?
- Do we have enough comfortable seats for the session?
- Do I have enough forms for referral?
- Do I have enough samples of contraceptive methods for demonstration purposes?
- Do I have the models and pictures of menstrual cycle, reproductive organs etc.?

Procedures of a counseling service session

After you have finished your preparation the counseling session can be held in steps. For example, a counseling service about contraception and HIV/AIDS can be given in six steps.

Counseling about Contraception

Step 1: Introduction

- Give enough attention to the client.
- Greet the client, invite her/him to sit, introduce yourself and make the client feel comfortable.
- If he/she is a new client, register her/him on the registration form (name, sex, age, address, family status etc.).
- Make your questions short and simple, and maintain eye contact with the client.
- Assure the client that his/her secret will be kept safe and no one else is listening to your conversation.

Step 2: Ask the client about his/her attitude and practices about contraception

- Ask the client, 'How can I help you?' May be he/she comes to you because he/she is worried about unwanted pregnancy, HIV/AIDS, menstruation, etc. Therefore, allow the client to feel at ease and express his/her fear and worries openly and comfortably.
- If it is a problem that you cannot handle, tell the client that you will refer her/him to a SRH clinic/centre where he/she will get the service needed.
- If the client comes for contraception services, ask why he/she needs it? Which contraceptives he/she knows? And give him/her the chance to ask any questions about the contraceptive methods he/she wants to know more about. Inform the client



that you are asking these questions to assist her/him to choose appropriate contraceptive methods applicable for his/her needs.

Step 3: Discussion with client about contraceptive methods

- Ask the client why he/she wants to use contraceptive methods and assess his/her knowledge about it.
- Try to help the client to avoid misconceptions he/she has about contraceptive methods based on the discussion, and
- Brief the client about the available contraceptive methods.

Step 4: Help the client to choose appropriate contraceptive methods

- Ask the client which of the contraceptive methods he/she wants to use?
- Assess what the client knows about this method. It is necessary to make sure that the client is able to understand whether his/her need matches with the contraceptive method chosen.
- Brief the client about the contraceptive method he/she has chose including its use and sides effects.

Step 5: Discussion about the use of the chosen contraceptive methods

- Give the client the contraceptive method he/she wants to use.
- If it is not available, tell the client where to get the service.
- Ask if the client is able to use the contraceptive method, if not tell her/him how to use it.
- To ensure that the client has understood exactly how to use it effectively, ask the client to brief you on how to use the chosen contraceptive methods.
- Address the side effects of the contraceptive method chosen and inform the client what to do about it.
- Give the client any informational materials (such as leaflets) you have about the contraceptive method the client chose.
- Invite the client to come again and assure her/him that you will be happy to help if need be.

Step 6: Follow up

- When the client comes for a follow up, ask her/him if he/she is using the contraceptive method,



- Ask the client what side effects, challenges and problems he/she has faced in using the contraceptive,
- Ask how the client is using the contraceptive. If there is any mistake in its use, please correct her/him,
- If the side effect is severe, refer the client to a health center/clinic,
- If the client wants to change the contraceptive method, help her/him by providing more information on the method the client wants to use.

Counseling about HIV/AIDS

Step 1: Introduction

- Greet the client,
- Invite the client to take a seat and introduce your self,
- If the client is new, register details about her/him on the registration form (name, sex, age, family status); make your questions short and clear; maintain eyes contact with client while talking,
- Assure the client of the confidentiality of the discussion between the two of you.

Step 2: Help the client to assess risky behaviours that expose one to HIV

- Ask the client what he/she needs and what you can help with. The client might come to you because he/she is worried about HIV infection. Allow the client to express his/her fears, worries and attitudes about the disease,
 - The counseling depends on the risk assessment of the client vis-à-vis his/her practices, which might expose her/him to HIV infection.
- a) If the client thinks that he/she **IS NOT** infected, then the counseling session will:
- Assess why he/she thinks that he/she is not infected,
 - Identify the strengths and weaknesses of the measures taken by the client to protect her/himself from HIV infection,
 - Ask the client how the strengths of these measures can be further strengthened and comment on it based on the response of the client,
 - Brief the client if he/she needs more information about HIV/AIDS,
 - If the client is willing to take HIV test, you can refer her/him to places providing such services.
- b) If the client thinks he/she **IS** infected, the counseling session will:
- Not concentrate on providing information about HIV/AIDS,



- Emphasise that the client needs to self assess risky behaviours and attitudes that might expose her/him to HIV infection,
- Focus on facts that the client believes or does not believe,
- Not spend time in discussing issues that are not relevant to the session,
- Identify the risk factors that the client thinks have exposed her/him to infection. This will help you to help the client identify which behaviours to change in order to protect her/himself from getting infected,
- Ask the client if he/she has taken any measures to protect her/himself from HIV infection and assess the strengths and weaknesses of these measures,
- Assess if the client has any addictions, such as alcohol and drug addictions, and attitudes that will expose her/him to HIV infection,
- Inform the client that you will refer her/him to a health care centre if need be.

Step 3: Discussing behavioural changes needed to protect oneself from HIV infections

- Give more emphasis to measures that will decrease the risk of infection,
- The measure should be appropriate to the client and easy to apply,
- In case of having multiple risk factors, the client is advised to concentrate on key risk factors that make her/him vulnerable to HIV infection,
- The measures should be simple and applicable,
- Discuss the obstacles that might hinder the measures the client would like to take,
- Ask the client about the protective measures he/she wants to practice/use,
- Correct the client if he/she has misconceptions,
- Inform the client about the alternative means of protection and where to get them,
- It is advisable to avoid the attitude of promoting only one protective measure such as condom use or being faithful to one's partner,
- Brief the client about the positive and negative sides of each option and their application to protect oneself from HIV infection.

Step 4: Pre-test counseling

- Knowing one's HIV status is very advantageous to a person wondering whether he/she is infected or not. Many people are worried about their HIV status due to their experience and risk to HIV infection. In such cases the counseling should help the clients to go for voluntary counseling and testing.
- Together with the client, assess the risk factors and vulnerability of the client. The client can only proceed to the test if he/she has understood his/her risk to HIV infection.

- Give the client the necessary information about the test. Do not concentrate on providing too detailed and technical information.
- Inform the client about the window period and ask her/him when he/she had had unsafe sex or any other practice that could expose her/him to infection.
- Inform the client about the benefits of knowing one's own HIV status. If not infected at the moment, it will help the client to protect her/himself from getting infected in the future.
- An HIV+ve result might disturb the client. However, knowing the presence of the virus in his/her blood will help her/him to take the necessary measures, which will prolong his/her life, protect oneself from opportunistic infection and to seek care and support. It will also help the client develop positive behaviour that helps her/him live positively with the virus and limit the infection rate. Not knowing one's HIV status early enough shortens one's life.
- To accept the result the client needs to overcome his/her fears.
- Assure the client that his/her status will be kept strictly confidential.
- The client should be informed that it is ultimately his/her decision whether or not to take the test. Give enough time to your client to decide.
- Refer the client to the laboratory if he/she is willing to do the testing.

Step 5: Post-test counseling

This is a session that is generally conducted when the client comes to receive the laboratory result.

a. If the test result is HIV-ve,

- Welcome the client, make her/him feel comfortable and tell her/him the result.
- Ask the client what he/she feels about the result.
- Remind the client about the window period and inform her/him of the need for a second test after the window period (This depends on when he/she had had an unsafe practice that might expose him/her to infection).
- Ask the client what he/she has intended to do to protect her/himself from future infection. Assist her/him to use different life skills such as critical thinking, decision-making, self-respect, etc. to protect her/himself from HIV infection.
- Discuss protective measures and make sure that the client has acquired the right skills to protect her/him from future infection.

b. If the test result is HIV+ve,

The peer counselor should be ready to help the client cope with the psychological reactions caused due to the result.

- Assess the readiness of the client to receive his/her result and what he/she will do if he/she is HIV positive.
- Make sure the client is ready to accept the result and is ready to live with the virus without feeling guilty and/or ashamed.



- Help the client not to take the result as a death sentence but rather to take care of her/himself to prolong his/her life by eating balanced diet, taking care of personal hygiene, seeking treatment for opportunistic infections etc.
- The client should be reminded of the need for safer sex practices and for preventing oneself from STIs,
- Discuss with the client what he/she has planned to protect his/her partner.
- Refer the client to psychosocial centers where he/she will be able to get ongoing counseling and psychosocial care and support if needed.
- The peer counselor should have information about organizations that are involved in providing ongoing counseling and psychosocial care and support services for people living with the virus.

Step 6: Follow up

- Invite the client to come for ongoing counseling.
- Ask the client what he/she is doing to protect themselves from risky practices.
- Ask if the client is using condoms and how he/she is using them?

Process facilitation

If this session starts in the morning, the facilitator can do the following activities for 20 minutes:

1. Ask the responsible trainee for the day to ask the participants:
 - How they spent the day before,
 - If they had any problems, and
 - To share anything funny they might have come across.
2. Ask the participants responsible for energizers to give the energizer (3 minutes).
3. Remind the time-keeper to do his/her job.
4. Revise the previous day's session.
5. Then move to the next exercise.

Exercise 1: About peer counseling and its need

Purpose: Enable participants to understand what peer counseling is all about

Method: Experience sharing and comparing it with facts

Tools: Discussion pairs and brainstorming, flipchart and markers

Duration: 30 minutes

The facilitator will:

1. Ask the participants to form pairs.
2. Ask the pairs to list what they know about counseling and why it is needed by their peers. They should not concentrate on the service provision. Advise them

to think about what counseling is and their peers need for it, without worrying about their answers being right or wrong (7–10 minutes).

3. When the allocated time is over, ask the participants to brainstorm what they have discussed.
4. Write what they present on a flipchart.
5. Merge repeated ideas.
6. Open a discussion session based on the handout. (Unit 10: What is counseling?)
7. Conclude with what peer counseling is, adolescents' need for it and its major benefits.
8. Ask for feedback to assess whether or not the session was understood.

Exercise 2: Qualities of an effective counselor

Purpose: By the end of the exercise the trainees will know the qualities of an effective counselor

Method: Comparing their wishes/thoughts about an efficient counselor with the basic criteria indicated in the handout

Tools: Group work

Duration: 60 minutes

The facilitator will:

1. Divide the participants into three groups, each with an average of 6 members.
2. Ask Group 1 to list the qualities of an efficient/good peer counselor based on their wishes and thoughts. Remind them to use their life skills.
3. Ask Group 2 to write down the knowledge a peer counselor should acquire which is very important to his/her role. Remind them to use their knowledge on sexual and reproductive health issues.
4. Ask Group 3 to write down the role of a peer counselor.
5. Ask the groups to compare their lists with the basic information (10 minutes).
6. When the allocated time is over, ask the group leaders from each group to present the main points the respective groups have agreed upon based on the questions given to each group.
7. Write the main points on a flip chart.
8. Compare the presentation with the basic information.
9. Ask for feedback to assess the participants' understanding of the session.

Exercise 3: Creating a conducive atmosphere for peer counseling

Purpose: At the end of the exercise the participants will be able to create a conducive environment for peer counseling

Method: Conducting group competition in creating a conducive environment

Tools: Group work

Duration: 60 minutes



The facilitator will:

1. Inform the participants to stick to the three groups they had formed in the previous exercise and discuss and create a conducive environment for peer counseling based on the existing environment and using their critical-thinking and problem-solving skills. Tell them to take the following into consideration.
 - A place conducive for personal discussion (neat, quiet, appropriate and with enough seats)
 - Registration and referral forms
 - Protective materials and their samples
 - Preparing pictures of reproductive organs, models etc.
 - Having leaflets and other informative materials properly in place.
2. Ask the groups to compare their preparations with the basic information given in the manual about creating a conducive environment for peer counseling (20 minutes).
3. When the allocated time is over, ask the group leaders from each group to show the place they have prepared to the rest of the participants.
4. Trainees will visit the counseling sites prepared by each group where each group leader will brief them about their work (20 minutes).
5. After visiting each site, the participants come together and give their feedback on what they have seen/visited.
6. Fill the gaps based on the comments given.
7. Identify the winner from the applause given to each group and give a prize to the winning group.
8. Ask the trainees if they have acquired enough knowledge and skills in organizing a conducive working place for peer counseling.

Exercise 4: Conducting peer counseling in steps

Purpose: At the end of the session the participants will develop peer counseling skills

Method: Training in peer counseling

Tools: Role-play in pairs

Duration: 60 minutes

The facilitator will:

1. Briefly recap the previous exercises and ask if the participants have read the six steps of peer counseling in Unit 10.
2. Remind participants that peer counseling is a face-to-face process not group work, and it requires individual training and commitment to acquire the skills.
3. Provide the trainees with a note on the six steps of peer counseling and distribute different topics for them to practice on.

Write different titles for the peer counseling exercise on pieces of paper (an example)

- Introduction for peer counseling
- Counseling to help a client choose contraceptive methods
- Counseling to help a client who wants to know their HIV status
- Counseling for a client not exposed to HIV
- Counseling for a client infected or at risk of being infected
- Pre-test counseling for a client who would like to know his/her status
- Post-test counseling for a client diagnosed to be HIV-ve
- Post-test counseling for a client who is diagnosed to be HIV-ve
- Ongoing counseling for a person living with HIV/AIDS

Put the pieces of paper in front of the participants and ask each pair to take one piece of paper.

Ask the pairs to discuss the topic they have on the piece of paper and, based on the basic information, to prepare their role-play.

4. Have each pair decide which person will be the “client” and which will be the “peer counselor” and give them 5 minutes to prepare their role-play.
5. Then call the whole group to the plenary and ask each pair to conduct their counseling in front of the whole group. (5–7 minutes for each pair).
6. After each presentation the facilitator will ask the following questions, first to the presenters and then to the rest of the group.
 - What have you planned to show us?
 - How accurately have you conducted your counseling session compared with the steps introduced?
 - Where have you gone wrong?
 - What does the rest of the group think about the presentation?
 - What was good about it? Where does it go wrong or where are its weaknesses?
7. Conclude by revising the main points of peer counseling.
8. Ask the participants what they think will be their biggest problem in conducting a peer counseling session.
9. Discuss in group.



Section 1: Referral of clients for Reproductive Health Services

Basic information

What is Referral?

Referral is when a service provider sends a client to a higher level of health care because the client has a reproductive health problem or a need that the service provider is not able to meet. The service provider may not offer the service because either he/she is not trained to handle the need or the service is not available at that service delivery point.

When the peer educators start working, they are much in demand, so much so that they may not handle all the cases of their peers or may not have the necessary skills, hence the need to refer. The people who come for the services then cease to be called peers but clients.

Who is a service provider?

A person with training on SRH issues who is simultaneously able to offer SRH service. In this program they include the peer educators, community reproductive health workers (CRHW), midwives and any other health worker trained in and offering adolescent- and youth-friendly services.

Who is a client?

A client refers to some one who is in need of a reproductive health service. The need may be either expressed or not expressed. In the case of clients that may not express the need for a reproductive health service, it is the responsibility of the service provider to ask the correct questions and gather the correct information to be able to identify them, do peer counseling and then refer the clients to a service provider.

Why refer a client?

All or any one of the following could be the reason for referring a client:

- The service to be provided is not part of the service provider's job description.
- The service provider has no expertise, training or technical ability to handle the situation.
- To allow the person referred to get more appropriate services from a person with better technical expertise.
- The service to be provided is not available.

Which clients should be referred?

- People who have selected certain contraceptive methods, such as IUD, Depo Provera, Norplant, Tubal Ligation, or Vasectomy,
- Clients with complications resulting from the use of any method of family planning,
- Clients with complaints of infertility,
- Those coming for medical check ups,
- Those coming for HIV/AIDS services comprising of more information about HIV/AIDS, VCT, Counseling, Treatment of HIV/AIDS and PMTCT,
- Those coming for STI diagnosis, treatment and/or management,



- Those coming to seek maternal-child health services, antenatal services, immunization, child growth monitoring and postnatal services,
- Those seeking psycho-social counseling services for sexual and reproductive health issues like relationships,
- Those seeking clinical sexual and reproductive health information.

Where can clients be referred to?

The clients should be referred to a trained and available health worker in any service delivery points such as,

- Youth-friendly reproductive health centres, AIDS Information Centres, government and NGO health facilities and church or faith-based clinics.
- Any other nearest health facility (Government or Non government hospitals, health centre or dispensary) with the services required,
- Trained health workers in private practices such as doctors, private midwives or trained traditional birth attendants,
- Resource persons within the community, for example, professional counselors.

What steps do you follow when preparing a client for referral?

- Assure the client that the referral is for his or her own benefit.
- Explain the reasons to the client why she or he is being referred.
- Discuss with the client where he/she should be referred.
- Where possible, explain to the client the procedure he/she is likely to go through at the referral place, according to the problem or need at hand.
- Explain the terms of services to the client, including any service charge and how charges are to be paid.
- Inform the client about the day and time when the services are available.
- Allow the client to ask questions and express any concerns and respond to them accordingly.

What steps do you follow when conducting a referral?

- Fill in a referral form specifying the reasons for referral.
- Give the completed form to the person being referred and ask her/him to present the form to the service provider she or he is being referred to.
- Give the client any additional instructions, such as whether the client is to bring back a referral feedback form to you.
- Ask the client a few questions and/or to repeat instructions to make sure he/she has understood what has been said.
- Reinforce if responses are correct and complete or correct the answers if they are incomplete or wrong.
- Discuss with the client the possibility of being escorted to the referral point, and what to do if the referral form gets lost.



Factors effecting the functioning of the referral system

Information about the service delivery point

The service provider should have information about the service delivery point in terms of the history of the place, existing services, distance, quality of care and cost.

Establishing a relationship with a service delivery point

The partner NGO usually identifies and signs a Memorandum of Understanding (MoU) with the service delivery point. The service provider establishes a working relationship with the service delivery point; this will ensure that the young people referred receive the service and facilitate the follow up of a client.

Handling the client at the service delivery point by the health workers

The health workers should be trained in providing adolescent-friendly services so that they are able to attract them to the facility, provide a comfortable and appropriate setting for them, meet the needs of the young people and retain them for follow up and repeat visits.

Costs of the services

Most young people don't have money and may not be able to ask their parents/guardians for it. This means that if the services are offered at a fee, many of them may not seek the services. You need to keep this in mind when referring clients.

Client satisfaction at delivery point

The client will only go back to the same delivery point for more services and also inform other youth about the existing services in future when he/she is satisfied with the service.

Process facilitation: Referring clients for reproductive health services

Getting started: (15 minutes) We assume that the facilitator has read the basic information in advance and prepared the methods, tools and the illustrations for this session. We also assume that the participants have received the handout the day before and have read them before this session. If Peer Educators cannot distribute handouts, they should at least be able to write the headings on a large piece of paper and explain briefly.

The facilitator will:

1. Allow the participants assigned to perform the energizer (3–5 minutes), then
2. Recap the previous session very briefly (3 minutes), and
3. Introduce the handout on referring of clients for reproductive health services (5–7 minutes).
4. Make participants aware that the knowledge about referring clients for reproductive health services is essential to understand the referral system. Finally,
5. Conduct the exercise, which concentrates on enhancing knowledge of participants on referring of clients for reproductive health services.
6. Tell the time-keeper to be alert.



Exercise 1: Enhance knowledge on referring clients for reproductive health services

Purpose: Participants will acquire in-depth knowledge on referring clients for reproductive health services

Method: Brainstorming, lecture and large group discussions

Tools: Pens, paper, butcher paper, backboard, chalk

Duration: 40 minutes

The facilitator will:

1. Allow participants to stay in the whole group but to form a circle.
2. Ask participants what they understand by “referral”.
3. If there are more than 7 participants, divide them into 3 small groups if need be. Encourage everyone in the group to be involved in sharing views actively.
4. Give each group flip chart papers or large pieces of paper and markers to work individually for 15 minutes on the following.
5. Ask Group 1 to write and explain the reasons for referring clients for reproductive health services.
6. Ask Group 2 to discuss what places they can refer clients to.
7. Ask Group 3 to discuss what they would like as preparation for referral, if they were the clients.
8. When the allotted time is up, bring participants together.
9. Ask the presenter of each group to share their work. This is the process of sharing experiences through reporting (5 minutes for each group).
10. Write down participants’ contributions on paper then emphasize the important referral sites.
11. Summarize and fill in the gaps if any.
12. Wrap up by explaining the steps for preparation.

Exercise 2: Role-play to enhance the skill of referring clients

Purpose: Through a role-play, participants will become more confident and competent to refer clients for reproductive health services

Method: Role-play

Tools: Flash cards (referral form)

Duration: 40 minutes

The facilitator will:

1. Ask the participants to pair up to act out a role-play (at least 3 pairs).
2. Ask them to prepare a role-play (5 minutes).
3. Make them take turns to play the role of a client and the service provider who refers the client (having already identified the referral point).
4. Have the group watch the role-plays.



5. After each presentation, analyze the role-plays.
6. Ask for feedback and if there is anything that is not clear, then summarize the session.

Glossary

Abortion	The ending of a pregnancy. It can happen on its own (spontaneous abortion or „miscarriage“) or it can be caused by a medical procedure (induced abortion).
Abstain	To avoid doing something, for example abstain from sex or from drugs and alcohol.
Antenatal	The period before birth, for example antenatal care is the care needed by a woman throughout pregnancy/before birth.
Brainstorming	Is a participatory learning technique in which participants are encouraged to give as many ideas as they can think of on a particular subject without challenges or questions.
Buzzing	Is a participatory learning technique in which groups of two or three participants discuss a topic without breaking the whole group. This technique allows a quick discussion process.
Caesarean section	A medical operation to take the baby out of the uterus by making a cut in the woman's abdomen. This operation is performed when a woman is not able to deliver the baby through the vagina.
Cervical vault caps	A soft rubber cap contraceptive method covering only the cervix.
Cervix	The lower end of the womb that connects with the upper part of the vagina.
Chancroid	Painful swelling and sores or ulcers around the genital area and inside the vagina.
Check-in	Is a participatory learning technique exploring the situation of participants and showing interest in their well being. A facilitator invites each participant to say how he/she feels at the moment or during the experiences encountered.
Chlamydia	An infection of the tissues lining the urethra and the opening of the womb with signs similar to those of gonorrhoea.
Circumcision	In a man: when the loose fold of the skin (foreskin) at the end of the man's penis is removed. In a woman: when part or all of the woman's genitals are removed.
Clitoris	A small, sensitive organ above the vagina that responds to stimulation and makes sexual intercourse pleasurable.
Combined oral contraceptive	The pill that contain both estrogen and progestogen hormones.
Condom	A soft rubber tube that is put on a man's penis before sexual intercourse. Condoms provide protection against pregnancy and sexual transmitted diseases.
Contraceptive sponge	A round sponge containing spermicide.

Diaphragm	A shallow rubber cup with a rim inserted in the vagina as a barrier method.
Egg	Ovaries produce an egg every month, which, if fertilized by sperm, will grow into a baby.
Ejaculation	The release of semen from a man's penis.
Emergency contraception	A contraceptive method that can be used to prevent pregnancy after unprotected sex, such as if the condom broke or slipped. It must be taken within a few days of unprotected intercourse.
Energizer	Is an energizing activity performed to break the monotony and stress of a learning session and raise the learning enthusiasm for learning. Energizers are songs, dances, short games, jokes, exercises which take about 2-3 minutes.
Erection	When the penis becomes hard and stiff as a result of feelings of sexual excitement.
Estrogen	Female hormone produced by the ovaries, greatly influencing the growth, development, and function of the entire female body, and the reproductive organs, throughout a woman's life.
Fallopian tubes	The two tubes that lead from the female ovaries to the uterus. After an egg is released from one of the ovaries, it travels down these tubes to the uterus.
Feedback	A training process by which a facilitator asks and obtains reactions from participants about the performance of the training or informs trainees that he/she is right or wrong.
Female circumcision (also called female genital mutilation-FGM)	A traditional practice in which all or part of the female genitals are removed. The practice has negative health consequences and is considered by many people to be a violation of girls' and women's rights.
Fertilization	Is a process in which the sperm of a man finds and attaches itself to the egg released from the ovary.
Fishbowl	A group work technique used for participatory training or evaluation. Dividing the group into three smaller groups, one group of 2 serves as facilitator, another as trainees and the third as observer. The trainees and the observers comment upon the facilitation approach and skills of each group.
Fistula	It is usually caused by several days of obstructed labour, without timely medical intervention - typically a Caesarean section to relieve the pressure. The consequences of fistula are life shattering: The baby usually dies, and the woman is left with chronic incontinence. Because of her inability to control her flow of urine or faeces, she is often abandoned or neglected by her husband and family and ostracized by her community.
Gender	Is socially determined or acquired characteristics, roles, and ideas, attitudes and beliefs that the culture of a particular society attributes to males and females.

Genitals	The private parts; the external sexual organs.
Genital herpes	Is a non-curable disease caused by a virus resulting in a painful, swollen blisters or sore on the penis in a man, and in the vagina of a woman. It can also cause sores in the anus.
Gonorrhoea	Is the most common STD that causes burning sensation when passing urine and a thick discharge from the penis. Some women have the same symptoms – pain with urination and discharge from the vagina.
HIV/AIDS	HIV, or Human Immuno Deficiency Virus, is the virus that causes AIDS. The term „HIV/AIDS“ is often used because infection with HIV eventually leads to AIDS, which is Acquired Immune Deficiency Syndrome. A person has AIDS (rather than just being infected with HIV) when the immune system gets so weak it can no longer fight off common infections and illnesses.
Hormones	(As related to reproductive organs) Hormones are chemical elements such as estrogen and progesterone produced by the female body or artificially that greatly influence the growth, development and function of the entire body.
Implantation	Indicates the process in which the fertilized egg moves from the fallopian tube into the womb and attaches itself to the lining of the womb.
Implants (Norplant)	A contraceptive method in which six small thin plastic tubes containing a hormone that prevents ovulation are placed in the upper arm of the woman through a minor operation.
Injectables	Long acting injection containing hormones (artificial) that prevent ovulation. It is given to a woman every 2-3 months.
Intrauterine devices	Are plastic devices inserted into the womb through the vagina by a trained person. They are left in place for a period of time to prevent pregnancy.
Labia majora	Are the outer folds of skin of the female genitals that are thick and covered with hair.
Labia minora	Are the two thin inner folds of skin that cover and protect the vaginal opening and form a hood around the clitoris.
Learning cycle	Is a participatory experiential learning process that starts with identifying and sharing experiences, goes to analysis of causes and effects and then passes to planning and action. Through this action a new experience is created and thus the learning starts again making the cycle complete.
Learning heads	The principle of participatory learning that proposes the use of the mind, hands and emotions in the process of the learning cycle.
Life skills	Are personal abilities, competencies or social skills that enable us to deal effectively with the demands of the everyday life, including sexual life.

Lining of the womb	The wall surrounding the inside of the womb.
Menarche	The time at which the menstrual periods start, usually between the ages of 12 and 15 years.
Menopause	The age at which the menstrual period ends, usually between the ages of 40 and 50 years.
Menstruation	Also called menstrual period or monthly period. The flow of blood and tissue from the uterus out of a woman's body, usually occurring every 28 days. Menstruation starts during adolescence and ends between the age of 45 to 55.
Mime	A mime is acting using the body language without talking but using body movement.
Natural methods	Methods that do not involve taking any drugs or using a device to prevent pregnancy but find out when ovulation occurs and then one avoids sexual relations during those fertile days.
Ovaries	Two female internal reproductive organs that produce the egg. They are of the size of a small nut and are placed on either side of the womb.
Ovulation	The release of an egg from one of the ovaries. It usually occurs 14 days before the next menstrual period.
Ovum, Ova (plural)	A female egg. A cell which, when released from a woman's ovary, may be fertilised by a man's sperm.
Pelvic	The bone parts of the female body that protect the reproductive organs.
Pelvic Inflammatory disease	An infection of female reproductive organs causing constant lower abdominal pain, painful menstruation and menstrual disorders, fever and bad smelling of vaginal discharge.
Penis	The male sex organ, also used to pass urine.
Postnatal/postpartum	The time after childbirth or delivery.
Progestogen	Female hormone produced by the ovaries, greatly influencing the growth, development, and function of the entire female body, especially the reproductive organs, throughout a woman's life.
Progestogen-only pills	Oral contraceptive pills that contain only progestogen hormones.
Puberty	The period of life when a person changes physically from a child into an adult, usually between 10 and 16 years of age.
Quiz	Is a learning technique in which the facilitator formulates key questions on a topic and ask participants for their reactions and checks their knowledge.
Recap	A brief summary of the topic covered or lessons learned performed at the beginning of each session.
Role-play	Presentation of real life situations in a theater/drama form in order to explore feelings, behaviours, attitudes or strategies to

	cope with situations. In a role-play we take someone else's character.
Scrotum	A sac of skin in front of and between the thighs of a male that holds the testes.
Sculpture	Is a technique of demonstrating a message through body language without talking and moving.
Semen	A liquid that is produced by the man's reproductive organs and carries the sperm through vas deferens and out of the penis.
Seminal vesicles	Two glands in the male reproductive system where semen is made.
Sex	Sex, as opposed to gender, is an inborn or biologically determined characteristic or role of man and woman that cannot change: a woman can menstruate, become pregnant and breast feed and a man can impregnate: not viceversa.
Sperm	Male reproductive substance, similar to the female egg, that is produced in testes and released into the vagina in millions when ejaculating during sexual intercourse.
Spermicide	Chemical contraceptives, such as creams, jellies, foam, tablets, suppositories.
Sterilization	Is small cuts of vas deferens in male or cutting of each fallopian tube and tying them in females.
STDs/STIs	Sexually transmitted diseases or infections which are passed from one person to another through sexual contact.
Syphilis	Is an STD caused by germs and transmitted during sexual intercourse with an infected person. It develops in three stages: 1. Consists of a small and painless sore in the genital area or vagina. 2. Is marked by fever and pain in the bones and muscles. 3. May appear after as long as 15 or 20 years.
Testes	Are two egg-shaped internal reproductive organs of a male located in front of and between the thighs within a sac of skin known as the scrotum. Testes produce the sperm from puberty until old age.
Traditional Methods	Cultural practices used as contraceptives, such as charms, spells, tying a string or amulets around the waist, drinking teas from certain leaves or roots, or eating certain food or taking the holy water.
The tools of planning	A technique of planning using the adverbs Why? What? Who? How? When?
Trichomonas	Is an STD caused by germs or bacteria. The signs are increased fluid from the vagina, fluid that looks frothy and causes itching and pain during urination.
Tubal Ligation	Female sterilization in which the fallopian tube is cut in two and tied.

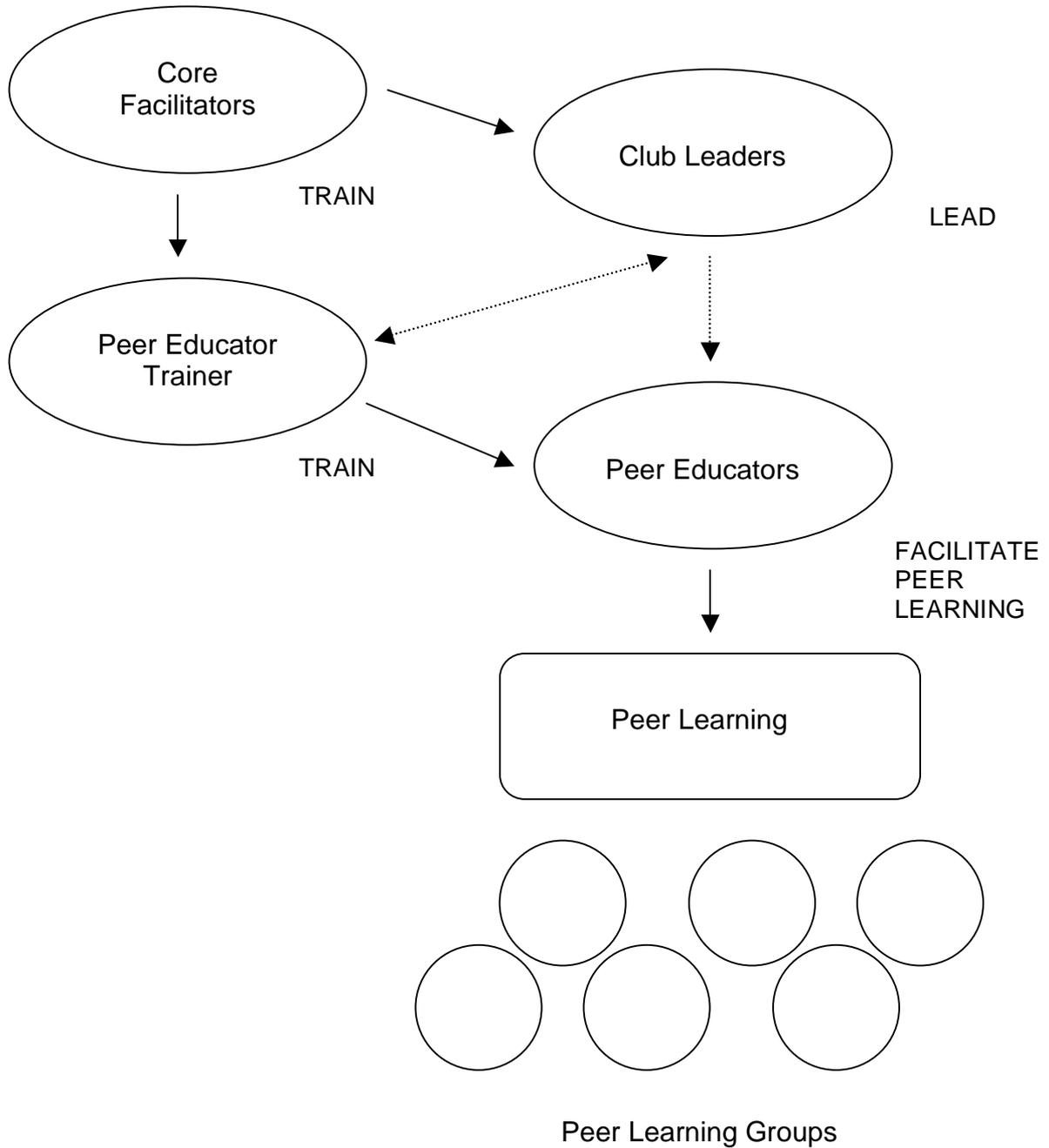
Urethra	A tube through which both semen and urine pass through into the penis.
Uterus	Is the womb, which is about the size of small mango or it is about nine centimeters long, and weighs only 60 grams. The fertilized egg attaches itself to the lining on the inside of the womb.
Vagina	Is the channel between the womb and the outside of the body. Menstrual blood flows out of the womb through the vagina. The vagina is the “birth canal”: During childbirth the baby leaves the womb and enters the world through the vagina, the wall of which is elastic and can stretch to allow the passage of the baby’s head and body.
Vas deferens	A tube through which the sperm produced in testes passes and enters the penis.
Vulva	Is the area around the opening of the vagina, which can be seen from the outside.
Warm-up	Warm-ups or icebreakers are fun-type activities performed to make participants feel relaxed or raise the energy level in the group. They do not need to relate in any way to the content of the training.
Vasectomy	Male sterilization performed by making a small cut in the vas deferens.

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Youth-to-Youth Training Cascade





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We would like to learn more about your ideas and suggestions regarding DSW's *Adolescent Sexual and Reproductive Health Training Manual*. Please take a moment to share with us your opinion and evaluate the manual by completing the following questionnaire.

Thank you very much for helping us to improve our materials!

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	Poor		Good		Excellent
1. How would you rate the book overall?	<input type="radio"/>				
	Not at all		Partly		Very
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Comments:

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1. How did you like the illustrations?	<input type="radio"/>				
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2. Do they fit into the cultural context?	<input type="radio"/>				
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Comments:

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	Yes	No			
1. Did you use the glossary?	<input type="radio"/>	<input type="radio"/>			
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