Sexual, Reproductive Health and Life Skills for Youth Peer Education

A GUIDE FOR TRAINERS OF FACILITATORS
Strategy 2020

Strategy 2020 voices the collective determination of IFRC in tackling the major challenges that confront humanity in the next decade. Informed by the needs and vulnerabilities of the diverse communities where we work, as well as the basic rights and freedoms to which all are entitled, this strategy seeks to benefit all who look to Red Cross Red Crescent to help to build a more humane, dignified, and peaceful world.

Over the next ten years, the collective focus of the IFRC will be on achieving the following strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disasters and crises
2. Enable healthy and safe living
3. Promote social inclusion and a culture of non-violence and peace
In 2007, about 33 million people were living with HIV and AIDS and 2.5 million people were newly infected. HIV and AIDS affects people of all ages but the consequences of the HIV and AIDS pandemic on younger generations are particularly acute and troubling.

Tragically, more than half of all new infections worldwide occur among people under the age of 25, and almost 6000 youth ages 15-24 are infected with HIV daily. 11.8 million youth aged 15-24 are living with HIV and AIDS.

Youth in sub-Saharan Africa and young women are among the most vulnerable. Half or more of new infections in sub-Saharan Africa are among the under-24 age group. Seventy-five per cent of these are among young women and the proportion of new infections among young women is on the increase.

In Southern Africa alone, there are eight new cases of infection in the 15 -24 age group among females for every one case among males.

Today’s youth has only known a world with HIV and AIDS and any sustainable impact on the future of the HIV and AIDS epidemic will depend on the behaviour of today’s young people; the adults of tomorrow.

This training manual for peer educators is the outcome of a consultative process involving 10 National Red Cross Societies in the Southern Africa region. The 10 National societies are: Angola, Botswana, Lesotho, Malawi, Mozambique, Namibia, Swaziland, South Africa, Zambia and Zimbabwe. These National Societies determined the content of the training package based on what is perceived as a solution to challenges facing the majority of young people in the region.

This training package is intended for peer education programmes, which are believed to be a pillar of any HIV and AIDS prevention effort. This programme prepares young people to undertake organised educational activities with those similar to themselves in age, background or interests over a period of time, aimed at developing their knowledge, attitudes and skills and enable them to be responsible and protect themselves from HIV infection.

National Societies’ efforts in empowering and supporting peer educators significantly influence the success of the programme. We hope this will complement the other HIV prevention interventions.
FOREWORD

Faced with many challenges in Southern Africa, including the scourge of HIV and AIDS, it was imperative for National Societies in the region to use a collective approach to reduce these challenges, particularly among the youth.

It is therefore commendable that the International Federation of Red Cross and Red Crescent Societies as well as National Societies in Southern Africa have once again developed and produced this resourceful, valuable and informative manual concerning Peer Education Programmes in Southern Africa. The manual is user-friendly and relevant to the youth’s needs. It is my hope that the core message will reach many young people in their communities across Southern Africa as they use it on a daily basis.

The Red Cross Southern Africa Youth Network (RC-SAY Net) welcomes this manual and hopes that it will achieve the desired goals.

Jethro Mndzebele
Chairperson
Red Cross Southern Africa Youth Network
RC-SAY Net
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<th>Abbreviation</th>
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<tbody>
<tr>
<td>AIDS</td>
<td>Acquired Immunodeficiency Syndrome</td>
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<tr>
<td>AZT/ZDV</td>
<td>Zidovudine</td>
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<td>ART</td>
<td>Antiretroviral Therapy</td>
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<td>ARVs</td>
<td>Antiretroviral Drugs</td>
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<td>D4t</td>
<td>Stavudine</td>
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<td>Efavirenz</td>
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<td>GBV</td>
<td>Gender-Based Violence</td>
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<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<td>IFRC</td>
<td>International Federation of Red Cross and Red Crescent Societies</td>
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<td>NS</td>
<td>National Society</td>
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<td>NVP</td>
<td>Nevirapine</td>
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<td>PLHIV</td>
<td>People Living With HIV</td>
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<td>PMER</td>
<td>Planning Monitoring Evaluation and Reporting</td>
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<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
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<td>PPTCT</td>
<td>Prevention of Parent-to-Child Transmission</td>
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<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<td>STIs</td>
<td>Sexually Transmitted Infections</td>
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<td>TB</td>
<td>Tuberculosis</td>
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<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
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<td>3TC</td>
<td>Lamivudine</td>
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<td>DAY 1</td>
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<td>Participants introduction</td>
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<td>11:00-13:00</td>
<td>Programme planning</td>
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<td>13:00-14:00</td>
<td>LUNCH BREAK</td>
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<td>Working with peer educators (Module 1)</td>
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<td>AFTERNOON TEA BREAK</td>
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<td>12:30-13:00</td>
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**Suggested schedule for the Youth Peer Educational Training**

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Introduction

The youth are our future: because they’re at the centre of the global HIV epidemic, they are our greatest hope for changing its course. Accounting for 29% of the population, youth aged between the ages of 19 and 24 comprise 1.4 billion people in low- and middle- income countries. Sadly, over 50% of all new HIV infections occur among people younger than 25; approximately 6,000 people between the ages of 15 and 24 are infected with HIV daily. There are 11.8 million youth living with HIV or AIDS, with increased vulnerability to HIV infection among women.1

Youth leaders can help young people by providing correct information and the skills needed to behave responsibly and remain safe throughout adolescence, an ever-changing and challenging phase. By creating new opportunities for peers to discuss gender relations and sexual relationships, peer educators can play a vital role in the prevention of HIV.

What is Peer Education?

Peer education refers to the process whereby motivated and well-trained young people participate in organised educational activities with people close to them in age, background or interests over a period of time. Peer education aims to develop peer knowledge, attitudes and skills, enabling them to be responsible for and protect their own health.

Peer education may occur in small groups or through individual contact and in a range of settings such as schools, clubs or anywhere young people gather.

Education refers to the development of a person’s knowledge, attitudes, beliefs or behaviour resulting from the learning process.

Why Peer Education?

A young person’s circle of friends greatly influences personal behaviour whether it is safe or risky behaviour. Peer education uses peer influence positively. Young people look to peers for information on sensitive matters or issues generally not openly discussed in a particular culture.

Peer education offers young people the opportunity to participate in activities that enhance their level of understanding, attitudes, behaviour, skills and knowledge. Consequently, they also receive the necessary information and services needed to protect their health.

Peer education is responsible, rewarding work that can truly make a difference to the lives of many young people. Working in this field is a satisfying way of positively changing communities.

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1 See reference page (UNAIDS report)
What is the role of a peer educator?

Peer Educators are young people volunteering to provide behaviour-changing information to other young people – their peers. Peer educators may:

• Recruit youths in or out of school for peer education sessions.
• Run or co-facilitate peer education sessions.
• Refer peers to clinical services or other services as appropriate.

To gain the necessary confidence to participate in peer education programmes, it is important that youth leaders are knowledgeable about human sexuality, HIV and AIDS as well as how best to convey this information. They also need to be assured that they are doing the right thing.

Who should use this manual?

The manual is intended for trainers and facilitators who will in turn train peer educators. Many of the exercises included in this manual can be used with school-going as well as non-school-going youth. This manual is accompanied by a Peer Education Activity Kit to be used by peer educators.

Goal of the Peer Education Manual

This manual aims to guide peer educator trainers and facilitators on training on Sexual and Reproductive Health (SRH) life skills.

Objectives of the training course

By the end of the course participants will have:

• Strengthened their skills using different interactive methods of training;
• Strengthened their skills in training peer education facilitators;
• Gained knowledge and skills to provide SRH, HIV and AIDS training;
• Acquired accurate information relating to SRH issues, including HIV and AIDS;
• Explored their attitudes and values regarding SRH, HIV and AIDS;
• Strengthened these positive attitudes and values; and
• Developed interpersonal and group communication skills.

Expected Outcomes

Upon completion of this training, trainers and facilitators for peer educators should be confident, competent and able to design and implement a training programme for peer education.
Facilitation Tips

What is facilitation?
It is a process of sharing, giving and receiving information based on one’s knowledge and understanding of a certain issue.

What is a facilitator?
A person who guides and directs a group of people to an intended goal without imposing his/her views.

Role of the Facilitator

Introduce yourself at the beginning of the session and explain your role. This will enable your participants to understand your role as well as theirs. Facilitators or trainers joining at a later stage, even only for a single session, should also introduce themselves and clarify their part in the respective session.

Things you may discuss:
- The group is the customer and you are working for them;
- The group is there to talk as a group, not to you directly;
- You are there to help manage group dynamics;
- Your responsibility is to lead the overall training and keep the session and group on track;
• Your job ends at the end of the session. You do not interfere with their private lives beyond the session discussion;
• You may call “time outs” if the group is not adhering to time allocations;
• Time management is essential - let your participants know how much time is allocated for each activity.

**Tips for facilitators**

1. **A facilitator should ALWAYS remain neutral, objective and fair**

The moment you stop being:

  • neutral and start taking sides;
  • objective and start imposing your own opinions or start siding with one person or group over another, you are no longer a facilitator but just another person running a meeting.

2. **Record relevant information**

Write down all the information discussed in the session and display it where it can be viewed by all the participants. Record the main idea or fact, not every word.

3. **Eye contact**

Learn to write on a flip chart/white/black board while maintaining eye contact with your participants. Check your body language, posture and eye contact to show the group that you are relaxed, comfortable, motivated and confident.

4. **Be attentive**

Check participants’ body language, posture and level of participation, e.g. eye contact, yawning, leaning back or whispering. Should you observe some of these signs, you can call for a quick break or an energy booster.

5. **Do not be afraid to stop people from talking beyond individual time allocations**

This can be difficult to do at first but with time you will develop confidence to interrupt people in a way that will not make them withdraw their participation. A useful tip is using a page of paper where you record issues that could be discussed later, the idea of a ‘parking lot’.

6. **Time management**

Time management is crucial in earning and maintaining the group’s trust in you. Deviation from time allocations should only be done after consulting the group. Otherwise your credibility and the level of trust the group has in you are put at great risk.
7. **Call people by name**

This builds trust and a personal relationship with your participants. People feel good when they are called by name and become encouraged to perform better. Name tags are fine, but if the session lasts more than a day, learn names without tags.

8. **The participants need to speak to each other, not to you**

Ensure this is clear from the start and continue to reinforce this throughout the sessions as the natural tendency is to talk to the person in front. The following is an effective way of redirecting the conversation back to the group:

- If you ask a question during the session, start by checking if there is anyone in the group who can answer it before you provide the answer. In this way, you encourage the other participants to voice their opinion and consequently discuss the given question as a group.

9. **Know when to be quiet**

The facilitator or trainer should never dominate the discussion by providing all the answers. If you answer everything and dominate the session, you are teaching not facilitating.

10. **Summarise regularly**

End discussions by highlighting important messages and explaining anything that has not been understood.

11. **Instructions**

When giving instructions, always ensure that you are audible and clear. Written instructions are better. Allow participants to ask questions for clarity before starting the task.
Additional Information:

Questions

- Formulate questions that will start discussions.
- Ask open-ended questions such as, “What do you think about…?”; “Why…?”; “How…?”;
- Use close-ended questions for a direct answer.

Facilitating knowledge

- Only give relevant facts;
- Start with the participants’ personal experiences;
- Use all resources available to you;
- Use active learning participatory methods;
- Use visual aids to maximise participants’ attention and retention of information;
- Involve participants in reviewing and summarising;
- Verify that learning has taken place.

Session preparations

- Review the respective activity in advance and familiarise yourself with the content;
- Prepare the required material in advance;
- Arrive slightly earlier in order to arrange the materials and training venue;
- Remember to start all sessions with energy boosters;
- Review previous content and any assignments before continuing with the day’s session;
- If a video needs to be watched, review it before the session. Confirm the availability of power sources and cables, venue, television and video machine.

Focus group discussion

Refer to appendix 3 on page 209 for more information on how to conduct focus group discussions.
Getting Started

1. Participant Introductions

Ask participants to stand in a line, then ask each one to introduce themselves and give their reasons for wanting to reach out to other young people through SRH information and life skills. After participants’ introductions, the facilitator can summarise by saying that HIV and AIDS, teenage pregnancy, low self-esteem and other SRH issues are part and parcel of the realities young people are faced with in their country and communities.

2. Setting Ground Rules

Explain that ground rules are a form of agreement or contract for behaviour during the workshop. Everyone must agree to and respect these rules.

Ensure that all participants understand issues of privacy and confidentiality and that no-one may share personal information about other participants outside the group.

Give one or two examples of ground rules and then allow the participants to discuss and agree upon a set of rules. Write these down where everyone can clearly see them and put them up on a wall for the duration of the workshop.

Examples of ground rules:

- Agree to participate actively;
- Respect one another at all times;
- Respect confidentiality;
- Switch off mobile telephones.

3. Participants’ Expectations and Concerns

Participants need to indicate their expectations of the workshop and their concerns regarding peer education. Write down these responses. After assessing these responses, tell the participants which expectations go beyond the scope of the workshop and which ones are likely to be met.
4. Team-Building Activity

Activity: Building Trust

A group of six to eight people stand in a closed circle. One person stands in the circle’s centre with his/her eyes closed, body upright but relaxed and starts to fall forwards, backwards or sideways. The group gently pushes the person back into an upright position after each ‘fall’. Play the game slowly, either in silence or singing a lullaby. It is important to emphasise the seriousness of safety so that no-one is hurt. After the game, ask:

- Did you trust the people in your group to catch you every time you fell and put you back in an upright position?
- How does this game relate to our lives and SRH?
MODULE 1: Peer Education and Communication

DURATION: 5 HRS

Learning objectives

By the end of this module participants should be able to:

• Understand peer education;
• Understand programme planning and implementation of peer education activities; and
• Understand different forms of communication.
Session 1: Planning and implementation of Peer Education Programmes

Duration: 2 HRS

Learning objectives
By the end of this session participants should be able to:

- Know how to approach a community for programme planning and implementation;
- Know how to monitor and evaluate peer education; and
- Know the National Society support system available to peer educators.

Materials

- Large pages of paper or a board.
- Appropriate pens and markers.
- Material to stick the paper up on the walls.

Note to the facilitator:
The following information is an extract from the IFRC’s minimum standards for peer education (Standards 5, 6, 7, 8, 9 and 11). It has been simplified to suit our target group and make facilitation easier. However, you are encouraged to read the minimum standards to have a broader understanding of these standards. This session is an introduction for your participants. You need to bring all the necessary documents to the session, such as Volunteer policy and samples of volunteer contracts. Perhaps invite someone (e.g. an HIV coordinator/Health Care coordinator/District Project Officer) to assist you in answering some of the questions raised by participants.

Divide participants into 6 groups and allocate 1 of the following topics to each group.

1. How do you plan and prepare for the implementation of peer education in a new area?
2. What is the peer education structure of your National Society?
3. How do you recruit and retain peer educators?
4. What do you need for effective implementation of peer education?
5. How are peer educators supervised and supported in your National Society?
6. How is peer education monitored and evaluated in your National Society?
1. Approach the District AIDS Council

District AIDS councils have been formed in many countries to coordinate and facilitate access to HIV and AIDS services. The council includes leaders of all community sectors, service providers, PLHIV representatives and welfare organisations working to contain the spread of HIV and AIDS and to provide care for people living with HIV and AIDS as well as their families. Please remember that these District AIDS councils are not functioning well in all countries. In some places, the council may be very active while in others there may be little or no activity. However, this is not an excuse for not planning the implementation of peer education activities with other organizations. Adopt a mapping exercise - refer to Appendix 2 (on page 207) for more information on how to conduct a mapping exercise.

2. Peer education model

You may be required to present your peer education model at a meeting for stakeholders or at a school when requesting access to implement peer education activities. The next page includes a proposed peer education model structure to assist you.
Red Cross Peer Education Programme Model

PLHIV networks  
Government Ministries and departments, NGOs, CBOs, FBOs’  
Gatekeepers  
Parents of younger youth  

National Society  

HIV Programme Manager/Prevention officer/  
Health and care coordinator/ Youth officer  

Core/Master trainers/Branch HIV officers  
These are usually Red Cross Red Crescent staff, volunteers, or people from an external organization who have a training responsibility only. They can receive professional incentives. In some peer education Projects, core/master/branch HIV officers staff play both a training and supervisory role.

Peer trainers/ Facilitators/ Instructors/ Coaches  
These are usually volunteers whose role can be to train as well as supervise peer educators. Though this level is more common in larger peer education programmes, it can be used in any size peer education project to ensure adequate support and supervision of peer educators.

Peer educators/Supporters  
Volunteers whose role is to educate and support members of his or her peer group.

Peers/ target group/target population/beneficiaries  
Some peer education projects include the identification of a “take-home message” or activity. Peers are encouraged to take prevention messages and activities back to their friends and family members.

Community members
3. Community Presentation of Peer Education Guideline

How we approach community leaders or schools may have a positive or negative impact on the programme’s implementation. A correct approach is very important. First, create an appropriate environment for the implementation of peer education activities. In order to obtain support from community leaders and other beneficiaries, ensure that they understand that you are delivering a service which will benefit the community at large, e.g. reducing HIV infection.

However, although you are providing a service, you cannot do it alone; you need all key role players. Relevant service providers, including sexual and reproductive health, voluntary counselling and testing, and harm reduction service providers need to be informed about the programme and given training to ensure that services can be accessed by the target population and are delivered in a non-judgemental way. The community needs to be sensitised about the peer education programme, its objectives, content and benefits, and kept informed of programme activities.

4. Recruitment and retention of peer educators

The Red Cross is a volunteer-driven organisation and the recruitment and retention of volunteers is crucial to its success. Consequently, the following need to be in place:

1. National Society volunteer policy and management systems widely shared and openly discussed by governance, paid staff and volunteers.

2. Volunteer Recruitment Plan.

3. Pre-selection workshop or meeting to provide potential volunteers with:
   - General information about the Red Cross, volunteerism and the peer education programme, including its duration;
   - Information about the training process, its content and timing; and
   - The role of peer educators, including the required time commitment.

4. Written contracts should include a statement of minimum time commitment, roles and responsibilities, as agreed upon between peer educators and the National Society/branch. This ensures that everyone has a clear understanding of their roles and responsibilities.

5. Incentives.

**Professional incentives:** Locally agreed upon sustainable incentive or accreditation system with opportunities for increasing involvement and responsibility, e.g. where peer educators are trained as peer trainers.
Social incentives: System of social incentives to promote friendship and team-building e.g. provision of social and recreational opportunities; links with other National Societies and similar organisations for exchange of experiences and travel opportunities. Direct support for volunteers in the form of recognition, access to health and social services (volunteer insurance scheme and Masambo fund):

- Some National Societies may have initiated a global health insurance scheme for their volunteers.
- Should you come across a volunteer in need of support to manage his/her HIV infection, a special Federation fund called Masambo fund can be activated as a last resort to support him/her.
- In both cases you should request some information from your coordinator/supervisor. See appendix 5 on page 216.

Material incentives: System to provide material incentives throughout the programme, e.g. T-shirts, caps, bags, stationery and certificates.

5. Training Programme

The training programme should include the following aspects:

1. A training framework, including a developed evaluation framework to include:
   - An outline of training for staff and programme stakeholders for core/master trainer, peer trainer/facilitator and peer educator levels.
   - A training evaluation and methodology outline, including pre-test and post-test evaluation of knowledge and skills, used as a basis for assessing training effectiveness.

2. A pre-test (learning needs assessment) to ascertain knowledge, attitudes, practices and confidence level of peer trainers and educators. (Appendix 4 page 211).

3. Initial training
   - Peer educators who conduct formal or informal peer education receive a minimum of four to five days of initial training, using participatory methods ideally delivered to groups of no more than 25 participants.
   - Training should be in the appropriate language.
   - Opportunities should be provided for peer educators and peer trainers to practise their knowledge and skills in the actual community or a simulated environment within the initial training workshop before undertaking peer education activities.

4. Post-test to assess knowledge, attitudes, practices and confidence level of peer trainers and educators at the end of the training. (Appendix 4 page 211).

5. Certification

Peer educators and peer trainers are provided with a certificate once training is completed.
6. Implementation of Peer Education Activities

1. Community sensitisation regarding peer education programmes should be conducted across all peer education programme sites. For peer education programmes targeting youth younger than 15, parents and local leaders are sensitised on the programme’s benefits and are kept informed of programme activities.

2. Peer educators involved in conducting formal sessions should develop a monthly work plan, indicating objectives, strategies, and sequence of activities (formal or informal). The work plan needs to be realistic, appropriate to the target population, and include partners, budget and schedule. Such a plan should be integrated into existing National Society youth programmes where appropriate. The plan is then reviewed with a facilitator or peer trainer or staff member. Peer educators conducting informal sessions are also expected to plan their activities and have a work plan.

3. Peer educators are provided with training kits which may include an activity kit, IEC materials, referral contact list, and identity card.

4. Peer educators should act as role models, knowledgeable in issues affecting their peers and willing to provide peer education.

5. Educational and promotional materials, such as posters, brochures, newsletters and videos (IEC) are:
   - Targeted at a specific population and focus on certain behaviours.
   - Developed with the target population and use design, images and language familiar to the target group. These elements are clear and explicit enough to attract and influence the target population.
   - Pre-tested and reviewed with partners, peer educators and the target population to ensure that age, literacy, educational levels, gender, sexual diversity and current cultural norms are taken into account so that the message is effective enough to encourage the emergence of new behaviour.

6. The roles and responsibilities of other people involved in peer education, as small as they may be, need to be clear. For example: HIV coordinators, trainers and facilitators.

7. A dedicated budget for peer education needs to be developed with sufficient funds available to support the planned programme activities.

7. Supervision and support of peer educators

1. Meeting-based supervision:

A minimum of one meeting per month with an identified peer educator supervisor should be established where peer educators can:
   - Discuss their expectations;
   - Report back, discuss and receive emotional and practical support related to challenges with peer education activities;
• Plan activities such as community mobilization and group peer education;
• Submit monitoring and report forms and deal with any problems with the youth supervisor;
• Receive feedback on observation of peer educator activities; and
• Create and review work plans.

2. Field-based mentoring and supervision:

Establish a system to mentor and observe peer educators during work ensure that they receive individual and group feedback.

3. Community-based support:

Peer educators are encouraged to identify existing individuals and/or community based organisations/structures that they can draw on for support.

4. Appropriate administrative and logistics support at each level must be provided in order to ensure the smooth running of the peer education programme, e.g. report forms and training materials.

8. Monitoring and Evaluation

1. Monitoring and evaluation must be included in the work, operations plan, and/or log frame from the start, through the development of qualitative (data required in text or explanation form) and quantitative (data required in numbers) performance indicators.

2. Use of a data collection system, with tested, useable and gender-specific monitoring methods. The responsibility of managing and analysing the data generated by peer educators, is given to staff or volunteers who have received appropriate training. See Appendix 1 (page 198-206).

3. Staff and peer educators should be trained in data collection and analysis. If the training has not yet taken place, the project officer, coach, supervisor, Planning, Monitoring Evaluation and Report (PMER) officer or PMER unit should be able to assist with the training.

4. Involvement of staff, peer educators and other stakeholders.

• Staff, peer educators and other stakeholders should be actively involved in any decision-making related to the monitoring and evaluation of the peer education programme.
• Peer educators should be actively involved in monitoring and evaluation through the submission of reports and programme monitoring forms during formal and informal sessions conducted with the target population.
• National Society/branch/facilitator/coach should regularly report any collected data to peer educators.
Session 2: Peer Education

Duration: 1 HR

Learning objectives
By the end of this session participants should be able to:

• Know what peer education is;
• Know common terms used in peer education programmes; and
• Know the minimum conditions for peer education programmes.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

Note to the facilitator:
Ask participants to explain in their own words what peer education is, the importance of peer education and the role of peer educators in peer education. Write their responses down where they may be clearly viewed by the group. Then use the following information to make additions or corrections as needed. 20 Min

1. What is peer education?

Peer education is the process whereby motivated and well-trained young people participate in organized educational activities with people close to them in age, background or interests (peers) over a period of time. Peer education aims to develop peers’ knowledge, attitudes and skills, enabling them to be responsible for and protect their own health.

2. Why is it important?

A young person’s circle of friends greatly influences personal behaviour; be it safe or risky behaviour. Peer education uses peer influence positively. Young people look to peers for information on sensitive or culturally avoided matters.

Peer education offers young people the opportunity to participate in activities that enhance their level of understanding, attitudes, behaviour, skills and knowledge. Consequently, they also receive the information and services needed to protect their health.

Peer education is responsible, rewarding work that can truly make a difference to the lives of many young people. Working in this field is a satisfying way of positively changing communities.
3. What do Peer Educators do?

Peer Educators are young people volunteering to provide behaviour change information to other young people – their peers. Peer educators may:

- Recruit youths in or out of school for peer education sessions.
- Run or co-facilitate peer education sessions.
- Refer peers and community members to clinical services or other services as appropriate.
- Report on activities.

Note to the facilitator:
Write the following definitions (numbers 4 and 5) on a large piece of paper or board and present this to the group. Before presenting, you can also ask your group to try and define the terms. 20 Min

4. Common definitions of terms used in peer education programmes

**Peer:** A peer is a member of a group of people sharing the same characteristics. For example, people of the same age and background, or who do the same kind of work, have the same or similar lifestyle, experiences or beliefs.

**Near peer:** A person who shares many characteristics of a true peer but differs in some way, such as being slightly older or no longer belonging to the same societal group; for example, ex-alcohol addicts act as “near peers” to alcohol addicts.

**HIV peer education:** This is a process involving the selection, training and support of members of a specific group to educate their peers on HIV and related topics.

**Peer educator:** A person belonging to a group on an equal basis as other group members but who is trained (and supervised) to bring about a change in knowledge, attitudes, beliefs and behaviours at the individual level amongst his or her group members.

**Secondary peers:** In some instances it can be difficult to support and monitor the target group to act as peer educators, e.g. soccer players. “Secondary peers” are those who have frequent contact with the target group but are not their actual peers. Secondary peers can be trained as peer educators, e.g. in the case of soccer players, soccer coaches can become peer educators, as they have more frequent contact with soccer players.

**Formal peer education:** Formal peer education is repeated, formal contact by a trained peer educator with a group of up to 20 of his or her peers using a prepared session and involving active participation by the group. This can be carried out in any setting, for example, in a classroom, in the workplace or in a community setting.

**Informal peer education:** This is repeated, informal one-to-one or small group interactions by a trained peer educator with a member of his or her peer group. It can also be carried out in a variety of settings. What defines informal peer education is that the peer educator does not usually work through a prepared script but uses
information and skills gained through training to discuss a given subject with his/her peers and support safer behaviours.

5. Terms used in HIV prevention programmes

Access and equity: Measures to address institutional and/or other obstacles limiting individual and/or group participation in HIV prevention programmes and services. Access and equity may be impeded by direct, indirect and systemic forms of discrimination.

Behaviour change communication: An interactive process that is part of an overall HIV prevention programme, through which the target population receives basic facts about HIV and AIDS, as well as opportunities to develop skills for personal protection. It also enables them to access appropriate services and products in order to maintain and develop safer HIV practices.

Community mobilisation: Community mobilisation, in relation to HIV prevention, is a process through which community members unite to address their individual and collective vulnerability to HIV and AIDS. Community members identify their own concerns, participate in decision-making on what actions to take, evaluate the results and take responsibility for both success and failure.

Gatekeeper: A person or people outside a peer group who may influence or control access to a particular group, e.g. brothel owners or pimps may be the ‘gatekeepers’ of some sex workers. Factory managers or owners may be the ‘gatekeepers’ of factory workers.

Awareness-Raising: Awareness-raising activities are not classified as peer education as such because contact is not repeated and can be made with people of differing ages, status and background in groups varying in size. Evidence shows that peer education is most effective if awareness-raising activities are also conducted, as these help to create and reinforce safer cultural norms. Organising and participating in such mass events can be very motivational and help peer educators feel they are part of something bigger.

Positive health, dignity and prevention: Aims to meet the HIV health and prevention needs of PLHIV, supporting the right to sexual relationships and reproductive choices, and promoting the involvement and participation of PLHIV in the HIV response.

Positive health, dignity and prevention:

- Requires a supportive and protective legal and policy environment, free of stigma and discrimination.
- Should promote holistic health and wellness, including equitable access to voluntary HIV testing, treatment, care and support services.
- Should include addressing psychosocial, economic and educational socio-cultural vulnerabilities, gender and sexuality.
- Should be responsive to the needs of key populations and should respect and be tailored to specific contexts and the diversity among PLHIV.
• PLHIV must be leaders in the design, programming, implementation, research, monitoring and evaluation of all programmes and policies affecting the community.

**Life skills:** Basic psychosocial skills that define how successfully we resolve life’s challenges. These skills should include self-esteem, goal setting, clear values, decision-making, problem solving and critical thinking, as well as negotiation and respecting the rights of others. In the context of HIV prevention, life skills equip children, young people and adults to make better decisions regarding personal health and well-being, helping them to recognise and avoid situations and behaviours that place them and others at risk of HIV infection, and to manage such challenging situations.
Session 3: Different ways of communicating

Duration: 2 HRS

Learning objectives:

By the end of this session participants should be able to:

• Define communication;
• Explain the different communication methods;
• Differentiate between passive, aggressive and assertive communication; and
• Identify communication barriers.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

1. Introduction

Note to the facilitator:
Start the session by introducing the session topic and objectives. 5 Min

2. What is communication?

Note to the facilitator:
Ask participants to define communication and write down their responses on a large page. 10 Min

Communication is the method by which people share their ideas, information, opinions and feelings. Communication is a two-way activity between two or more people.

3. Different Communication Methods

Note to the facilitator:
Ask participants how communication takes place. Look for the information below and make any additional changes as required. 10 Min
Person to person | Face to face, reading a letter, making a phone call.
---|---
In a small group | Planning, problem solving, decision-making, written reports, memos, notice boards.
In a meeting | Presenting, bargaining, negotiating agreements.
Using mass media | Speaking in public, on radio or television, writing for print media such as newspapers and journals, books, advertising.
Others | Training, teaching, entertaining.

4. The passive, aggressive and assertive communication methods

**Note to the facilitator:**
Explain that this session will focus on three communication methods: passive, aggressive and assertive. Explain the three different methods, including their outcomes. 20 Min

**Passive Communication**
- Take no action to assert yourself.
- Put others first at your expense.
- Talk quietly.
- Give in to what others want.
- Remain silent when something bothers you.
- Apologise excessively.
- Make others feel guilty.
- Blame others and be a victim.
- Feel regret.

**Outcomes of passive communication**
- You do not get what you want.
- Anger builds up.
- You feel lonely.
- Your rights are violated.
Aggressive Communication

• Stand up for your own rights with no regard for the other person.
• Put yourself first at the expense of others.
• Overpower others.
• Be rude and disrespectful.

Outcomes of aggressive communication

• You dominate people.
• You humiliate people.
• You win at the expense of others.

Assertive communication

• Stand up for yourself without putting down the rights of others.
• Respect yourself as well as the other person.
• Listen and talk.
• Keep focused on what your position is and are not distracted by other arguments.
• Express negative and positive feelings.
• Confident but not pushy.
• Seek a compromise without compromising your health, safety or values.

Outcomes of assertive communication

• You do not hurt others.
• You gain self-respect.
• Your rights and the rights of others are respected and everybody wins.

Being assertive includes other nonverbal signs of communication, such as tone of voice, posture, eye contact and general body language.

5. Practising different communication methods (role play)

Note to the facilitator:
Write down the following exercises on the board and ask volunteers to explain how they would deal with the situation, using the assertive method. 15 Min

You go out with your boyfriend. He pays for food and buys you gifts. He insists that you go past his house on the way home. He insists that since he paid for the outing, you owe him and the two of you should have sex. You like him and saying no is hard. How do you deal with this situation in an assertive way?
Your aunt always asks you to look after your cousins, who are much younger than you, when she goes out. Sometimes she does not come back until very late at night. This means you have to walk home when it is very dark and unsafe to be out. She pays you for babysitting but you feel she is taking advantage of you. It is difficult to confront her as she has been good to you in the past. How do you speak to her?

6. Barriers to effective communication

Note to the facilitator:
Ask one participant to read the story below and then discuss what barriers are at play in this story. Use the questions following the story as discussion points. 20 Min

James is in grade 5. At break-time in school, he overheard some of the grade 7 boys saying that Shaun, one of their classmates had an STI. In the evening, James recounts the story to his mother.

1. James: “Mama, I heard one of the bigger boys in school saying that Shaun has an STI. What is an STI?”

Mama: “Why are you asking about this? You shouldn’t know about such things at your age. Now go and finish your homework!”

2. The next day James asks his neighbour, a health worker at the local dispensary.

James: “Good morning Mr Mwanza. Can you tell me what an STI is?”

Mr. Mwanza: “Yes. STI stands for Sexually Transmitted Infections.” Mr. Mwanza hurries along. James tries to repeat the phrase without much success.

3. James gets to school and tells his friends that he heard Shaun had Severe Tribal Infections. One of his friends says he has had this before and it makes one a real man. They decide to ask their teacher later on.

Discuss the following questions:

1. Was the communication effective? (Answer: No, it was not effective)

2. What barriers to effective communication can be identified? (Answer: Complex language, age difference, condescending attitude and feedback not waited for).

3. How can we overcome such barriers? (Answer: Be aware of these barriers and modify language and referrals).
7. Exercise: Oh John!

**Aim:** Enable participants to realise the power of the way in which we express language to communicate.

**Note to the facilitator:**
Get seven participants to role-play the following exercise. They should express the following feelings when they shout “Oh John!” anger, happiness, love, surprise compassion, fear and scolding. Then ask the rest of the group to identify what kind of feeling was expressed by each person. Also use the discussion questions listed below.

**Steps:**

- Write out the phrase “Oh John!” on the board.
- Select or ask for seven volunteers to do the exercise.
- Allocate the following expressions to the volunteers without the rest of the group present (anger, happiness, surprise, fear, love, compassion and scolding).
- Give the volunteers time to think about the emotion/state of mind they have been allocated.
- Now let the volunteers say (one by one) “Oh John!” in a manner that suggests their feelings/emotions to the rest of the group.

**Discussion points**

- What have they learned about communication from this exercise?
- Was the statement not the same? Did they convey the same meaning? Why? Why not?
- Words can convey different messages depending on how they are said / conveyed.

8. “Mime the Lie” Exercise 15 Min

**Aim:** Demonstrate that what people say and what they do sometimes do not correspond.

**Description:** Each participant has a turn to mime an action, but says he / she is doing something else. The next person has to mime what the previous person said he / she was doing.

**Steps:**

- Get everyone settled in a circle.
- Move to the middle of the circle and mime an action e.g. digging in the field.
- Ask the person next to you to ask you in a loud voice what you are doing.
• You then reply by saying something totally different e.g. I am cooking lunch (this is likely to draw laughter).

• Now ask the person who asked what you were doing to move into the circle and mime what you said you were doing (i.e. cooking lunch).

• When the person next in line asks them what they are doing, he/she also lies.

• The game continues until all have had a chance of miming the lie.

**Discussion points**

• At times we say we are doing one thing when we are doing something else.

• How often does this happen?

• What are the dangers of doing this? E.g. misleading others.

Therefore, as facilitators/peer educators, we should be role models and do what we say.

**Session conclusion 10 Min**

• Ask each person to mention one thing about the module they found to be good and one thing they found difficult. Ask them to mention one thing they will share with someone else.

• The facilitator then concludes the session by explaining how important communication is when dealing with behaviour change issues.
Module 2: Life Skills

Duration 6:15 Hrs

Learning objectives
By the end of this module participants should be able to:

• Set life goals to work towards;
• Understand the importance of self-esteem;
• Understand self awareness, empathy and sympathy;
• Understand decision-making;
• Know how to deal with peer pressure;
• Know how to manage conflict (conflict management); and
• Know how to cope with emotional stress.
Session 1: Life Goal Setting

Duration: 1 HR

Learning objectives
By the end of this session participants should be able to:

• Define what a goal is;
• Set goals for every area of their lives; and
• Define the SMART principle of setting goals.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls
• Black A4 papers

What is a goal?

Note to the facilitator:
After the introduction of this topic and the objectives of the session, ask your participants to define what a goal is. Later, give them your definition and some examples of goals mentioned below. Also, introduce them to the SMART principle of setting goals by using the information below. 20 Min

A goal is a specific, intended result of an action. Setting goals is a way to focus your attention on what you want in the future. If you are not specific, you will never know where you are going.

An example of a goal would be “I want to go back to school and get a Bachelors Degree in Mechanical Engineering.” This is very specific. It’s not just stating “I want to go back to school.” It’s stating exactly what type of degree you want to obtain. Think about it, if you just use “I want to go back to school” as your goal, there are still many unanswered questions, for example, which diploma or degree you should take. If you specify that you want a degree in Mechanical Engineering, you will be able to plan which classes to take, and it may narrow down your search for a school, as only certain schools offer degrees in Mechanical Engineering.

Goal setting techniques are used by top-level athletes, successful business-people and achievers in all fields. They give you long-term vision and short-term motivation. They focus your attainment of knowledge and help you to organise your time and your resources so that you can make the most of your life.
Starting to Set Personal Goals

**Note to the facilitator:**
Ask participants to think of where they want to be in 5 years’ time. Each participant should think of a goal they would like to achieve. The goal should be something specific, an improvement and something they want to work towards.

**Activity**

**Note to the facilitator:**
Ask participants to make drawings of where they see themselves in 5 years’ time. For example they can draw a family, a house, cars, or their workplace. These should be just sketches.

**Ask for volunteers who would like to share their drawings with the whole group.**

**Ask questions such as:**

- What will it take for you to reach this goal?
- Why do you see yourself as what you have drawn? 40 min

**SMART Goals:**
A useful way of making goals more powerful is to use the SMART principle of setting goals. While there are plenty of variants, SMART usually stands for:

- S - Specific
- M - Measurable
- A - Attainable
- R - Realistic
- T - Time-bound

For example, instead of having “sail around the world” as a goal, it is more powerful to say “To have completed my sail around the world by December 31, 2015.” Obviously, this will only be attainable if a lot of preparation has been completed beforehand!

Goal setting is an important method of:

- Deciding what is important for you to achieve in your life;
- Separating what is important from what is superficial;
- Motivating yourself; and
- Building your self-confidence, based on successful achievement of goals.

**Note to the facilitator:**
Conclude the exercise by reviewing the importance of having goals.
Session 2: Self-esteem

Duration: 1 HR 15 Min

Learning Objectives
By the end of this session participants should be able to:

- Understand self-esteem;
- Identify what boosts self-esteem;
- Use skills gained on self-esteem to make good decisions; and
- Link positive self-esteem with good decision-making.

Materials

- Large pages of paper or a board.
- Appropriate pens and markers.
- Material to stick paper up on the walls.

1. Self-esteem

What is self-esteem? 10 Min

Note to the facilitator:
Ask participants to define, in their own way, what self-esteem and self concept are. Make sure that terms such as ‘believing in yourself’, ‘confidence’, ‘self respect’, and ‘feeling that you are special and important in this world’ are mentioned. Then give them the definitions below.

Self-esteem is the way we feel about ourselves. We create this picture of ourselves:

- From the feedback we receive from other people - they act as a mirror, giving us a picture of who we are;
- From the expectations of our society - if we are different from what they expect, this can lower our self-esteem;
- From our own experiences - every time we achieve something positive, our self-esteem rises; and
- From imagining the future.

If we have low self-esteem, it will be difficult to assert ourselves, make a decision or take responsibility because we will always think our decisions are bad or that our plans will fail.

Self-concept is the accumulation of knowledge about the self, such as beliefs
regarding personality traits, physical characteristics, abilities, values, goals, and roles. Beginning in infancy, children acquire and organise information about themselves as a way to enable them to understand the relationship between the self and the social world.

**Exercise: How do I see myself?** 15 Min

- Write on an A4 page in big characters or upper cases, the words AGREE, DISAGREE and UNDECIDED and paste them on the wall of the training room.
- You can also do this exercise by asking participants to make a tick on options that appeal to them.
- Tell participants that you will read statements from worksheet 1 on page 44 and after each statement they need to decide if they agree, disagree or are undecided, and then move towards the corresponding sign.
- Ask 2 or 3 people from each group why they chose to move to that sign.

**Note to the facilitator:**
Divide your group into smaller groups of 5 to 6 people and ask them to answer this question in 5 minutes: “How can we develop high self-esteem and confidence?” Give them 1 minute to share their answers with the entire group. Later, give them the four conditions and self-esteem builders indicated below. 20 Min

**How can we develop high self-esteem and confidence in ourselves?**

There are four conditions that need to be met for an individual to have high self-esteem:

- **Connectedness:** feeling attached and connected to others; feeling as if they belong and are respected.
- **Uniqueness:** the sense that we are special, different from everyone else.
- **Power:** feeling in control of our lives: ‘I am competent’, ‘I have responsibilities’. To build this feeling we need options and responsibilities from which we can choose.
- **Role models:** to build self-esteem we need to have good role models.

**What builds self-esteem?**

- Tell each other when we have done well, the things we like about each other, and our strengths.
- Know that each of us is special and unique.
- Each of us experiences life in our own way. Try to put ourselves in each other’s shoes and accept each other.
- Our family and friends can help us to feel good about ourselves. We can encourage people to praise us by praising them.
• Being good at something helps us to gain confidence. When you are feeling low, remind yourself what you are good at.

• We all make mistakes – that is how we learn. We do not need to feel bad every time we make a mistake. Let us just admit that we made a mistake and learn from it.

• We need believe that we can achieve things. One small step can lead to another until we have travelled a long way.

**Summary 10 Min**

Self-esteem is the way you feel about yourself, whether you feel that you are valuable as a human being or not.

Remind the participants of the four conditions that need to be met for an individual to have high self-esteem.

• Connectedness.

• Uniqueness.

• Power.

• Role model.
WORKSHEET 1: How do I see myself?

Make a tick in the box you feel applies to you.

<table>
<thead>
<tr>
<th></th>
<th>Agree</th>
<th>Undecided</th>
<th>Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>I am an interesting person to other people.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>It takes me a long time to get used to anything new.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I do not like the way I look.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I have trouble controlling my feelings.</td>
<td></td>
<td></td>
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<tr>
<td>I want to achieve to the best of my ability.</td>
<td></td>
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<tr>
<td>If a friend were in trouble I would most likely drop him or her rather than get involved.</td>
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<td></td>
</tr>
<tr>
<td>I often do not get really angry.</td>
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<td></td>
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<tr>
<td>I handle most of my problems well.</td>
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<tr>
<td>I am happy most of the time.</td>
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<tr>
<td>I find it hard to get along with people.</td>
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<tr>
<td>I do not finish most things I start.</td>
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<tr>
<td>I always try to be fair.</td>
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<tr>
<td>I try to do what I think is right.</td>
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<tr>
<td>I am seldom at ease or relaxed.</td>
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<tr>
<td>I wish my body was shaped differently.</td>
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<tr>
<td>I do not know what to do in many situations.</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>I like to meet new people.</td>
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</table>
Session 3: Self-awareness, empathy and sympathy

Duration: 40 Min

Learning objectives
By the end of this session participants should be able to:

• Define what self-awareness is and develop their self-awareness;
• To define what empathy is and how to apply it; and
• Differentiate between empathy and sympathy.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

Note to the facilitator:
After introducing the objectives of the session, ask some of the participants to define self-awareness, empathy and sympathy in their own words. Then give them your definition of the same terms using the information provided below.

20 Min

1. What is self-awareness?

It includes recognition of one’s personality, strengths and weaknesses, likes and dislikes. Developing self-awareness can help you recognise when you are stressed or under pressure. It is also a prerequisite for effective communication and interpersonal relationships, and is important for developing empathy for others.

The benefits of self-awareness

The better you understand yourself, the better you are able to accept or change (for the better) who you are. Being in the dark about yourself means that you will continue to get caught up in your own internal struggles and allow outside forces to mould and shape you.

2. What is empathy?

Empathy is defined as one’s ability to step into another’s situation and experience it from that person’s perspective. It can also been defined as “putting yourself into another’s shoes".
Three elements involved in being empathetic:

- Respect (e.g. by being available to your peers, not judging someone for who they are);
- Trust (having faith in someone); and
- Care (concern for or interest in others).

3. What is sympathy?

Sympathy exists when the feelings or emotions of one person are deeply understood and appreciated by another person. It also can mean being affected by feelings or emotions. Thus, the essence of sympathy is that one has a strong concern for another person.

Note to the facilitator: Make copies of exercise 1 on page 47 and give it to your participants to complete. 20 Min
**EXERCISE 1: Self-awareness exercise**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What are your strengths?</td>
<td></td>
</tr>
<tr>
<td>2. What are your weaknesses?</td>
<td></td>
</tr>
<tr>
<td>3. How do your friends describe you?</td>
<td></td>
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<tr>
<td>4. Do you agree with their descriptions?</td>
<td></td>
</tr>
<tr>
<td>5. What types of activities did you enjoy doing when you were a child?</td>
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<td>6. What motivates you?</td>
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<tr>
<td>7. What are your dreams for the future?</td>
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<tr>
<td>8. What do you fear most in your life?</td>
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<tr>
<td>9. What stresses you?</td>
<td></td>
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<tr>
<td>10. How do you respond to stress?</td>
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</tbody>
</table>
Session 4: Decision-making

Duration: 50 Min

Learning objectives
By the end of this session participants should be able to:

• Define decision-making; and
• Explain the process of decision-making.

Materials
• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

Session introduction 5 Min
We make decisions every day: when to get out of bed, have breakfast, brush our teeth, meet certain people, etc.

Some decisions are very important to our lives. We should recognise their importance and think before we act. Decisions about sexual relationships are very important.

1. What is decision-making? 20 Min

Note to the facilitator:
After the introduction and objectives of the session, ask some of your participants what decision-making is and write their answers on a flip chart. Then provide them with your definition (see below) and take them through the steps in the process of decision-making.

Decision-making can be regarded as an outcome of mental processes leading to the selection of a course of action from several alternatives. Every decision-making process produces a final choice. The output can be an action or an opinion of choice.

2. Steps in the process of decision-making

Define the problem. State exactly what the problem is, or define the situation about which a decision needs to be made.

Consider all alternatives. List possible ways to solve the problem, all the possible decisions that could be made. You may need to gather more facts or consult with others to be sure you have not left out any options.
Consider the consequences of each alternative. List all the possible outcomes, positive and negative, for each alternative or each course of action that could be taken. Make sure that you have correct and full information for each point.

Consider family and personal values. Values include beliefs about how we should act or behave. The personal and family rules we live by and believe in are important. These could be beliefs about honesty, loyalty, or whether it is alright to smoke and drink alcohol. Most of our values come from the training we receive at home. Other values come from our friends and society. Consider whether each alternative fits with your personal and family values.

Choose one alternative. After carefully considering each alternative, choose the one that seems best based on your knowledge, values, morals, religious upbringing, present and future goals, and the effect of the decision on the people important to you.

Implement the decision. Do what is necessary for the decision to be carried out as you want it to be. You may have to develop a step-by-step programme with a timetable to make sure things are done.

3. Exercise on decision-making 25 Min

Note to the facilitator:
Ask two people to volunteer to role-play the exercise below. After the role play use the questions provided to facilitate a discussion.

1. David asked Mary on a date to Jo’s night-club one Friday evening. At first Mary is reluctant to go, then agrees on the condition that David makes certain promises.

2. Ask the two actors to stop at this point.

3. Ask the group what promises they think Mary wants from David? What things can she make him promise, before she goes to the nightclub?

4. When the group has answered let the actors continue:
   • Mary agrees to go to the nightclub if David promises her he will walk her home at 9pm.
   • At 9pm Mary was ready to go home but David said he was too drunk to walk such a long distance. David says they will have to sleep at his brother’s place.

5. Ask the actors to stop at this point and leave the story hanging.

6. Let two new volunteers act out what they think happens next to David and Mary.

7. When they have finished ask if there is another way the story could end.
   • Ask two volunteers act out what they think happens to David and Mary, by acting out a different ending to the story.
8. When they have finished, help the group to talk about the story by asking the following questions:

- What did you see happening in this story?
- Why did these things happen?
- How could Mary have made sure that David kept his promises?
- When were the decision points for Mary?
- When were the decision points for David?
- Do you think David was being honest with Mary?
- How can you tell if someone is being honest with you, or if they are trying to trick you?
- Why do we sometimes trick each other into having sex?
- When we make decisions, what makes us choose one option over another?
- How can we as young people get to know each other safely?

**Summary**

There are six steps in the process of decision-making:

- Define the problem. State exactly what the problem is or define the situation about which a decision needs to be made;
- Consider all alternatives;
- Consider the consequences of each alternative;
- Consider family and personal values;
- Choose one alternative; and
- Implement the decision.
Session 5: Dealing with peer pressure

Duration: 50 Min

Learning objectives
By the end of this session the participants will be able to:

• Define peer pressure;
• Define the two types of peer pressure; and
• Find effective ways of dealing with peer pressure.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

Note to the facilitator:
Ask the participants to share with the group their understanding of what peer pressure is. Also ask them to identify different types of peer pressure and write their responses on a flip chart. Afterwards, go through the definition and types of peer pressure indicated below. 20 Min

1. Definitions

Peer: is a member of a group of people sharing the same characteristics. For example, people of the same age and background, or who do the same kind of work, have the same or similar lifestyle, experiences or beliefs. The more a peer has something in common with the person they interact with, the more likely it is that person will be influenced by the peer.

Peer pressure: is when “friends” persuade you to do something that you do not want to do or are unsure about.

2. Two types of peer pressure

• Bad peer pressure: occurs when you are being coerced into doing something that you don’t want to. Friends have a tendency to think that they know what is best for you, and may offer their opinion whether it is wanted or not.
• **Good peer pressure:** is being pushed into something that you didn’t have the courage to do or didn’t think about doing. Another form of good peer pressure is walking away from a bad situation/ decision because your friends convince you it is not in your best interests. Some people say that good peer pressure is when you get pushed into something that you didn’t want to do and it turned out well.

3. **Exercise on resisting peer pressure 15 Min**

**Note to the facilitator:**
Ask the whole group to identify ways of resisting peer pressure and then share the information provided below.

• Think about what you do and do not want to do, and why. Be clear about the facts and values which are guiding you. Seek out further information which may help you make your decisions.

• Think about the consequences of your choice. Will you feel good about it the next day? Is it a healthy, positive decision? Are you fully in control of the situation and likely consequences?

• Stand your ground and do not give into pressure.

• This means being strong, determined and motivated to stick to your decision.

• Feeling strong and sure means that you do not give into threats of emotional blackmail (if you really loved me you would……..I will leave you if you do not……. I will have to get my sex from other girls then…).

• Keep focussed as to what your position is, and why you have decided to choose this path.

4. **Exercise on peer pressure 30 Min**

**Note to the facilitator:**
Divide participants into smaller groups of 5 – 6 people and ask them to discuss ways the adolescent could deal with the situation in the exercise below. Allow 10 minutes for this part, then ask each group to give their feedback (1 minute per group).

“I am having problems with my friends at school. We are a group of five. I enjoy being with them and doing things, but sometimes after school we get together and do things I do not feel good about, like stealing and smoking cigarettes. Another time they found a can of paint and sprayed words on a garden wall. I have sometimes said I do not feel it is right, but my friends have all laughed and teased me and called me names. They say that if I don’t want to do these things with them, then I must leave the group. I do not want to be without friends, but I feel bad doing these things. Please help me”.
Session conclusion by trainer or facilitator

- Peer group is important during adolescence;
- Most people feel the need to belong to a group;
- There is often a feeling of having to conform to fit into the group. This may lead to the individual being ‘swallowed up’ by the group;
- The group’s behaviour may be harmful to the adolescent, e.g. alcohol, drugs, truancy;
- The group may put pressure on the non-conforming individual;
- Adolescents fear the consequences of non-conformity e.g. ridicule, rejection;
- Conforming to potentially destructive behaviour is caused by a number of factors such as:
  - Low self-esteem and lack of assertiveness;
  - Poor adult support system and lack of confidence.
Session 6: Conflict Management

Duration: 40 Min

Learning objectives
By the end of this session participants should be able to:

• Identify causes of conflicts at individual, family, group and community level;
• Understand steps needed to solve conflicts; and
• Develop skills in conflict resolution.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

Note to the facilitator:
After the introduction and the session objectives, ask all participants to define, in their own words, what conflict and conflict management are. Write their responses on a flip chart.

1. What is conflict? 5 Min
Conflict may be defined as a struggle or contest between people with opposing needs, ideas, beliefs, values, or goals. Conflict in teams is inevitable; however, the results of conflict are not predetermined. Conflict might escalate and lead to non-productive results, or conflict can be amicably resolved and lead to a long lasting solution. Therefore, learning to manage conflict is integral to a high-performance team. Although very few people go looking for conflict, more often than not, conflict results because of miscommunication between people with regard to their needs, ideas, beliefs, goals, or values.

2. What is conflict management? 5 Min
Conflict management involves acquiring skills related to conflict resolution, self-awareness about conflict modes, conflict communication skills, and establishing a structure for the management of conflict in your environment.

Note to the facilitator:
Get a volunteer to read the story below to the entire group. Get 2 participants to role-play how they would resolve the conflict between Maud and her mother. After the performance, ask the entire group for other ideas on how the situation could be solved. Then take them through the steps for resolving conflict indicated below.
3. Conflict management exercise 20 Min

Maud is 16 and in grade 10. Her mother discovered that she is dating an older man who is working. Two months ago, she told Maud to stop seeing this 35 year old man. Now she has discovered that Maud is still dating him. She quarrels with Maud about this but Maud refuses to stop seeing him.

4. Steps in resolving conflicts 10 Min

- In some conflicts, it is helpful to talk to each person alone first to get their opinion on the situation.
- Set some rules: e.g. people will speak one at a time, listen to each other, not talk while the other is talking, or call each other names.
- Identify the problem clearly, as all people in the conflict see it. Make sure that everyone listens to the other people and understands their opinions. Summarise the problem clearly and get everyone’s agreement on it.
- Agree on aims and what each person hopes to achieve. Give everyone a chance to speak and try to bring out common aims.
- Summarise the agreed aims.
- Look for solutions to the problem.
- Think of as many solutions as possible and accept all at first. Praise people for their progress.
- Select those solutions which will achieve the aims and which everyone accepts.
- Gain agreement on the solutions.
- Make an action plan that achieves the solutions.

Session conclusion

- Conflict can have good or bad results.
- Through disagreement and discussion, people can come to better understand each other and make positive changes.
- Conflict can have bad results if it leads to harmful behaviour such as fighting and negativity. This happens if people do not handle conflict well or ignore it.
- Peer educators can help people use conflict in a good way to bring about positive change.
- Poor communication (not being able to talk to each other), disagreeing on important issues, and gender inequalities are major causes of conflict, especially between sexual partners.
- Many conflicts involve the use of resources including money. Poverty and envy worsen this.
Session 7: Coping with emotions and stress

Duration: 40 Min

Learning objectives
By the end of this session participants should be able to:
• Define stress;
• Know the signs and symptoms of stress;
• Identify the causes of stress; and
• Know how to manage stress

Materials
• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

1. What is stress? 10 Min

Note to the facilitator:
Start by introducing the topic and take your participants through the objectives of the session. Then ask them for their definition of stress. You can then provide them with the definition below.

Stress is your physical, emotional and mental response to change, whether or not the change is positive or negative. It has also been defined as the extreme physiological, psychological and emotional arousal a person experiences when confronted with threatening situations.

Exercise on stress 20 Min

Note to the facilitator:
Divide your participants into 3 groups and assign the following questions: What are the causes of stress? What are the signs of stress? How to manage stress?

Give them a flip chart to document their responses (allow 10 minutes) and then give them each 2 minutes to present.
2. What are the causes of stress?
- Difficult living conditions
- Heavy workload
- Lack of leisure activities, social or cultural life
- Insecurity
- Threat to well being or health risks
- Challenges to a person’s values, ideas and beliefs
- Financial problems

3. What are the signs of stress?
- Sleeping and eating problems.
- Increased boredom and fatigue.
- Increased use of alcohol or other drugs.
- Decision-making problems.
- Becoming anxious or confused over unimportant events.
- Inability to get organised.
- Inability to concentrate or pay attention.
- Weakness, dizziness and shortness of breath.
- Persistent hostility or feelings of anger.
- Nightmares.
- Overpowering urges to cry, run, or hide.
- Frequent headaches and ailments.
- Frequent indigestion, diarrhoea or urination.
- Frequent colds and infections.
4. How is stress managed?

- Establish realistic goals of what you can and cannot do and talk to your supervisor about making appropriate changes at work.
- Divide tasks into manageable parts.
- Ask others for help, or discuss your problems and feelings with a friend.
- Take time off work.
- Make use of your spiritual support system.
- Engage in recreational activities outside of work.
- Get some rest - listen to what your body is telling you.
- If you are feeling very stressed and are unable to cope, seek professional help.
MODULE 3: Adolescent Development

Duration: 1Hr 30 Min

Learning objectives
By the end of this module participants should be able to:

• Understand growing up from childhood to adolescence; and
• Understand the human reproductive system.
Session 1: Growing up

Physical, emotional, spiritual and social changes at puberty

Duration: 40 Min

Learning objectives
By the end of this session participants should be able to:

• Understand the changes that happen during puberty; and
• Understand how the human body develops during that period.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

1. What changes take place at puberty? 5 Min

Note to the facilitator:
As you introduce the topic, explain to your participants that, when boys and girls reach the ages of approximately 10 and 11, their bodies begin to change from a body of a child to that of an adult. This change is called puberty. It happens between the ages of 10 and 18. Puberty is the start of the period we call adolescence. Chemicals in the body called hormones cause these changes. These hormones make the body produce the eggs in females and sperm in males that can make a baby. Both girls and boys develop pubic hair around their private parts and in their armpits.

2. Group work 15 Min

1. Take two pages, write BOYS on the one and GIRLS on the other.
2. Divide participants into groups of 5. Ask each group to choose someone to write.
3. Ask the groups to discuss and write down all the changes that take place in boys’ and girls’ bodies.
4. Ask each group to present their discussion to the other groups.
5. Discuss the different presentations and look for similarities.
6. Summarise the changes that take place during puberty as illustrated below.
### 3. Handout 1: What changes occur during puberty?

<table>
<thead>
<tr>
<th>BOYS</th>
<th>GIRLS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height suddenly increases.</td>
<td>Girls are often smaller than boys.</td>
</tr>
<tr>
<td>Get pimples. Glands called sebaceous glands produce too much oil.</td>
<td>Get pimples.</td>
</tr>
<tr>
<td>Moustache and beard start to grow. Voice gets deeper. For a while the voice is squeaky (voice breaks).</td>
<td>Hair starts to grow under arms.</td>
</tr>
<tr>
<td>Shoulders and chest get broader.</td>
<td>Breasts develop.</td>
</tr>
<tr>
<td>Hair starts to grow under arms.</td>
<td>Pubic hair starts to grow.</td>
</tr>
<tr>
<td>Pubic hair starts to grow.</td>
<td>The ovaries get bigger and develop. Female sex cells, called ova, or egg cells, develop in the ovaries.</td>
</tr>
<tr>
<td>Penis and testes get bigger. Male sex cells called sperm, start being produced in the testes.</td>
<td>Periods usually start about a year after breasts develop.</td>
</tr>
</tbody>
</table>
4. WORKSHEET 2: Puberty Quiz 20 Min

**Note to the facilitator:**
Put up 3 A4 pages on the wall, labelled “True”, “False” and “Don’t know”. Tell the participants that you will ask them questions and they will be required to move to “True” if they agree with the statement, “False” if they disagree and “Don’t know” if they are unsure. After each decision, ask why they chose a certain option. If their choice was wrong, use the answers provided to correct them.

<table>
<thead>
<tr>
<th></th>
<th>True</th>
<th>False</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. All girls’ bodies begin to change at about the ages of 10 and 11.</td>
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<td></td>
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<tr>
<td>2. Girls start puberty before boys.</td>
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<tr>
<td>3. Girls have monthly periods on the same day every month at the beginning of puberty.</td>
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<tr>
<td>4. Menstruation happens so that girls can have babies when they are ready to have children.</td>
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<tr>
<td>5. Changes in the body happen because of hormones.</td>
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<tr>
<td>6. As our bodies change, our feelings also change.</td>
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<tr>
<td>7. There is no need to worry about the size of our sexual organs.</td>
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<tr>
<td>8. Sperm comes out of the body through the boy’s penis.</td>
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<tr>
<td>9. Sometimes sperm comes out of the boy’s penis at night.</td>
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<tr>
<td>10. Playing with sexual organs is bad for you.</td>
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<td></td>
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</tr>
<tr>
<td>11. All boys will end up with deep voices.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. All boys will grow hair on their chests.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>13. The hormones that causes changes in the body are different in girls and boys.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>14. A girl can fall pregnant before her first period.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>15. It is important to wash even more carefully at puberty.</td>
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</tbody>
</table>
Facilitator: Answers for worksheet 2: Puberty Quiz

1. **False.** Every girl develops at her own time, some as young as 8 or 9 years, others not until the ages of 11 to 14.

2. **True.** Boys’ bodies usually start to change about two years later than girls of the same age. But some girls change at a later stage, and some boys change at an earlier stage. Each person is different.

3. **False.** It is very common for monthly periods (menstruation) not to happen at fixed times. After one or two years the menstrual cycle becomes more regular.

4. **True.** Menstruation is the first sign that a girls’ body is preparing to have children in the future. However, this does not mean that the girl is ready now, she still needs to grow and develop some more. She needs to mature emotionally and be responsible in every possible way.

5. **True.** Chemicals called hormones are responsible for the changes in our body. They make the sex organs grow and develop, and they change the way we feel and behave.

6. **True.** During puberty, your moods change more often. You may also start to learn more about yourself, worrying about the way you look and what other people think of you. Sexual feelings will also become stronger and boys may find themselves attracted to girls and vice versa. Sometimes boys are even attracted to other boys and girls attracted to other girls. This is very normal and a natural part of puberty.

7. **True.** Boys’ penises are all different sizes when they are soft and when they are hard (erect), they all get bigger. The size of a man’s penis is not what makes a woman enjoy sex. It is love, care and skill that matters. The vagina can stretch big enough for a baby to pass through, or can fit tightly around a penis because it is very elastic. Sperm is responsible for the ability of a man to have children and not the size of his penis.

8. **True.** Sperm is made in the testicles and comes out through the penis.

9. **True.** Sometimes young men’s and boys’ penises become erect and release sperm while they are sleeping. These are called ‘wet dreams’ and are normal.

10. **False.** Playing with private parts (sexual organs) can be very enjoyable, and cannot cause harm to the mind or body. Just make sure you are not rough, your hands are clean and you do not use anything that will cut or bruise your sexual organs.

11. **False.** There are no rules: some men have deep voices and others do not. You do not need a deep voice to be a man, to have children or to satisfy a woman through sex.

12. **False.** Some men have hair on their chest but others do not. You do not need hair on your chest to be a man.
13. **True.** The hormone that causes changes in girls is called oestrogen; the one that causes changes in boys is called testosterone.

14. **True.** A girl can fall pregnant before her first period because she releases an egg before that first period.

15. **True.** Sweat glands start working more and the skin becomes oily, so it is important to wash regularly. Your sex organs also start making their own fluids, so they must be washed every day to stop them smelling or becoming dirty.
Session 2: Human Reproductive System

Duration: 50 Min

Learning objectives

By the end of this session participants should be able to:

• Know the different male and female reproductive organs;
• Explain the various functions of the different parts of the reproductive organs;
• Know how to keep the reproductive organs clean; and
• Know how menstruation works.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

1. Female Internal Reproductive System

Note to the facilitator:

Introduce the session and explain the session’s objectives. Divide participants into smaller groups of 5-6 participants and give each group copies of male and female reproductive organs diagrams. Ask them to discuss the functions of each part indicated in the diagrams and write them down on a flip chart. Then ask the groups to present their information to the whole group. Use the information provided to make corrections. Give the groups 30 minutes to discuss and 2 minutes each to present.
The Vagina

- The walls of the vagina are made of muscles that women can flex to make sex enjoyable and keep fit for childbirth.
- The walls of the vagina produce fluid that keeps the vagina clean. This fluid is normal and healthy; do not wash it off with soap or water.
- The amount of fluid produced changes during the menstrual cycle. When the egg is released from the ovary, the fluid is stretchy, like egg white. This is a sign that a girl could become pregnant if she has sex.
- If the fluid is itchy or smelly, medical treatment may be needed.
- The vagina grows and stretches during puberty. The walls of the vagina and the mouth of the womb are not fully-grown until the girl is about 18 years old. Before this, the girl’s reproductive system can be easily damaged by childbirth.
- If a girl has not yet had sex, a thin layer called the hymen sometimes covers the vagina. In some cultures, people say a girl without a hymen is not a virgin. This is not true. Some girls are born with very thin hymen and exercise or use of tampons can easily break it.

The Cervix

The cervix is the mouth or opening of the womb. It is a very small opening and nothing can get through except sperm, germs and menstrual blood.
Uterus

The uterus or womb is a pear-shaped organ where the baby (foetus) lives for nine months before it is born. The uterus is made of muscle that stretches.

Ovaries

There are two ovaries and these take turns every month to release an egg that can join with a sperm to make a baby.

Fallopian tubes

The Fallopian tubes lead from the ovary to the uterus. The egg travels along the tube to the uterus every month. If a girl has a serious sexually transmitted infection that is not treated, the tubes can become blocked. Then the egg will not reach the uterus and the girl cannot fall pregnant.

Endometrium

Endometrium refers to the tissue lining the uterus. The primary function of the endometrium is to help the fertilized egg implant into the uterus and to form the maternal portion of placenta.

Menstruation / Periods

One of the early signs of puberty in girls is bleeding from the vagina. This is called menstruation or a period. The blood comes from the lining of the womb when it is broken down. Menstruation is caused by changes in the body’s hormones that happen around every four weeks.

Many girls begin to have periods when they are about 11 years old but this can happen between ages of 9 and 18. Periods often start about a year after breasts appear. A girl can fall pregnant before her periods start because she releases an egg before her first period.

Some girls experience bad pain and moods in the days just before their periods, while others have no pain at all.

It is important to keep clean during a period by changing the sanitary towels, tampons or cotton wool regularly. If using pieces of cloth it is important to change and wash these frequently.

Menstrual cycle

An average menstrual cycle lasts 28 days - that’s counting from the first day of one period to the day before the next period. Some women have much shorter cycles, possibly lasting only 23 days, and some have longer ones, lasting up to 35 days. Cycles which are shorter or longer than this range are not normal and should be checked by a doctor. Bleeding between periods or after sex are also abnormal should be seen to.
2. Male reproductive system

Sperm

Millions of sperm are stored in tightly coiled tubes called the epididymus. If the sperm is not used, the body clears them away and produces new sperm. It is not harmful for a boy to ejaculate his sperm.

Foreskin

The foreskin is a retractable double-layered fold of skin and mucous membrane that covers the penis glans when the penis is not erect.

Penis

The penis is the tube shaped organ through which men pass urine and semen. It is the male sex and reproductive organ and it consists of a head (glans) and a shaft (body). The shaft is made up of soft spongy tissue into which extra blood can flow causing the penis to become erect.

Prostate Gland

This is the gland located near the base of the bladder. The mixture of sperm and fluids from the prostate gland and seminal vesicles is called semen.
**Scrotum**

A scrotum is a muscular bag that sits behind the penis. The scrotum contains the testicles, also called testes.

**Testicles**

Two ball shaped organs kept within the scrotum. The testes produce sperm.

**Urethra**

The urethra is the tube that carries urine from the bladder to outside of the body. In males, it has the additional function of expelling (ejaculating) semen when the man reaches orgasm. When the penis is erect during sex, the flow of urine is blocked from the urethra, allowing only semen to be ejaculated at orgasm.

**Bladder**

The bladder is a hollow, muscular, balloon shaped organ that lies in the pelvis. It collects urine from the kidneys and stores it until it is full enough to empty through the urethra. The bladder swells into a round shape when it is full and gets smaller when empty. If the urinary system is healthy, the average adult bladder holds about 2 cups of urine for 2 to 5 hours.

**Seminal vesicles**

The seminal vesicles are sac-like pouches that attach to the vas deferens (see below) near the base of the bladder. The seminal vesicles produce a sugar-rich fluid (fructose) that provides sperm with a source of energy and helps with the sperms’ motility (ability to move). The fluid of the seminal vesicles makes up most of the volume of a man’s ejaculatory fluid, or ejaculate.

**Vas deferens**

The vas deferens is a long, muscular tube that travels from the epididymus into the pelvic cavity, to just behind the bladder. It transports mature sperm to the urethra in preparation for ejaculation.

**3. Hygiene (Private Parts) 10 Min**

**Note to the facilitator:**

Facilitate a discussion for the whole group on how to take care of the private parts.

Taking care of your personal hygiene is very important once puberty has started. Your sweat glands start to work overtime and if you do not wash often, particularly around your private parts and arm pits, you will start smelling bad. Looking after your body is the first step towards good health.

It is important to wash the genital area regularly, including the anus, to help ward off infections and bad odour. Since the genital area is moist and warm, infections can easily start and develop. Cleaning the genital area with a mild soap and water on a
regular basis will help limit infections. Besides washing the external genital area, it is important to wipe it with toilet paper after urinating or bowel movements. Wear loose cotton undergarments. Tight/ill-fitting underwear can cause problems.

Summary

When boys and girls reach the ages of 10 and 11, their bodies begin to change from the body of a child to that of an adult. This change is called puberty. It happens between the ages of 10 and 18. Puberty is the start of the period we call adolescence.

Chemicals in the body called hormones start the changes at puberty. These hormones make the body produce the eggs and sperm that can make a baby.

It is important to keep clean during a period by changing the sanitary towels, tampons or cotton wool regularly. If using pieces of cloth it is important to change and wash these frequently.
MODULE 4: Sex and sexuality

Duration: 7 HRS

Learning Objectives
By the end of this module participants should be able to:

• Define sex and sexuality;
• Define different sexual orientations;
• Understand values and attitudes;
• Understand the sexual response cycle;
• Explain masturbation;
• Manage relationships; and
• Negotiate sexual debut.
Session 1: Sex and sexuality

Duration: 40 Min

Learning Objectives
By the end of this session participants will be able to:

• Define sex and sexuality; and
• Differentiate between facts and myths regarding sex and sexuality.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

1. Defining sex and sexuality: 10 Min

Note to the facilitator:
Explain that, in this session, participants will explore definitions and messages regarding sex and sexuality. Ask your participants to define what sex and sexuality are and write down their responses. Use the definitions below to make corrections and additions. Then move to the myths and facts about sex and sexuality (Worksheet 3 on page 79).

• Sexuality is the sum of person’s inherited make-up, knowledge, attitudes, values, experience and behaviour as they relate to being a man or woman. Sexuality is the total of who you are, what you believe, what you feel and how you respond.

• Sex refers to one’s reproductive system and genitalia; as well as how we outwardly express our sex through gender roles and behaviour as male or female (The word “sex” refers to a person’s identity as a male or female). It is an important part of everyone’s sexuality.
2. Myths and facts about sex and sexuality: 15 Min

Explain what a myth is and what a fact is. A myth is something that is not true. A fact is something that is true.

• Explain that there are many myths about sex and sexuality. To emphasise this point hand out the myths and facts worksheet 3 on page 68 for participants to fill in.

• Once they have completed this, review the answers and correct any misconceptions participants may have. You can also ask them to discuss any other myths they may have heard of that aren’t on the worksheet.

• Allow time for any questions the participants may have.
## WORKSHEET 3: Myths and facts about sexuality

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
</tr>
</thead>
<tbody>
<tr>
<td>A woman cannot get pregnant the first time she has sex.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A woman will fall pregnant if she has sex without using contraception.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If an old man with a sexually transmitted infection has sex with a virgin he will be cured.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a woman has sex standing up she will be cured of STIs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If a woman doesn’t menstruate (has her period), she is sick.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>When a woman doesn’t menstruate, bad blood stays in her body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex cures period pains.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A girl can’t fall pregnant until she starts menstruating.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The contraceptive pill will damage a woman’s reproductive organs.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A condom can get lost inside a woman’s body.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The wider a girl’s mouth, the larger her vagina.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The longer the penis the more sperm it discharges.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you have sex with a woman who has just had an abortion, you will get sick.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The larger the penis, the more a woman enjoys sex.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You can tell the size of a man’s penis by the size of his feet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you go on a date with a boy you must have sex with him.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A man can have sex with a woman while she is having her period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fat men have small penises.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>A man’s strength is judged by the number of male children he has.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If you use the injection as a form of contraceptive you will get fat.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is a contraceptive called the female condom.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All men and women enjoy dry sex.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>You are not a real woman if you do not have at least one child.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abortion in your country is legal.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Session 2: Sexual orientation

Duration: 1 HR

Learning objectives

By the end of this session participants should be able to:

• Define what sexual orientation is; and
• Know the different sexual orientations.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

Note to the facilitator

1. **Explain to the participants that:**
   • Sexual orientation is our sexual identity.
   • For example, most individuals are attracted to a person of the opposite sex (heterosexuals), but some individuals are attracted to people of the same sex (homosexuals) for men and lesbians for women).

2. **Explain that there are also other sexual orientations**
   • There are some people who are bisexual. Bisexuality refers to people who are attracted to both men and women.
   • There are also some people who are asexual, this means that they have little or no desire to have sex with anyone.
   • The reason for people’s sexual orientation is either socially or biologically determined (neither has been scientifically proven).

How we feel about different sexual orientations: 15 Min

1. On a board or large page of paper, write down the words “homosexual” and “heterosexual”.

2. Ask participants to brainstorm what they associate with these words e.g. gay.

3. Then lead a discussion about why and how people with different sexual orientations are treated differently. Do they think that they should be treated differently? If so, why? If not, why not? Discuss whether or not the constitution in your country protects the rights of people with different sexual orientations.
4. Ask them how they would cope if they found out that someone in their family or someone they respect told them that he or she were a homosexual/lesbian.

Clarify that people do not choose their sexual orientation, some people know from the time they are young that they are attracted to other males or to other females.

1. Role-play: 20 Min

**Note to the facilitator:**
Ask 2 participants to role-play the conversation between James and Paul, his father.

James is the only son of Paul and Beauty and they have high expectations for him. His parents became worried because James never brought up the subject of marriage with them. One day his father decided to confront James about his future plans and marriage. James told his father that marriage was not part of his plans. After a long conversation James told his father that he is homosexual and does not intend to get married. Paul became upset and told James to take all his belongings and leave his house.

**Discussion questions**
- Were James’ parents justified in asking him about his future plans? Why?
- Was James justified to not inform his parents about his sexual orientation? Why?
- Was Paul justified to ask James to live his house? Why?
- What are some of the challenges which people with different sexual orientation like James face?
- How can we help our society to accept people of different sexual orientation like James?

**Summary**

It is important to feel comfortable with ourselves as sexual beings.

Sexuality is the basis of our identity, self-esteem, confidence and relationships with other people.

It is important to know the facts from myths and not believe everything we hear about sex and sexuality. Always go to an informed and reliable source for information on sex and sexuality.

It is important to maintain our neutrality.
Session 3: Attitudes and values

Duration: 55 Min

Learning objectives
By the end of the session participants will be able to:

• Identify what and who influences their attitudes and values;
• Identify their own values towards sex and sexuality; and
• Understand the importance of values and attitudes in the choices one makes in life, and how they influence behaviour.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

Exercise instructions: 15 Min

Note to the facilitator:
Divide participants into groups of five people per group. Distribute an A4 page or flip chart to each group. Ask the groups to define what attitudes and values are, and give examples of each. Each group reporter should present the results of their group discussion to all the participants with help from group members. Use the information below to make correction and additions.

Values are what we believe in and are willing to stand up for in front of others.

Personal measure of worth is shaped by our beliefs, ideas and principles. Our values are influenced by our families, teachers, friends, traditional and religious leaders, and the media.

Attitudes are our ways of thinking and behaving, and our feelings about issues.

Note to the facilitator:
Explain that these are not easy concepts to understand but that they are an important part of all our personalities. At the end of the session let your participants know that worksheet 6 on page 87 is an exercise they can do at home to reflect on what has been covered.
Exercise: Linking attitudes and values with sex and sexuality 20 Min

- Divide the participants into groups of five
- Ask them to discuss and write down how attitudes and values are linked to sex, sexuality and relationships. Allow 10 minutes for group work.
- Ask each group to report back to the larger group.
- Hand out worksheet 4 on page 85 ("Attitudes and values") to each participant to fill in. Alternatively, you can put up signs on the wall marked Okay and Not Okay. Ask the participants the questions from worksheet 4 and get them to move to the sign they agree with. After completion of the worksheet/activity allow time for questions and discussion.

Exercise: Making up our own minds: 20 Min

- Hand out worksheet 5 on page 86 ("What I should know about making up my mind")
- Ask participants to complete the exercises. Alternatively, you can put up signs on the wall marked Yes and No. Ask the participants the questions from worksheet 5 and get them to move to the sign they agree with.

Summary

The facilitator should explain the following:

- We all have attitudes and values about all aspects of our lives that are different from each other.

Values are beliefs, principles and standards that we think are important. These are the things we prize and value.

Attitudes are our views, opinions and feelings about things.

Where do we get our values and attitudes from? From parents, our community, religion, friends, school, and media such as radio, TV, videos, magazines, advertisements, and movies.

Values clarification means sorting our own true values from the values of the outside world. We need to separate our personal beliefs and feelings from other people’s values.

- Our sexual behaviour and the partners we choose to be with are just two of the many aspects that are guided by our attitudes and values.
- We make decisions based on our values.
WORKSHEET 4: Attitudes and Values

None of us are born with a value system. Values are things we develop. Since everything we do is based on our beliefs, attitudes and values, it is helpful to find out what we value. These values may change as we change and grow. You may wish to make an extra copy of this questionnaire to fill out in the future.

<table>
<thead>
<tr>
<th>I think it is ......</th>
<th>Okay</th>
<th>Not Okay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having sex before marriage.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex to be popular.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex so I won’t be lonely.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex so I won’t be frustrated.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex because I got carried away when we were partying.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking about sex.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex because everybody’s doing it.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Waiting until I am married to have sex.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex with someone of my own sex (gender).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Not having sex because I am not ready for it yet.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex when I am in love.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex for fun.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Having sex to repay an obligation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Showing off about having sex with someone.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Getting pregnant so my boyfriend knows I love him.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using family planning methods.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Practising masturbation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Living with a person I am not married to.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note to the facilitator:
Ask the entire group this question: ‘What should a person ask himself/herself when considering having sex for the first time?’ Write down their responses and then ask them the questions indicated below.
WORKSHEET 5: What should I know about making up my mind?

Should I have sex or should I wait?

Decisions regarding sex may be the most important decisions we have to make as young people. Some young people decide to go ahead. But remember, the results of this decision are your responsibility.

Facilitator: Here are some questions you could ask yourself before making up your mind about having sex:

• Can I take full responsibility for my actions?
• Am I willing to risk pregnancy, HIV infection or an STI?
• Am I willing to make a girl pregnant?
• Am I willing to become infected with HIV?
• Can I handle being a single parent? Am I ready to support a child on my own?
• Can I handle being a young father/mother?
• Can I handle the guilt and conflict I may feel?
• Will my decision hurt others – my parents, my friends?

Think about the following, when you want to have sex:

<table>
<thead>
<tr>
<th>Deciding about sex</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is having sex in agreement with my own values?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If I have a child, am I responsible enough to provide for its emotional and financial support?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the relation breaks up, will I be glad I had sex with this person?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am I sure no one is pushing me into having sex?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does my partner want to have sex now?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Am I ready to have sex?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do I feel there is a commitment that goes with having sex?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
WORKSHEET 6: Questions you may have on dating

• Do I feel ready to date?
• Do I want to date now?
• What would I like to get out of dating?
• Whom would I like to date?
• What qualities would I like my dating partner to have?
• How old should a person be to date?
• Who should do the “asking out” for date?
• Who should decide what to do or where to go on a date?
• If I date someone, do I need to have sex with that person?
• If I date someone, must I French kiss with that person?
• Who decides how far you go on a date?
• Is it OK if someone decides that she or he does not want to date?
• Is there really such a thing as a “perfect” partner?
• Should we discuss our feelings towards each other?
• What should be discussed before accepting a date from someone?
• Should I know the person I’m going on a date with well?
• Is it possible to have a loving relationship without having sex?
• Why is communication important between dating partners?
• Should parents set down rules about dating behaviour?
• How can I discuss personal “ground rules” with a partner?
• What responsibilities should I have for myself with regard to dating?
Session 4: Understanding the sexual response cycle

Duration: 45 Min

Learning objectives
By the end of the session participants should be able to:

• Understand the sexual response cycle; and
• Examine factors which may affect a sexual experience.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

Note to the facilitator:
Divide your participants into 4 smaller groups. Allocate one sexual response cycle to each group i.e. Excitement, Plateau, Orgasm and Resolution. Ask them to identify what happens to the sexual organs during the phase they have been allocated. After the group work, each team must present to the larger group. Use the information below to clarify any points that are raised.

All people respond to sexual stimulation. Knowing when, what and how our bodies respond during sexual intercourse, will increase understanding of the sexual response between the partners and enable them to better control and enjoy their sexual life.

Stages of sexual arousal

• When a person is sexually aroused, physical changes occur.
• These changes are grouped into phases to facilitate understanding.
• The cycle is not necessarily always completed, nor is it essential for sexual enjoyment.
• It is important that the couple does only what is comfortable for them.
• Behaviour from one of the partners imposed on the other person is a form of abuse and disrespect.
The sexual phases are:

- Excitement
- Plateau
- Orgasm
- Resolution

Males and females differ in the length of each phase, as well as in the time taken to complete the sexual response cycle. Phases in the sexual response may vary between and within individuals. Therefore, partners need to tell each other on how their bodies respond. It takes men on average 4-6 minutes to reach orgasm while for women it is between 12-16 minutes.

**Excitement**

<table>
<thead>
<tr>
<th>Genital changes</th>
<th>Female responses</th>
<th>Genital changes</th>
<th>Male responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoris</td>
<td>Swells, lengthens and hardens becoming more sensitive as it fills with blood</td>
<td>Penis</td>
<td>Rapid erection, the degree of which may fluctuate. This cannot be willed or forced, but is due to stimulation</td>
</tr>
<tr>
<td>Vagina</td>
<td>Vaginal lubrication begins, vagina widens and lengthens and the vaginal wall becomes distended with blood and turns purplish in colour</td>
<td>Scrotum</td>
<td>Elevates, skin becomes covered with goose bumps and changes colour</td>
</tr>
<tr>
<td>Labia Majora</td>
<td>Flattens and separates away from vagina opening</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labia minora</td>
<td>Thickens and expand to extend vagina outward by about 1 cm</td>
<td>Testes</td>
<td>Elevate and change colour</td>
</tr>
</tbody>
</table>

**Body changes**

<table>
<thead>
<tr>
<th>Body changes</th>
<th>Female Responses</th>
<th>Male responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Breasts enlarge, nipples become erect</td>
<td>Nipples become erect in 30% of men</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>Increases</td>
<td>Increases</td>
</tr>
<tr>
<td>Breathing</td>
<td>Increases</td>
<td>Increases</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Increases</td>
<td>Increases</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Increases</td>
<td>Increases</td>
</tr>
</tbody>
</table>

**Plateau**
### Genital Changes vs. Male Responses

<table>
<thead>
<tr>
<th>Genital Changes</th>
<th>Female Responses</th>
<th>Genital Changes</th>
<th>Male Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoris</td>
<td>Withdraws to a position higher up above vaginal opening</td>
<td>Penis</td>
<td>Becomes double its flaccid size and pre-ejaculatory fluid is released which can contain sperm</td>
</tr>
<tr>
<td>Vagina</td>
<td>Increases further in width and depth</td>
<td>Scrotum</td>
<td>Colour deepens</td>
</tr>
<tr>
<td>Labia Majora</td>
<td>Become congested and swollen with blood</td>
<td>Testes</td>
<td>Pull closer to body – the pooling of blood often causes a tingly sensation and if prolonged it may be painful.</td>
</tr>
<tr>
<td>Labia Minora</td>
<td>Colour changes to a vivid red</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Body Changes vs. Male Responses

<table>
<thead>
<tr>
<th>Body Changes</th>
<th>Female Responses</th>
<th>Male Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Breasts enlarge, nipples become rigid</td>
<td>Nipples become erect and remain erect in some men</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>Increases further</td>
<td>Increases further</td>
</tr>
<tr>
<td>Breathing</td>
<td>Becomes deeper and faster</td>
<td>Becomes deeper and faster</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Increases</td>
<td>Increases</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Increases</td>
<td>Increases</td>
</tr>
</tbody>
</table>

### Orgasm

<table>
<thead>
<tr>
<th>Genital Changes</th>
<th>Female Responses</th>
<th>Genital Changes</th>
<th>Male Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoris</td>
<td>There are no obvious changes</td>
<td>Penis</td>
<td>Rhythmic throbbing/pulsation and then ejaculation occurs</td>
</tr>
<tr>
<td>Vagina</td>
<td>Strong contractions occur, followed by slower contractions</td>
<td>Scrotum</td>
<td>There are no further changes</td>
</tr>
<tr>
<td>Labia Majora</td>
<td>There are no obvious changes</td>
<td>Testes</td>
<td>There are no further changes</td>
</tr>
<tr>
<td>Labia minora</td>
<td>There are no obvious changes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uterus</td>
<td>Pulls up, cervix opens</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Body changes

<table>
<thead>
<tr>
<th></th>
<th>Female Responses</th>
<th>Male responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>There is no further change</td>
<td>There is no further change</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>Extensive muscle spasm occur (loss of control)</td>
<td>Extensive muscle spasm occur (loss of control)</td>
</tr>
<tr>
<td>Breathing</td>
<td>Increases</td>
<td>increases</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Increases</td>
<td>increases</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Increases</td>
<td>increases</td>
</tr>
</tbody>
</table>

- Orgasm is a very individual experience and varies from person to person.
- You do not have to reach orgasm to have a fulfilling sex life.
- Some women do not experience orgasm regularly.
- Orgasm lasts a few seconds to a few minutes.

### Resolution

#### Genital changes

<table>
<thead>
<tr>
<th></th>
<th>Female Responses</th>
<th>Genital changes</th>
<th>Male responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clitoris</td>
<td>Returns to the normal position after orgasm</td>
<td>Penis</td>
<td>There is a rapid loss of rigidity followed by slower shrinking</td>
</tr>
<tr>
<td>Vagina</td>
<td>Blood leaves the vaginal tissues and walls relax – normal colour returns</td>
<td>Scrotum</td>
<td>Relaxes and returns to normal, loose state</td>
</tr>
<tr>
<td>Labia Majora</td>
<td>Return to normal</td>
<td>Testes</td>
<td>Return to normal size and elevation</td>
</tr>
<tr>
<td>Labia Minora</td>
<td>Colour fades to light pink, size returns to normal</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Body changes

<table>
<thead>
<tr>
<th></th>
<th>Female Responses</th>
<th>Male responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Breasts and nipples shrink in size and return to normal</td>
<td>Nipple erection, when present disappears</td>
</tr>
<tr>
<td>Muscle tension</td>
<td>Some muscle tension may remain until five minutes after orgasm</td>
<td>Some muscle tension may remain until five minutes after orgasm</td>
</tr>
<tr>
<td>Breathing</td>
<td>Rapid return to normal</td>
<td>Rapid return to normal</td>
</tr>
<tr>
<td>Heart rate</td>
<td>Rapid return to normal</td>
<td>Rapid return to normal</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>Rapid return to normal</td>
<td>Rapid return to normal</td>
</tr>
</tbody>
</table>
Refractory phase

- This phase occurs in men, not women.
- Men are sensitive and react negatively to touch.
- The period is shorter in young men.
- It increases with stress, fatigue and ageing.
- There is a general feeling of well-being and contentment.

Factors affecting a sexual experience

- These can be positive or negative.
- Self-esteem, mutual respect, mutual desire for intimacy and affection are basic ingredients for a satisfying sexual experience.
- Natural responses and functioning can be blocked by psychological and/or physical factors.
Session 5: Masturbation

Duration: 45 Min

Learning objectives
By the end of this session participants should be able to:

• Explain what masturbation is; and
• Clarify the myths surrounding masturbation.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

Note to the facilitator:
Facilitate a discussion on masturbation using the following questions.

1. What is masturbation?
   • Pleasurable stimulation of the genitals causing sexual arousal.
   • Stimulation of the genitals may take place using hand movements, clothing and other objects.
   • An orgasm does not necessarily result.
   • Masturbation may include an individual stimulating his or her own genitals or another person’s.

2. Who can masturbate?
   Anyone can masturbate including boys, girls, young or old.

3. What is mutual masturbation?
   It is when two people stimulate each other’s genitals causing sexual arousal.

4. What have you heard about masturbation?
   • You can lose your virginity.
   • Masturbation is only for boys.
   • If you masturbate too often you can go blind.
   • Masturbation is wrong and evil.
• Only perverts masturbate.
• You cannot catch diseases from masturbating.
• Masturbation is a good way of dealing with sex urges.
• Can cause damage to private parts.

5. Are there any side effects?

• There are no recorded harmful side effects of masturbation. Medical science has debunked many myths formally associated with masturbation, such as hair growing on the palms, insanity, or that masturbation will drain an excessive amount of fluid from the body.
• Some people report feeling guilty about masturbating. Negative feelings associated with any behaviour can threaten a person’s well-being.
Session 6: Sexual decision-making

Duration: 45 Min

Learning objectives
By the end of the session participants should be able to:

• Explain what sexual decision-making is; and
• Explain when a person is ready to engage in sexual intercourse.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

Note to the facilitator.
Start the session by asking your participants the question: “When is a person ready to have sex?” Then use the following information to add to the discussion. 20 Min

Explain that as girls and boys grow up, they become interested in each other in a sexual way. They are attracted to each other. This is natural. It is better for young people to know each other as friends first until they are sure that they want a closer relationship and are mature enough to handle a sexual relationship.

One of the most difficult decisions young people have to make is deciding whether or not to have a sexual relationship with a special partner, with someone they love, with a casual acquaintance, or even not to have sex at all.

Deciding on what is right for you regarding sexual activity should take time and thought. It is not a choice that can be made lightly or on the spur of the moment. It is unwise to make a decision when pressured or when already petting.

Young men and women may feel pressured to enter into a sexual relationship and become boyfriend and girlfriend before they know each other well and are ready for it. This can result in hurt feelings, and, if they do not use a condom, unintended pregnancy or sexually transmitted infections, including HIV.

Many sexual health problems arise because women and men sometimes do not have control over their sexual lives. In some cultures women are the property of their fathers, brothers or husbands. The low status of women means that many women have less education and lower paying jobs and are therefore poorer. With few ways to earn money, girls and women are pushed into selling sex for money or goods.
If a teenager can decide freely whether to have sex or not, they need to think very carefully before acting.

1. Sexual decision-making role play: 10 Min

*Ask for two volunteers to role-play a girl and a boy in a relationship who are thinking about whether to have sex or not. They need to act out a conversation around this issue.*

**Discussion questions**

Are these young people ready to have sex?

What other things do they have to consider before engaging in sexual activities.

2. Sexual decision-making role play: 15 Min

*Ask for two volunteers (boy and girl) to role-play the following scene.*

*John and Maria are ‘going out together’. He expects her to have sex with him and is angry when he sees Maria talking to another boy. Maria wants to get to know John better before they have sex and does not see why she should not talk to anyone she chooses.*

- What is happening in this relationship?
- What are the good and bad points about waiting to get to know someone before having sex?
- What more might Maria want to know about John?
Session 7: Relationships

Duration: 1 HR 20 Min

Learning objectives
By the end of this session participants should be able to:

• Determine the personal qualities necessary in developing relationships;
• Develop and keep good relationships with people of the same sex and the opposite sex;
• Distinguish between different kinds of relationships;
• Determine the factors that have a negative impact on relationships;
• Explore the concept of relationships; and
• Build skills for managing peer pressure.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls

Note to the facilitator:
Start the discussion by asking they group what they think a relationship is. Then pose the question: “What makes a good relationship?” Use the information below to make corrections and additions.

1. What is a relationship? 15 Min

A relationship is the interaction between two or more people. It varies in intensity, type and commitment. It could also be defined as the glue that holds people together. The more solid the relationship, the more cohesive the group is.

How we get along with people is important throughout our lives. If our relationships with our family and friends are good, and later our partners and children, we feel safe and secure.

2. What makes a good relationship?

1. Mutual respect
2. Trust
3. Honesty
4. Support
5. Fairness/equality
6. Good communication
7. Accepting differences

3. Relationship exercise: 15 Min
1. Ask participants questions to encourage them to think about why we establish relationships and to identify different types of relationships, for example social, family, sexual, work-related, etc.
2. Discuss the different needs that each relationship meets, focussing mainly on peer relationships.

4. Relationship exercise: 10 Min
• Divide participants into smaller groups of 4-6 members.
• Ask them to write an advertisement to put in a newspaper.
• These advertisements should discuss the qualities that they think are important in good friendships/relationships.
• Girl seeks boyfriend
• Girl seeks girlfriend
• Boy seeks boyfriend
• Boy seeks girlfriend
• After the ads are written, ask each group to present them and stick their advert on the wall. Allow everyone to read them.

Discussion questions
• What kinds of qualities were similar between the adverts?
• How important are the qualities indicated in the adverts?

5. Relationship exercise: 15 Min
• Ask the participants to divide into gender groups of five people per group. Ask them to brainstorm all the various qualities that are important to them in choosing a partner and to put these qualities on colour cards.
• Next, each group should rank the qualities in order of importance, and be prepared to explain why these qualities are important.
• Finally, each group should list the qualities of the ideal man (if they are males) and ideal woman (if they are females).

Bring the groups together and ask them to share their lists.
Discussion questions

• What kinds of qualities were similar between the lists?

• Were there differences between the sexes with regard to the order in which they ranked certain qualities?

• Ask the participants what differences they noted between the ideal man and ideal woman.

• How do you find the qualities you are looking for in your ideal person?

6. Exercise: Relationship spoilers 25 Min

This activity explores issues that may spoil a relationship.

Divide the participants into smaller groups and ask them to identify relationship spoilers. Also ask them to offer solutions to those relationship spoilers.

Qualities that are important for a good friendship:

<table>
<thead>
<tr>
<th>Self-worth</th>
<th>Reliability</th>
<th>Genuineness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Honesty</td>
<td>Acceptance</td>
<td>Sharing</td>
</tr>
<tr>
<td>Equality</td>
<td>Respect</td>
<td>Social confidence</td>
</tr>
<tr>
<td>Spontaneity</td>
<td>Consistency</td>
<td>Social skills</td>
</tr>
<tr>
<td>Humour</td>
<td>Understanding</td>
<td>Gentle assertiveness</td>
</tr>
<tr>
<td>Integrity</td>
<td>Self-awareness</td>
<td></td>
</tr>
</tbody>
</table>

Note to the facilitator:
Conclude the session by reading the four different scenarios mentioned in worksheet 7 page 102. For each scenario, ask participants what they would advise the person to do.
WORKSHEET 7: What would you do in this situation?

1. At times I feel as if I have no friends. I am a very shy person and I get embarrassed easily. I want to try and meet more people and make friends, but where do I start? At times I really want to start speaking to someone but then I get shy and can't move. Where can I meet people and make friends? (Shy and lonely)

2. I am nothing. I fail at everything I do. I cannot play sport. I fail in class and every time I try and join a group, I am told to buzz off. I am ugly and fat. Even my mother says I am useless. (Desperate)

3. I used to have a friend to whom I could tell all my secrets. Now she has joined a group at school and won't have anything to do with me anymore. I have also found out that she has told the others all my secrets. What can I do? (Hurt)

4. Where I live, all teenagers belong to gangs. These gangs do things I think are wrong, and I know that if I join I will become like them. I was told that I could become a leader of one of the gangs, but if I don't do what they want they will beat me up. Please help me. (Frightened)
Session 8: Negotiating sexual debut

Duration: 50 Min

Learning objectives

By the end of this session participants should be able to:

- Enhance their ability to resist situations that place them at risk for pregnancy and contracting sexually transmitted infections, including HIV; and
- Demonstrate negotiation and refusal skills.

Materials

- Large pages of paper or a board
- Appropriate pens and markers
- Material to stick paper up on the walls

Note to the facilitator:

Explain to the participants that knowing what is best for you and doing something about it can be two different things. Even though abstinence can prevent pregnancy and the transmission of STIs, including HIV infection, raising the subject can be difficult.

However it is very important that a person talks with their partner about their feelings, condoms and safer sex. An open and honest discussion can protect partners and correct any misunderstandings.

At the end of each role-play discuss the situations by:

- Asking the participants what they saw happening and if it was realistic for them, then encourage them to talk about situations they would face and how they would practice safer sex in that situation.
- Examining the pressures that the characters felt.
- Asking the actors to explain their view and feelings.
- Discussing whether safer sex was considered.
- Inviting alternatives for handling the situation.

Also note whether or not they used assertive messages.
Role-plays: 40 Min

Note to the facilitator:
Get 2 participants to role-play a conversation between Sarah and Jennifer. Jennifer should start the conversation by telling her friend Sarah about her new relationship and her unwillingness to risk losing her boyfriend by asking him to use a condom. Sarah’s role will be to encourage her to use a condom.

Role-play Scenario 1

Sarah: Your close friend Jennifer is about to go to bed with a new guy. She does not think she should be concerned about protection, especially using condoms. She thinks that if she asks him to use a condom she will lose him. Encourage her to use a condom.

Jennifer: You have just started dating a new guy. You really like him and think he might be serious about you. You have decided to have sex with him. You are afraid to discuss condoms with him because you think he might dump you if you suggest using them.

Summary
If you value your friend and care about her as a person, you should help her make safe decisions. You can help your friend to say NO, or you can suggest the use of a condom.

Role-play Scenario 2

Note to the facilitator:
Ask 2 participants to role-play the Christopher and Miriam scenario.

Christopher: You and Miriam have been seeing each other for a while. You have been fooling around but have not had sex. You are ready for sex and hope it works tonight since the two of you are going to be alone at your house. You bring up the subject of having sex.

Miriam: You and Christopher have been dating each other for a while. You have been fooling around but have not had sex. You really don’t feel ready for sex yet. The two of you are going to be alone at Christopher’s house tonight and Christopher is now talking about having sex. You tell him that you do not want to have sex because you do not feel ready for it.

Summary
If you are not ready for sex it is important that you are careful not to get yourself in situations that place you at risk of engaging in behaviours that you may not want to be involved in.
MODULE 5: Sexual and Reproductive Health (SRH)

Duration: 4 HRS

Learning objectives
By the end of this module participants should be able to:

- Identify ways of preventing unwanted pregnancy;
- Know the importance of consistent condom use;
- Identify skills involved in abstaining from sex;
- Discuss the physical, social and emotional results of teenage pregnancy; and
- Describe the different STIs and prevention measures.
Session 1: Preventing pregnancy

Duration: 40 Min

Learning objectives
By the end of this session participants will be able to:

• Understand how to prevent unwanted pregnancy;
• Make an informed decision about their sexual behaviour;
• List the different methods of contraception; and
• Explain the social and health consequences of early pregnancy.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.
• Examples of all the different types of contraceptives, including male and female condoms, available in your country.

1. Exercise: 30 Min

Note to the facilitator:
Ask participants to list ways of preventing pregnancy and write their responses on paper or a flip chart. Ask them what the good and bad things are about each method. Use the information provided below on the different methods of preventing pregnancy to clarify any issues.

2. What are the different prevention methods?

The contraceptive pill (sometimes known as the birth control pill)
The pill contains manufactured hormones (oestrogen and progesterone), which are normally produced by a woman’s own body.

• Taking one pill every 24 hours maintains the body’s hormone level which prevents ovulation. The ovaries do not release eggs as long as the woman sticks to her pill-taking schedule.
• Take the pill at the same time every day.
• There are two main types of pills. Combined oral contraceptives and mini pills. The mini pill is not as reliable as the combined pill. When taking the mini pill, it is important to take it at the same time every day.
Injectable hormonal contraceptive

- The most popular form is Depo-Provera, which is an injection once every twelve weeks.
- The injection works in the same way as the oral pills, but has the advantage that you do not have to remember to take a pill every day.
- It also has the same disadvantage as the hormonal pill, in that it provides no protection against STIs including HIV.
- It is therefore recommended to use condoms in conjunction with your pregnancy prevention method.

Morning after pill (emergency contraceptive)

- If a woman has had unprotected sex but does not want to have a baby, one option is 'the morning after pill' – an emergency contraceptive that can prevent pregnancy, when taken after sex.
- The name is actually slightly misleading, as it doesn’t necessarily have to be taken ‘the morning after’ – it can work up to 72 hours after you’ve had sex.
- However, it’s most effective when taken within 24 hours of sex, and the sooner you take it, the better. In many countries you cannot get the morning after pill for free, without a prescription from your doctor or healthcare provider.
- Although the morning after pill can be an effective way to avoid pregnancy if you have had unprotected sex, you should not rely on it, or use it regularly. It’s not as effective as other methods of contraception, and can have side effects. What’s more, it won’t protect you from HIV or other STIs.

The male condom

A male condom is made of very thin latex (rubber) and fits over the man’s erect penis.

- A condom acts as a barrier between the penis and the vagina, the penis and the mouth or the penis and the anus.
- A condom covers the whole of the penis and stops sexual fluids from being exchanged (semen and vaginal fluids).
- Condoms provide protection against STIs, HIV as well as unwanted pregnancy.

The female condom

Female condom is a thin, plastic, tunnel-shaped device that is closed on one end. The closed end is placed over the cervix. It protects against STIs, HIV and pregnancy. The condom is inserted into the vagina. The large end should be placed over the vaginal opening to protect the outer genitalia from infection.

More information on how to use condoms is provided in the next session.
Summary

Pregnancy may be prevented by using various forms of contraceptive methods as mentioned above. In many countries, the above-mentioned contraceptives may be provided free of charge. To obtain these services, approach your nearest health facility.
Session 2: Condom use

Duration: 1 HR

Learning objectives
By the end of the session participants should be able to:

• Explain the importance of condoms in the prevention of STIs, HIV and unwanted pregnancies; and
• Demonstrate the proper use of male and female condoms.

Materials

• Large pages of paper or a board
• Appropriate pens and markers
• Material to stick paper up on the walls
• Male and female condoms
• Dildos for male and female condom demonstration

Note to the facilitator:
Use the questions below to facilitate a discussion. Also conduct a condom demonstration to ensure your participants know the proper use of both male and female condoms.

Abstaining from sex is the surest way to avoid contracting STIs and HIV. However, there are many for whom abstinence is not a practical solution to prevent STIs and HIV.

1. Why are condoms important?
Condoms serve two main purposes: Condoms reduce your risk of contracting STIs, including HIV. Condoms are also an effective, accessible and inexpensive method of birth control.

2. How to use a male condom

Note to the facilitator:
Follow the instructions on page 111 to conduct a male condom demonstration.

1. Check the expiry date and then open the sachet. Take care not to rip the condom inside. Make sure the tip of the condom is pushed through the outside of the coiled ring

2. Ensure the penis is erect. If necessary, pull back the foreskin.
3. Pinch the tip of the condom and place the ring over the head of the penis.
4. Unroll the condom to the base of the penis. The tip of the condom is left exposed to collect semen.
5. Smooth out the air bubbles before inserting the penis into the vagina or anus.
6. Always use a condom for anal as well as vaginal intercourse.
7. After intercourse, carefully remove the condom from the penis, ensuring no semen is spilt.
8. Tie a knot in the condom and collect in a tissue or another disposable material.
9. Place the wrapped condom into a sealed bin, or bury if not bin is available.
Wash your hands

**Poster on male condom use**

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>1.</td>
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</tr>
<tr>
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<tr>
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</tr>
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</tr>
<tr>
<td>9.</td>
<td>Place the wrapped condom into a sealed bin, or bury if not bin is available. Wash your hands</td>
</tr>
</tbody>
</table>

The male condom CANNOT be re-used. It is a ONE USE ONLY product.
Note to the facilitator: Follow the instructions on page 114 to conduct a female condom demonstration.

1. Always check the expiry date on the wrapper or package.

2. Rub the sides of the condom together to spread the lubrication inside.

3. Hold the small ring (at the closed end of the condom) between your thumb and middle finger.

4. Find a position in which you feel comfortable inserting the condom – like lying down, squatting or standing with one foot raised on a stool, chair or the side of the bath. Squeeze the small ring and put it into the vagina, pushing it as far inside as possible with the fingers.

5. Put a finger inside the condom and push the small ring as far inside as possible.

   The inner ring keeps the condom in place during intercourse.

6. Make sure that the outer ring of the condom (the ring with the open end) is outside the body. The outer ring will lie flat against the body when the penis is inside the condom.

7. Be careful to guide the penis into the condom and not to the side of it. If the penis ends up on the side, the condom will offer no protection.

8. After sex and before the woman sits or stands up, take out the condom by gently twisting the outer ring and pulling the condom out, being careful to ensure that no semen is spilt.

9. After using the condom, throw it away safely. The female condom CANNOT be re-used.

   It is a ONE USE ONLY product.
<table>
<thead>
<tr>
<th>Illustration</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>After checking the expiry date, open the sachet, taking care not to rip the condom inside. Do not use scissors or a knife.</td>
</tr>
<tr>
<td>2</td>
<td>The outer ring covers the area around the opening of the vagina. The inner tip ring is used for insertion and to help hold the sheath in place during the intercourse.</td>
</tr>
<tr>
<td>3</td>
<td>Hold the condom at the closed end and grasp the inner ring.</td>
</tr>
<tr>
<td>4</td>
<td>Squeeze the ring with the thumb and the second or middle finger so that it becomes long and narrow.</td>
</tr>
<tr>
<td>5</td>
<td>Insert the inner ring into the vagina. Feel the inner ring expand and move into place. Place the index finger inside the condom and push it as far as it will go.</td>
</tr>
<tr>
<td>6</td>
<td>The outer ring remains outside the vagina.</td>
</tr>
<tr>
<td>Illustration</td>
<td>Explanation</td>
</tr>
<tr>
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</tr>
<tr>
<td>7.</td>
<td>Guide your partner’s penis into the condom, taking care it does not enter your vagina between the condom and the vaginal wall.</td>
</tr>
<tr>
<td>8.</td>
<td>To remove the condom, twist the outer ring to seal the semen inside and gently pull the condom out of the vagina.</td>
</tr>
<tr>
<td>9.</td>
<td>Place the condom into a tissue or another disposable material and throw away into a sealed bin. Do not dispose of the condom down a flush toilet. Wash your hands</td>
</tr>
</tbody>
</table>

The female condom CANNOT be re-used. It is a ONE USE ONLY product.
Condom demonstration

Female condom

Male Condom

3. What if a male condom breaks?

If a condom breaks during sex, pull out quickly and replace it. If semen has leaked into the vagina during a woman’s fertile period, talk to a medical professional about starting emergency contraception within 72 hours (the sooner the better!). A man should be able to tell his partner as soon as the condom is broken.

Summary

- Condoms play a dual role for both male and females. They prevent pregnancy as well as the transmission of STIs, including HIV, from one partner to another.
- They work effectively only when you wear them correctly and consistently.
Session 3: Abstinence

Duration: 1 HR

Learning objectives
By the end of this session participants should be able to:

- Explain the importance of abstinence in relation to HIV and unwanted pregnancy; and
- Identify skills involved in abstaining from sex.

Materials

- Large pages of paper or a board
- Appropriate pens and markers
- Material to stick up paper on the walls

Note to the facilitator:
Start the session by asking your participants what they understand by abstinence, and what the advantages of abstinence are. Use the information provided below for additions and corrections.

1. What is abstinence? 5 Min
Abstinence is refraining from vaginal, oral, or anal intercourse. Abstinence is the only 100% effective method for avoiding unintended pregnancy and sexually transmitted infections, including HIV infection. Abstinence means that a person does not have sexual intercourse at all.

2. What are the advantages of abstinence? 10 Min

- Abstinence is the only 100% safe way of protecting yourself from pregnancy, STIs and HIV infection. If you abstain, you will not have any concerns about these issues.
- If you value sex as something very special only to be done with your spouse, you will feel a sense of pride in maintaining your values.
- You will be able to enjoy yourself without tying yourself down to a sexual relationship. Getting to know different people without sexual pressure can help you to choose a good partner when you are ready.
- You will not risk being emotionally hurt or abused.
- Young people will concentrate better on other important things such as school.
3. How can you make abstinence work?

**Abstinence exercise: 20 Min**

- Break participants into groups of five and ask them to discuss some of the things that they think would make abstinence work and write these on a flip chart.
- Give them 10 minutes to discuss in their group, then allow each group 2 minutes to present.

**Conclude the exercise by mentioning the points below: 10 Min**

- Be clear that you do not want to have sex.
- Practise saying you do not want to have sex with a friend.
- Explain your reasons for not wanting to have sex yet clearly.
- Discuss what would happen if you fell pregnant or caught an STI or HIV.
- Say that you can love someone without having sex with him or her.
- Say that you want to enjoy spending time together, having fun and building trust before you begin to have sex.
- Talk about your goals in life. Tell your partner that having a baby or getting sick will upset these goals.
- Agree to stay away from alcohol and drugs because these make it harder to abstain.
- Go out with other friends. Avoid being alone with your partner.

4. Exercise (Role-play) 15 Min

- In groups of three, role-play talking about abstinence with a boyfriend or girlfriend.
- Talk about what helps you and what issues are difficult.
- Role-play the lines that boys or girls use to persuade them to have sex and find good ways to answer them.
- Find ways to resist pressures to have sex. **BE ASSERTIVE**

**Summary**

**Abstinence** is the only 100% safe way of protecting yourself from pregnancy, STIs and HIV infection.
Session 4: Teenage Pregnancy

Duration: 50 Min

Learning objectives
By the end of this session participants will be able to:

• Discuss the physical, social and emotional results of teenage pregnancy;
• Explain the causes of teenage pregnancy; and
• Outline ways to prevent teenage pregnancy.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

1. Teenage pregnancy exercise 20 Min

Note to the facilitator:
Break participants into groups of 5-6 participants according to gender. Ask groups to identify the causes of teenage pregnancy, and to identify the consequences of teenage pregnancy for the boy, for the girl and for the baby. Give them 10 Minutes to discuss and 2 minutes per group to present. Use the information provided below to make corrections and additions including the sexual rights of women.
2. Some of the causes of teenage pregnancy

- Early pregnancy happens when a boy and a girl have sex without using contraception or protection (condom).
- People may have sex without contraception because they did not plan ahead of time to have sex.
- Young people may not have the knowledge and skills that they need to use contraception well.
- Young people may be afraid of what contraceptives do to the body.
- Young people may want to have a baby.
- Young people may not be able to get contraceptives when they need them.
- Condoms may break if not used or stored correctly.
- Inconsistent use of condoms can lead to early pregnancy.
- A parent may encourage a young person to go and have sex with an older person for food or money because they have nothing to eat.

3. Some of the dangers of teenage pregnancy include:

- Pregnancy in girls who are not fully developed is dangerous for both the mother and baby. The younger the girl, the more dangerous the pregnancy.
- If the mother does not eat well, her growth and that of her baby may not be adequate.
- If the pelvis is not fully-grown, she may be in labour for a long time and need an operation to deliver the baby.
- Babies born to teenagers are more likely to be born too early and be small and weak.
- Early pregnancy may have a negative social and economic impact on both young women and young men.

4. Remember your sexual rights

Women have the right:

- Of control over their bodies.
- To only have sex when, with whom and how they want to.
- To decide about their sexuality.
- Not be forced into having sex through the use of violence or non-physical force.
• To sexual enjoyment.
• To be protected from the risk of disease such as HIV and other sexually transmitted infections.
• To have access to services that help them deal with concerns in relation to their sexual health.

5. Exercise: 20 Min

Note to the facilitator:
This is both an exercise and a conclusion of the session

Plans for the future

Give each participant a piece of paper and pen/pencil. Ask each person to write down what their plans are for the future according to the periods indicated below. When complete, ask each person to explore the effect of a pregnancy on these plans at each of these times.

9 months ..........................................................  
..........................................................

18 months ..........................................................
..........................................................

2 years ..........................................................
..........................................................

5 years ..........................................................
..........................................................

10 years ..........................................................
..........................................................

Session 5: Sexually transmitted infections (STIs)

Duration: 2 hr 05 Min

Learning objectives
By the end of this session participants should be able to:

- Identify the basic signs and symptoms of STIs;
- Describe risky and non-risky behaviour;
- Be able to negotiate safer sex with a partner; and
- Be able to negotiate condom use.

Materials

- Large pages of paper or a board
- Appropriate pens and markers
- Material to stick paper up on the walls

Note to the facilitator:
Start the session by asking participants to explain, in their own words, what STIs are. Use the information below to make corrections and additions.

1. Sexually Transmitted Infections (STIs) 20 Min

- These are infections passed on by intimate body contact and by sexual intercourse. They are caused by different tiny organisms/germs (bacteria, viruses and protozoa).

- People (especially women) may sometimes have an STI but have no symptoms for a long time. Therefore, it is important to inform your partner if you have an STI and to encourage him/her to see a doctor.

- Most STIs can be cured if treated correctly, but some are hard to treat and the medicine prescribed by a healthcare professional must be taken according to the instructions. Follow-up visits with your partner to the clinic are crucial.

- It is important not to have sex before the treatment of the STI is complete.

- Most STIs do not cause serious problems if they are detected and treated early. If this is not the case, the infection may spread and cause serious complications such as sterility.

- Most STIs in pregnant women can infect the baby in the womb or during delivery and can cause serious illness.
• Some STIs, such as herpes or HIV, cannot be cured. It is possible to treat the symptoms, but not cure the disease.

• The best way of protecting yourself against STIs is to use a condom when having sex.

2. Exercise: 20 Min

Note to the facilitator:
Ask the group to give you the signs and symptoms of STIs and write them down. Use the information below to make additions and corrections.

You may have a sexually transmitted infection if you have one or more of the following symptoms:

• In men, burning pain when urinating or a discharge (liquid from the penis).

• Sores, blisters or warts on the genitalia or anus that may be painful or painless. There may be one sore or many. Sometimes the glands in the groin swell up and the sores may burst.

• Signs of STIs in women are an unusual white, yellow or greenish discharge, which may smell bad. The genitals may itch, burn or feel sore. A woman may have pain in her lower abdomen, backache, fever and chills.

• A less serious STI is pubic lice. These are tiny lice that live in the pubic hair and go from one person to another during sex. A special lotion kills them.

• A person with HIV may not show signs and symptoms for many years but can still infect others without knowing it.

• Visit a healthcare provider or clinic if you have sores on your genitals, discharges or have lower belly pain, fever and chills.

Important information:

• Some unusual discharges in women are not signs of a STI. Women may get an infection called thrush that is not sexually transmitted. This causes a thick, white discharge and itching, and may cause sore genitals.

• When women are sexually aroused, the vagina becomes wet. This is normal; it does not mean that the girl has an infection.

When you have an STI, the healthcare provider at the health centre or clinic will examine you and will prescribe treatment. In cases of syphilis, a blood test is done to identify the organisms that cause syphilis. It is important to answer the healthcare worker’s questions truthfully so that you get the correct treatment. Remember that the healthcare worker is trained and there is no need to be embarrassed. Everything you discuss with them is confidential.

It is important to be aware that STIs increase the risk of HIV transmission.
3. Exercise: 30 Min

**Note to the facilitator:**
Divide participants into 3 groups and allocate the three discussion questions below. Give them 10 minutes to discuss the question and 2 minutes to report to the entire group.

1. Discuss the consequences of STIs.
2. Discuss ways to prevent STIs and where they would go if they had an STI or where they would refer a person with an STI.
3. What makes it difficult for young men and young women to use these services? Discuss ways young people can ensure they are attended to with respect.

4. How can a person prevent transmission of STIs?
   - Always use a condom with every sexual encounter.
   - Both partners should have only one partner, as multiple partners may put you at risk for STIs.
   - If you suspect an STI or are on treatment for an STI, do not have sex until treatment is completed and you have been cleared by the healthcare worker.
   - In new relationships it is important to talk about past sexual histories.
   - Avoid casual sexual relationships.
   - Remember, abstaining is the safest choice.

5. Exercise: 20 Min

**Note to the facilitator:**
Ask for a pair to volunteer to role-play telling a partner that he has an STI and that she should go for treatment. Then role-play this scenario with the girl telling her partner that she has an STI and that he should go for treatment. Discuss ways of informing the partner about the STI. After this exercise take the participants through the different types of STIs indicated below, including their symptoms.

**Some common STIs: 15 Min**

**Chlamydia**

This is a very common infection caused by a bacterium, and there are often no symptoms. If symptoms do occur, they include a discharge or burning sensation when urinating.

If Chlamydia is not treated, the infection may spread, causing inflammation in the womb and sterility.

**Treatment:** Antibiotics (prescribed by a healthcare professional).
Gonorrhoea
This is often called the “drop”. Symptoms occur three to five days after infection. In men, it causes a yellow discharge and pain when urinating. Women may also have a discharge, but both women and men may have no symptoms at all. The infection may therefore be passed on without the carrier’s knowledge.

If the infection is not detected and treated, it will spread and may cause sterility. Children born to infected mothers can become infected during delivery.

Treatment: Antibiotics (prescribed by a healthcare professional).

Herpes
Herpes is caused by a virus which lives in the nerve-root endings and, once infected, a person is infected for life. The first attack after infection is often the most painful. Small blisters occur around the site of infection, the mouth or the genitals about 2 to 20 days after infection. The blisters may be accompanied by a high fever and general aches and pains. Attacks occur about three or four times a year for many years but gradually decrease in intensity.

Treatment: There is no cure for herpes. The symptoms can be reduced by bathing the blisters in warm salty water and by taking painkillers. To avoid spreading the infection, patients should avoid touching their eyes without washing their hands.

Hepatitis B
This is also caused by a virus. You can get hepatitis B through direct contact with the blood or body fluids of an infected person. Hepatitis B is not spread through food or water, or by casual contact. The symptoms are fever, fatigue and jaundice, sometimes there are no symptoms. The infection causes liver inflammation. When not treated, the patient can develop a chronic disease or liver cancer, which can lead to death.

Treatment: There is no cure for Hepatitis B; this is why prevention is so important.

Genital warts
Warts appear on or around the penis, vagina or anus. They are caused by a virus (human papilloma virus) and are very easily spread during sex. They are easy to see if they appear on the outside of the body, but difficult to detect if they are inside a woman’s vagina or on her cervix.

Treatment: A wart-removing preparation is applied to each wart.

Syphilis
A small, painful ulcer on the genitals that eventually disappears. A few months later, a red rash may occur over the body. Untreated, the infection can cause joint pain, hair loss and liver inflammation. Syphilis may then affect the nervous system, the heart and the bones. The final stage of syphilis may lead to insanity, paralysis and death. The unborn child of an infected mother can be infected as well.

Treatment: Antibiotics (prescribed by a healthcare professional).
6. What should I do if I suspect I may have contracted an STI?

**Note to the facilitator:**
Write down the information below in advance on a board or large page of paper and bring it to the session. Go through this list and clarify any points that might not be understood. 5 Min

- It is important to go to your clinic immediately to see the healthcare worker if you have any signs of a sexually transmitted infection. They will give you treatment to kill the germs. This will protect your fertility and general health, and prevent the infection from being transmitted to your partner.

- You must finish all the treatment, even if you feel better. Not finishing your medicine can cause your body not to respond to the same treatment when you need it in future. It may not kill some of the germs completely.

- You must inform all your sexual partners so that they can go for treatment.

- You cannot cure a sexually transmitted infection or HIV by having sex with a virgin. You will still have the germs in your body after sex and will also infect the virgin.

- Do not have sex until you are cured, otherwise you will pass the germs to your partner and you will be infected again.

- HIV passes more easily into a man or woman with sores or discharges from an untreated sexually transmitted infection. It is important that you get proper treatment.

Remember that sexually transmitted infections can infect anyone who has unprotected sex with an infected person. STIs can infect anyone, male or female, young or old, single or married, rich or poor.

7. What is the relationship between STIs and HIV? 5 Min

- The presence of other STIs can facilitate the transmission of HIV. Many STIs causes sores, which are openings on the skin in and around the genitals. These sores make it easier for HIV to get into the body.

- The predominant mode of transmission of STIs and HIV is sexual. Therefore, many of the measures for preventing sexual transmission of HIV and STIs are the same.
8. Myths about STIs

Note to the facilitator: Ask participants to give you a list of myths about STIs. Correct the myths as you go along. 5 Min

- Passing urine after sex guarantees my protection against an STI.
- You can see when someone has an STI.
- Only promiscuous people get an STI.
- You cannot get an STI if you only had sex once.
- All STIs can be cured.
- Using contraception like the pill or injection protects against STIs.
- You cannot prevent an STI by washing.
- Only poor and dirty people have STIs.

Session conclusion

- Always use a condom with every sexual contact. It is important that the condom is used and stored correctly.
- Both partners should have only one partner, as multiple partners may put you at risk for STIs.
- If you suspect an STI or are on treatment for an STI, do not have sex until treatment is completed and you have been cleared by the healthcare worker.
- In new relationships it is important to talk about past sexual transmitted infections.
- Avoid casual sexual relationships.
- Remember that abstaining is the safest choice.
MODULE 6: HIV and AIDS

Duration: 8 Hrs

Learning objectives

By the end of this module participants should be able to:

- Increase their knowledge of HIV and AIDS;
- Understand positive health, dignity and prevention; and
- Understand stigma and discrimination and its effects.
Session 1: HIV and AIDS

Duration: 5 HRS 15 Mins

Learning objectives
By the end of this session participants will be able to:

• Define HIV and AIDS;
• Describe how HIV is transmitted;
• Identify risky behaviour;
• Identify factual information, myths and misconceptions about HIV and AIDS;
• Gain information on HIV testing; and
• Gain information on HIV treatment.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.
• Masking tape.

Before the lesson have the following materials ready:

• Pieces of card with the risky behaviours from Worksheet 8: “The risk game” on page 140 written on them.
• Make the signs and make sure that HIGH is written in big red letters, LOW is written in big blue letters and NO RISK is written in big green letters.
• Copy of “The story of Harry and Daniel” on page 141.
• Make a copy of Worksheet 9: “Questions and answers fact sheet” on page 152 for each participant.

Note to the facilitator:
Ask participants to define what HIV and AIDS are (not just the acronyms of HIV and AIDS, but the meaning of the words and how they affect the body.

1. What is HIV? 5 Min

HIV stands for Human Immunodeficiency Virus. When HIV enters the body through semen, blood, vaginal secretions, or breast milk, it damages the immune system that normally protects us from infections. HIV is the virus that causes AIDS.
2. What is AIDS? 5 Min

AIDS is the name given to a group of illnesses in HIV positive people. These are illnesses that arise when PLHIV are no longer able to fight off infections because of lowered immunity.

A-I-D-S stands for: Acquired…..something you get rather than you are born with.

   Immune……resistance or protection from diseases.
   Deficiency…absence of protective power.
   Syndrome…a variety of symptoms rather than one single disease.

Note to the facilitator:
Divide participants into 6 groups and allocate the following topics: 1. Where does HIV come from? 2. How does HIV weaken the immune system? 3. What are the symptoms of HIV and AIDS 4? How does a person become infected with HIV? 5. How does mother-to-child transmission occur? 6. What are the methods of preventing HIV infection, including PMTCT? Allow each group 15 minutes to discuss and write their responses on a flip chart then give them 2 minutes to present back to the larger group. Allow 5 minutes for discussion after each presentation and read the information provided in the manual for corrections and additions.

70 min

3. Where does HIV come from?

This question is often asked. Although various people have speculated on the geographical origin of the virus, it is unlikely that we will ever know where it came from. It is certain, however that it is not man-made. We know that viruses can sometimes change from being harmless to harmful. This could have happened to HIV before the virus spread rapidly and before the AIDS epidemic started.

4. How does HIV weaken the immune system?

Our immune system contains white cells in the bloodstream and lymph nodes, which can recognize foreign substances or germs entering our bodies and destroy them. The white cells also remember these germs and can kill them even more rapidly the next time they enter the body.

When the Human Immunodeficiency Virus attacks our immune system, it starts to destroy our white cells. HIV can stay in the body for some time without making us ill. But, eventually as more and more of these white cells are destroyed, the body is unable to fight off the many germs that live in and around our bodies. In time, as the immune system becomes weaker and weaker, infections take hold and the body cannot fight them.

5. What are the symptoms of AIDS?

People infected with HIV become seropositive or HIV positive. Except for a generally mild illness (fever, sore throat, rash, swollen glands), that about 70% of people
experience a few weeks after initial infection with the virus, most HIV infected people have no symptoms for a long time. They may look and feel perfectly healthy and be unaware that they are infected.

Eventually, the virus destroys the immune system to such an extent that the infected person may become ill. AIDS is the end-stage of infection with HIV, characterized by a range of symptoms.

Major signs are:

- Loss of weight greater than 10 per cent of body weight within a month.
- Fever for longer than one month.
- Chronic diarrhoea for longer than a month.
- Persistent, severe tiredness (fatigue).

Minor signs are:

- Persistent cough for longer than a month.
- Profuse sweating at night.
- Itchy skin rash.
- Mouth ulcers.
- Oral thrush (a fungal infection of the mouth and throat).
- Herpes infection.
- Swollen glands.

These symptoms are also common features of many other diseases, so don’t forget that HIV infection can only be confirmed by a blood test. As the infection progresses, the infected person becomes susceptible to a number of so-called opportunistic infections: infections that rarely occur in people whose immune systems are normal. Tuberculosis (TB) is an example of an opportunistic infection frequently seen in patients with AIDS. In countries with severe HIV epidemics the number of patients with TB has risen dramatically.

In the late stages of HIV infection, the virus may also attack the nervous system and cause mental confusion and poor coordination.

The person with AIDS may recover from some of these illnesses. Periods of serious illness may alternate with long periods of relative health. The length of time between initial infection with HIV and developing symptoms varies. Up to 60 per cent of people infected with HIV will develop AIDS within 12 to 13 years after being infected if not on treatment. As long as there is no vaccine or no cure available, HIV-infected people will eventually die as a result of their damaged immune system.

6. How does a person become infected with HIV?

It has been proven that HIV passes from an infected person to another person in three ways.
• Unprotected sexual intercourse with someone who has HIV.
• Through blood, blood products or transplanted organs which contain the virus.
• From an infected mother to her child during pregnancy, childbirth or through breastfeeding.

A. Infection through sexual contact.

During unprotected sexual contact with an infected person, HIV can enter a person’s bloodstream through the vagina, penis or anus.

HIV is thus a sexually transmitted infection.

The risk of infection is greater if either partner has another sexually transmitted infection, such as syphilis or herpes, where a sore or lesion is present. This is because semen or vaginal secretions of an HIV infected person can pass into the partner’s body more easily through these open sores or ulcers.

B. Infection through contact with blood.

In areas where donated blood is not screened for HIV, receiving a transfusion represents a high risk of contracting the virus: infected blood will transmit HIV directly into the bloodstream of the recipient.

Worldwide efforts are being made to ensure that blood for transfusions is tested for HIV and that blood products used by people with haemophilia are heat-treated to inactive the virus.

In addition, recruitment of voluntary, non-remunerated, regular blood donors is encouraged and guidelines are in place for pre-donation counselling in blood transfusion services. Similarly, potential sperm and organ donors are increasingly tested for HIV.

Intravenous drug users draw blood up into the needle and syringe, so sharing needles becomes a very risky activity and has caused many cases of HIV infection.

Any used needle and syringe which has not been properly sterilized can carry the virus from an infected person to the next user of the needle. It does not matter what the syringe contains. The risk is from the blood in the needle and the syringe. Therefore needles and syringes used by injecting drug users or used for medical treatment need to be sterilized or only used once.

HIV can be passed on from one person to another through infected blood left on instruments used in activities which draw blood, such as male and female circumcision, tattooing, acupuncture, traditional scarification, cutting of uvula or tonsils, and ear piercing. Tools used for any procedure that cuts the skin should be properly sterilized before each use.

Although the risks are very small, sharing toothbrushes and razors should be avoided.
C. Transmission from mother to child.

An HIV-positive mother can pass the virus to her child during pregnancy, labour and delivery or through breastfeeding. The overall risk of mother-to-child transmission of HIV is about 15 to 25 per cent among seropositive women who do not breastfeed, and between 25 to 45 per cent among women who do breastfeed.

The risk of transmission is increased if the mother has recently been infected or is already ill with AIDS.

Research now shows that breastfeeding accounts for an estimated one-third of all HIV infections in infants. On the other hand, it is recognized that breastfeeding is normally the best way to feed infants. Breast milk contains many substances that protect an infant's. Therefore, the dilemma between the choice of breastfeeding and the risk of HIV infection for the baby is not only a personal concern for many women, but also one of public health importance.

The overall objective should be to prevent HIV transmission through breastfeeding while continuing to promote and support breastfeeding for uninfected women and women whose HIV status is not known. If a mother is infected with HIV and can afford replacement feeding, it may be preferable not to breastfeed. However, it is important to weigh the risks. Are the risks from replacement feeding (illness, diarrhoea and dehydration and perhaps death from unhygienic preparation such as the use of contaminated water), lower than the potential risk of HIV transmission through infected breast milk? If not, there is no advantage to replacement feeding.

An HIV-positive woman who is considering pregnancy should seek information and advice from a trained counsellor or healthcare worker about the possible risks involved during pregnancy and thereafter.

7. How can you protect yourself from becoming infected with HIV?

A. Avoid infection through sexual contact.

Abstinence is the only 100% safe way of protecting yourself from becoming infected with HIV. If abstinence does not work for you, you can choose to have sexual contact with an uninfected, faithful partner only and be faithful to him/her. Unless you and your partner have been tested and are HIV negative, make sure that you or your partner:

- haven’t engaged in unprotected sex with someone else;
- haven’t received HIV-infected blood; and
- haven’t used intravenous drugs.
B. Practice safer sex.

What does safer sex mean? Safer sex includes any sexual activity which provides protection against the risk of infection:

- Avoiding penetration and contact with semen or vaginal secretions is one way to lower the risk of infection. If either you or your partner might be HIV-positive, there are many sexual activities for you to consider which do not involve penetration, such as caressing or massaging any part of the body. Also safe are masturbation (provided that sexual secretions do not come into contact with exposed mucous membranes or with cuts or sores on the partner’s skin) and kissing that does not involve exchange of blood.

- Another way to reduce the risk of infection is through the use of condoms. A male condom is a close-fitting latex cover, which fits over the penis during sexual intercourse. A female condom is a transparent sheath, which is inserted into the vagina. Condoms prevent contact with high-risk body fluids – blood, semen, and vaginal secretions. For this reason they are also useful as a protection against many other STIs and pregnancy. Condoms make sex safer, but not 100 per cent safe. However, if condoms are used correctly, they significantly reduce the risk of infection with HIV and other STIs.

Remember: if you have sex with several partners, you increase the risk of becoming infected with each partner you have. However, it is not just a question of how many partners you have. Just one act of unprotected intercourse (sex without a condom) with a person who is infected with HIV could result in you becoming infected.

Although it is not always easy, talking openly about these topics with your partner is very important. Don’t forget it may not only help you create a healthier sexual relationship, but also save your life!
C. Through the prevention of mother to child transmission (PMTCT).

- A course of antiretroviral drugs given to the mother during pregnancy and labour as well as to the newborn baby can greatly reduce the chances of the child becoming infected. Although the most effective treatment involves a combination of drugs (known as HAART) taken over a long period, even a single dose of treatment can cut the transmission rate by half.

- A caesarean section is an operation to deliver a baby through its mother's abdominal wall, which reduces the baby's exposure to its mother's body fluids. This procedure lowers the risk of HIV transmission, but is likely to be recommended only if the mother has a high level of HIV in her blood, and if the benefit to her baby outweighs the risk of the intervention.

- The World Health Organization advises mothers living with HIV not to breastfeed whenever the use of replacement feeding is acceptable, feasible, affordable, sustainable and safe. However, if safe water is not available, the risk of life-threatening conditions from replacement feeding may be greater than the risk of breastfeeding.

- Healthcare workers and peer educators need to make communities (men, women and community leaders) aware of PMTCT programmes.

- All pregnant women are routinely screened for HIV by testing and counselling. This is called provider-initiated Voluntary Counselling and Testing.

D. Avoid coming into contact with blood products.

Sharing of needles and syringes should be avoided as they could carry the virus from an infected person to the next user.

Observe the global precautions when caring for an HIV positive person or when administering first aid to a bleeding person to avoid coming into contact with infected blood.

E. Treatment of sexually transmitted infections (STIs).

Another significant intervention is providing treatment for sexually transmitted infections, such as chlamydia and gonorrhoea. This is because such infections, if left untreated, have been found to facilitate HIV transmission during sex.

**Note to the facilitator:**
Ask participants what are some of the ways in which HIV cannot be passed from one person to another. Then use the information provided below to make additions and corrections. 10 Min

8. HIV CANNOT be passed from one person to another in the following kinds of contact:

- Wearing clothes or using articles belonging to a person living with HIV (for example, towels, bedding, and eating utensils).

- Living with or sleeping in the same room as a person with HIV and AIDS.
• Hugging or playing with a baby or a child who has HIV or AIDS.
• Caring for children when the adult is HIV positive.
• Swimming in the same pool, river or waterhole with a person or people living with HIV or AIDS.
• Travelling on crowded buses with a person or people with HIV or AIDS.
• A person with HIV or AIDS coughing or sneezing on you.
• Sharing food, cups and plates with a person with HIV or AIDS.
• Caring for someone who has developed AIDS when good basic hygiene is observed.

Note to the facilitator:
Use the 3 questions below to facilitate a discussion among the whole group. Write their responses on a flip chart. Ask one question at a time and make corrections or additions using the information provided below.

A. Why don’t mosquitoes spread HIV? 5 Min
There is clear evidence from research that HIV is not transmitted by mosquitoes or any other biting insects.

If you are not convinced, remember that almost no cases of AIDS occur in children aged from 5 to 12, although children of this age are often bitten by mosquitoes. (HIV infections in children are mainly caused by blood transfusions and sometimes by sexual abuse). Very young infants can also be infected by HIV-positive mothers during pregnancy, childbirth, and through breastfeeding.

B. Can kissing pass on HIV? 5 min
Kissing can only carry a risk if there is an exchange of blood from an HIV-positive person to his or her partner. Bleeding might occur because of damage caused to the skin or mucous membranes around the mouth. Saliva, tears or sweat do not contain HIV in sufficient quantity to be infectious.

C. Who can get HIV? 5 Min
• Anyone, male or female, young or old, from any country or any religion can acquire HIV.
• HIV and AIDS are not limited to certain groups of people, sexual preferences, or jobs.

9. Risk and vulnerability exercise: 20 Min
• Before the session starts, create small cards by cutting an A4 paper into smaller cards. It is advisable to use different colours to enable you to identify the group by the colour of the card (e.g. yellow, blue, red, purple, and orange). You can also use sticker notes to do this exercise.
• Place the **HIGH, LOW** and **NO RISK** signs on the wall of the training room.
• Divide the participants into groups of 4-6 members.
• Hand out the same number of cards/sticker notes to each group. Explain the game to them as follows:
  • The signs on the wall refer to the different behaviours on the cards.
  • Each group writes the statements from worksheet 8 on page 140 on separate cards/sticker notes and indicates their group number (e.g. G1, G2, G3, G4) on the corner of the card/sticker note. Place the card under the sign that the group feels matches the behaviour.
  • For example: the **HIGH** sign refers to high-risk behaviour which involves the exchange of blood, semen, breast milk or vaginal fluids from one person to another. The **LOW** sign refers to low risk behaviour such as using a condom when having sex. The **NO RISK** sign refers to behaviour that will not put you at risk from getting HIV, in other words, there is no exchange of body fluids from one person to another.
• Give the groups ten minutes to decide where to place their cards.
• Use the answers provided on the risk game worksheet 8 on page 140 to correct any mistakes that participants may have made.
WORKSHEET 8: The risk game

<table>
<thead>
<tr>
<th>Behaviour</th>
<th>Correct placement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Vaginal sex without a condom.</td>
<td></td>
</tr>
<tr>
<td>2  Vaginal sex with a condom.</td>
<td></td>
</tr>
<tr>
<td>3  Oral sex with a guy without a condom.</td>
<td></td>
</tr>
<tr>
<td>4  Oral sex with a guy with a condom.</td>
<td></td>
</tr>
<tr>
<td>5  Anal sex without a condom.</td>
<td></td>
</tr>
<tr>
<td>6  Anal sex with a condom.</td>
<td></td>
</tr>
<tr>
<td>7  Self masturbation.</td>
<td></td>
</tr>
<tr>
<td>8  Mutual masturbation.</td>
<td></td>
</tr>
<tr>
<td>9  Wet kissing.</td>
<td></td>
</tr>
<tr>
<td>10 Dry kissing.</td>
<td></td>
</tr>
<tr>
<td>11 Massage.</td>
<td></td>
</tr>
<tr>
<td>12 Showering/bathing together.</td>
<td></td>
</tr>
<tr>
<td>13 Romantic conversation.</td>
<td></td>
</tr>
<tr>
<td>14 Sharing needles without cleaning them.</td>
<td></td>
</tr>
<tr>
<td>15 Sharing needles and cleaning them with bleach.</td>
<td></td>
</tr>
<tr>
<td>16 Doing drugs but not sharing needles.</td>
<td></td>
</tr>
<tr>
<td>17 Having sex with many partners without using a condom.</td>
<td></td>
</tr>
<tr>
<td>18 Having sex with many partners and using a condom.</td>
<td></td>
</tr>
<tr>
<td>19 Having unprotected sex with a person who injects drugs or shares needles.</td>
<td></td>
</tr>
<tr>
<td>20 Having sex with a person who injects drugs and using a condom.</td>
<td></td>
</tr>
<tr>
<td>21 Having sex with someone who has had many partners without using a condom.</td>
<td></td>
</tr>
<tr>
<td>22 Having unprotected sex with a man who is having sex with other men.</td>
<td></td>
</tr>
</tbody>
</table>

Answers for WORKSHEET 8

Read the story below to the participants and facilitate a discussion using the question provided. 15 Min

The story of Harry and Daniel

Harry is 21 years old. He has a son, Daniel who is nearly 2 years old. They both appear to be like any normal father and son. But there is a very sad bond, which binds them. Harry and his son both have HIV. The virus has already brought grief to Harry’s once happy family. His wife Jane, a newly qualified teacher, died of AIDS five months ago. She was only 23. Harry and Jane married two years ago, six months after meeting each other.

A few months ago Jane had a boil in her throat. Her weight dropped from 60kg to 38kg, and she was admitted to hospital with high fever. After doing a few tests the doctors broke the news to them – Jane had AIDS. Harry and baby Daniel soon had tests done. They learnt that both of them were also HIV positive.

Jane’s death left Harry very confused. How did he and Jane become infected, as they were both faithful to each other?

Harry then remembers that Jane told him that she was involved in a one night stand with a guy she had met at her friend’s birthday party. He recalls her telling him that she had had a little too much alcohol that evening and was not aware of what she was doing. Luckily for Jane, she did not fall pregnant. But the guy she slept with might have been HIV positive.

Harry thinks about his past as well. He recalls with deep regret the many girls he had sex with during his teenage years. He did not use a condom during those relationships. He also recalls the days when he and the guys used to smoke dagga together for fun, and when they used to inject themselves with drugs. Could Harry have picked up HIV infection during his flings with those girls or could it have been through the sharing of needles? He stopped doing drugs before his marriage to Jane, but will never know which of the risks that he or Jane took during their teenage years could have cost them so heavily.

Discussion Questions

These could include questions like:

What are some of the ways in which Harry and Jane could have contracted HIV?

Suggested Answers

- **Jane** – During her one-night stand with a guy she did not know well.
- **Harry** – through his many sexual relationships. He did not use a condom. Also through sharing needles during drug use.
- Either one of them could have passed it to each other through sexual contact.
- Baby Daniel got the virus from his mother Jane.
Note to the facilitator:
Divide participants into 2 groups and allocate the following topics: 1. Factors that increase the risk of HIV infection 2. Factors that increase vulnerability to HIV infection. Allow 10 minutes for the groups to discuss the topic and write their responses on a flip chart. Give each group 2 minutes to present and allocate 5 minutes for discussion after each presentation. Refer to the information provided in the manual for any corrections and additions. 30 Min

10. Factors that increase risk
Risk can be considered as the things you do that might increase your chances of transmitting or contracting HIV:

- Unprotected sexual intercourse.
- Drug abuse and alcohol consumption can increase risky behaviour and make an individual to take chances such as having unprotected intercourse.
- Unprotected sex with multiple sexual partners and or unprotected casual sex.

11. Factors that increase vulnerability:
Vulnerability can be thought of as the environmental aspects influencing “who you are” that may impact your risk of contracting or transmitting HIV.

For example, certain groups of people – such as sex workers, men who have sex with men (MSM), injecting drug users – have long been regarded as being particularly exposed to “high risk practices” and therefore more vulnerable to HIV infection.

Other factors that may increase vulnerability include:

- **Mobile populations** such as seasonal workers can be at greater risk because they may not have a regular sexual partner. Sex workers also follow routes of trade.
- **Trucking routes** and cross-border traders.
- **Stigma and Denial** – because of stigma and denial, people may not make use of HIV testing and counselling services to find out their status or the status of their partner.
- **Conflict** – In displaced populations, such as in times of war or conflict, HIV may spread more easily. Rape, use of sex workers and inadequate health care services worsen in times of war.
- **Culture** – culture includes traditions, beliefs and practices that can influence the way people think and behave. Cultural traditions such as wife inheritance, polygamy, rites of passage and genital cutting can increase risk if people are not well informed on how to reduce transmission of HIV through safe practices.
• Early sexual debut.
• Gender - gender inequalities increase the vulnerability of women to HIV infection (a woman’s ability to negotiate for safer sex, women engaged in transactional / intergenerational sex).
• Poverty – reduces people’s ability to access accurate information on HIV and AIDS and how to protect themselves. Poverty can force young people into transactional sex to meet basic needs, increasing their vulnerability to HIV.

12. HIV treatment: 15 Min

Note to the facilitator:
Ask participants to share their understanding of the following concepts: ART and ARVs. Then provide the explanation below. Also go through the most important things to know about antiretroviral drugs, using the information provided below.

Antiretroviral drugs (ARVs) are drugs used to treat HIV.

Antiretroviral Therapy (ART) is a term used to describe giving ARV drugs in the correct way.

Antiretroviral drugs help to stop HIV from making copies of itself (replicating) within the immune system of people living with HIV. If HIV cannot replicate, the damage to the immune system is reduced and the risk of developing opportunistic infections is decreased.

Important things to know about antiretroviral drugs:
• ART involves a combination of antiretroviral drugs.
• ART is not a cure for HIV and AIDS but a treatment which stops HIV from continuing to destroy the immune system.
• A person on ART can still transmit HIV and can become re-infected with HIV.
• ARVs are taken for life.
• ARVs are only given to PLHIV who are eligible to take the drugs (not all PLHIV need to take ARVs).

13. The benefits of ART: 25 Min

Note to the facilitator:
Use the instructions below to facilitate this section of the session.

Divide your participants into four groups and ask them to list the benefits of ART for individuals in the category to which they have been assigned. Give them 10 minutes to generate their list. Give each group 2 minutes to present to the whole group. After each presentation, use the list below to make additions.
Categories:

1. People living with HIV and AIDS
2. Family
3. Community
4. Nation

<table>
<thead>
<tr>
<th>Statement</th>
<th>PLHIV</th>
<th>Family</th>
<th>Community</th>
<th>Nation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolongs life and improves the quality of life of PLHIV.</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reduces mother to child transmission of HIV.</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Helps households stay together by reducing illness and death caused by HIV and AIDS.</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Increases voluntary counselling and testing uptake.</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increases awareness of HIV and AIDS in the community as more people use HIV testing and counselling services.</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Increases motivation of community based volunteers who can better help PLHIV.</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Overall country development is dependent on the ability of its people remaining productive and healthy.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Reduced burden on health facilities.</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Reduced stigma associated with HIV by making HIV a chronic, manageable illness and not a death sentence.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Less time and money spent treating opportunistic infections and providing palliative care.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Decreased number of children orphaned by AIDS.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Has the potential to help prevent the spread of HIV by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Increased exposure to information on HIV prevention while assessing treatment.</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>- More people are encouraged to know their HIV status when treatment is available.</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
14. First-line ARV regimens: 10 Min

Note to the facilitator:
Start this section by explaining that ARVs are always taken as a combination of three antiretroviral drugs. Use the information below to explain why. Ask them to explain in their own words what drug resistance is. Use the explanation below to clarify any misunderstandings.

A. First-line regimen is the name of the combination of ARV drugs used first to treat HIV and AIDS. ART is always taken as a combination of THREE antiretroviral drugs since:

- Antiretroviral drugs from different drug groups are needed to attack the different enzymes of the virus.
- Combinations of antiretroviral drugs may overcome or delay resistance.

B. What is resistance?

Resistance is the ability of HIV to change its structure in ways that make drugs less effective. HIV has to make only a single, small change to resist the effects of some drugs. If the three drugs are given together, it takes longer to make those changes. If the drugs are always taken as prescribed, it is unlikely that those changes will happen at all. If the three drugs are not taken properly, the person may become resistant to the treatment.

C. Names of drugs used in the first-line regimen: 15 Min

Note to the facilitator:
Write down the information about the drugs used in the first-line regimen and ARV combinations on a flip chart before coming to the session. Discuss this information with the group.

Some of the drugs used in first-line regimens include:

- Zidovudine (AZT or ZDV)
- Lamivudine (3TC)
- Stavudine (d4t)
- Nevirapine (NVP)
- Efavirenz (EFZ)
D. ARV Regimens

<table>
<thead>
<tr>
<th>ARV Regimen</th>
<th>Used in women in childbearing age or pregnant</th>
<th>Used in PLHIV with TB</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZDV + 3TC + NVP</td>
<td>Yes</td>
<td>Yes, but with caution in Rifampicin-based regimens</td>
</tr>
<tr>
<td>D4T + 3TC + NVP</td>
<td>Yes</td>
<td>Yes, but with caution in Rifampicin-based regimens</td>
</tr>
<tr>
<td>ZDV + 3TC + EFV</td>
<td>No</td>
<td>Yes, but not in pregnant women</td>
</tr>
<tr>
<td>D4T + 3TC + EFV</td>
<td>No</td>
<td>Yes, but not in pregnant women</td>
</tr>
</tbody>
</table>

15. Side effects of ARVs: 20 Min

**Note to the facilitator:**
Write each of the minor and major side effects that can be associated with first-line regimens on separate cards. Create two flip charts, one entitled “Minor side effects” and another entitled “Major side effects”. Divide participants into two teams and ask them to take turns to read the side effects out loud and stick their cards on either the “Minor” or “Major” flip chart. Use the information below to make corrections. The team with most correct matches wins.

**Minor side effects**

The following are some minor side effects that individuals starting a first-line regimen should be prepared to cope with:

- Sleeplessness
- Upset stomach
- Nausea
- Diarrhoea
- Drowsiness
- Headache
- Fatigue
- Mild rash
- Confusion
- Nightmares

If a person experiences these side effects over a long period of time or if the side effects are making the person very uncomfortable, the person should be referred to the local health facility.
Major side effects

The following are some major side effects (also called toxic effects) that can occur with first-line regimens:

- Severe headaches.
- Tingling in extremities: hands, feet, arms and legs (neuropathy).
- Fat changes: arms, legs, buttocks, and cheeks become thin, breasts, belly, back of neck gain fat.
- Severe abdominal pain (due to pancreatitis).
- Yellowing of skin and abdominal pain (due to liver toxicity or jaundice).
- Severe rash.
- Severe fatigue or shortness of breath.
- Fever.
- Severe mental disturbance (confusion, psychosis, depression).
- Severe muscle pain or cramping.
- Anaemia.

16. Voluntary counselling and testing (VCT) 5 Min

**Note to the facilitator:**

Explain to your participants what voluntary counselling and testing is and explain the two different forms of HIV testing and counselling. Use the information provided below to guide you.

In most parts of the Southern Africa region, the majority of people are unaware of their HIV status. Voluntary counselling and testing (VCT) is a confidential process through which people first determine whether or not to be tested and, should they decide to be tested, can find out their HIV status in an informed and supportive way. It involves the analysis of blood or body fluids for the presence of antibodies to HIV. It is an essential entry point for care, support and treatment.

VCT services should:

- Be fully voluntary, enabling people to give their informed consent to be tested.
- Be based on pre-test information about the purpose of testing and the treatment, care and support available once the result is known.
- Incorporate post-test support and services to educate those who tested HIV positive on the meaning of their diagnosis and on the prevention, care, treatment and support programmes available to them.
HIV testing and counselling can take two different forms:

1. **Provider-initiated**: This is when HIV tests are conducted by healthcare professionals when trying to determine the cause of an illness or when HIV tests are offered to all sexually active people seeking medical care (called routine offer). Within provider-initiated HIV tests, individuals have the choice to say no, or ‘opt-out’, of taking an HIV test if they don’t want one conducted.

2. **Client-initiated**: This means that people seek out a facility through which they can take an HIV test. Client-initiated testing is often referred to as Voluntary counselling and testing, or VCT.

It is important to remember that all forms of HIV testing and counselling should be voluntary and confidential, meaning the results of a person’s test should not be shared with anyone else without their consent.

HIV testing and counselling services can be offered by:

- Local clinics and hospitals.
- Special clinics set up just for HIV testing and counselling.
- A mobile unit that offers services to the community.

**Note to the facilitator:**
Divide your participants into 2 groups and ask one group to discuss and write down (on a flip chart) what the benefits of HIV testing and counselling are. The other group will discuss what the barriers to HIV testing and counselling are. Give them 10 minutes to discuss and 2 minutes to present to the larger group. Use the information below to make additions or corrections. 20 Min

**Benefits of HIV testing and counselling:**

- Helps people know their HIV status, whether positive or negative.
- If negative, an individual can learn about ways to protect themselves from HIV infection.
- If positive, an individual can learn about how to live positively, which includes not passing on the virus to others or becoming re-infected with HIV.
- Pregnant women can seek advice at HIV testing and counselling centres on how to reduce the risk of transmitting HIV to their babies.
- By knowing their status, people can begin treatment if necessary and learn to live as healthily as possible.
- HIV testing and counselling services can link the person up with other services such as support groups and medical facilities.

**Barriers to HIV testing and counselling:**

- Fear of abandonment.
- Fear of violence.
• Loss of job.
• Loss of family support.
• Community rejection.
• Fear of illness/death.
• Denial of engaging in behaviours that have put them at risk.

The process of Voluntary Counselling and testing:

1. Explanation of HIV and AIDS to the client.
2. Explanation of confidentiality to the client.
3. Confirmation of client's willingness to proceed with the test.
4. Obtaining informed consent from the client to proceed with the test.
5. Blood test sample taken safely and privately.
6. Post-test counselling.

Special issues regarding voluntary counselling and testing:

1. Testing children
It is recommended that clients who would like their children tested first make use of voluntary counselling and testing services themselves.

2. Discordant couples
A discordant couple is a term used to describe a situation where one partner tests positive for HIV and the other tests negative.

3. The window period
The window period is the time immediately after HIV infection when antibodies are not detectable in a person's blood. Therefore it is possible that during this period individuals infected with HIV will test negative but can transmit HIV.

17. Male Circumcision and HIV 5 Min

Note to the facilitator:
Ask participants to define in their own words what male circumcision is. Use the definition below to make corrections.

Male circumcision is the removal of the foreskin or loose sleeve of skin covering the end of the penis so as to permanently expose the glans (or knob). Ideally it should result in full exposure of the whole glans.
Male circumcision provides significant protection against HIV infection; circumcised males are 60% less likely to become infected with HIV. Furthermore, circumcision also protects against other sexually transmitted infections, such as syphilis and gonorrhoea, and since people who have a sexually transmitted infection are two to five times more likely to become infected with HIV, circumcision may be even more protective.

Note to the facilitator:
Divide participants into 3 groups and allocate the following topics to each group 1. How does male circumcision protect against HIV infection? 2. What does a person with HIV need? 3. How can you take care of yourself when you are HIV positive? Give them 10 minutes to discuss and write their responses on a flip chart and give each group 2 minutes to present. Allow 5 minutes for discussion after each presentation. Use the information provided to make corrections and additions. Conclude the session by reading the key messages at the end of the session.

How does male circumcision protect against HIV infection?

• The majority of men who are HIV positive have been infected via the penis.
• There is conclusive epidemiological evidence to show that uncircumcised men are at a much greater risk of becoming infected with HIV than circumcised men.
• The inner surface of the foreskin contains Langerhans cells with HIV receptors; these cells are thought to be the primary point of viral entry into the penis of an uncircumcised man.
• Male circumcision should be seriously considered as an additional means of preventing HIV in all countries with a high prevalence of infection.

18. What does a person with HIV need?

• A person with HIV has a right to a full range of care, support, treatment and prevention, like any other person. This means being treated for any medical problems as well as receiving support for their psychosocial and economic needs and overall well-being.
• Care, support and treatment for people living with HIV should be comprehensive. This means that a variety of people and organisations – such as the family, doctor, and community must all play their part and work together to provide a ‘continuum’ of care, prevention and support.

19. Taking care of yourself when you are HIV positive

• Learn to be involved in your own health; this includes seeking care for those problems you cannot solve yourself.
• Understand your problems and what you need to do about them.
• Every day you will need to make decisions about:
  • Patterns of sexual behaviour and intimate relationships;
• Positive living and eating well;
• Taking medicines as prescribed; and
• Understanding the negative effects of use or abuse of drugs or alcohol.
• You should be part of every decision that is made related to your health.
• It is important to understand HIV and learn to manage the problems it presents.
• It is always important to ask questions if there is something you do not understand.

Key messages
• Do not share sharp objects such as needles, razor blades and toothbrushes.
• Cover any open cuts or sores.
• Clean up any blood or body fluid with mild disinfectant (diluted bleach) and protect hands with gloves or plastic bags.
• Wash clothes or linen contaminated with body fluids separately.
• Dispose of waste contaminated with body fluids safely.

Note to the facilitator:
Please note that worksheet 9 on page 152 (Questions and answers fact sheet) is a take-home exercise. Encourage your participants to read it at home to increase their knowledge on HIV.
## WORKSHEET 9: Questions and answers fact sheet

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
<tbody>
<tr>
<td>What causes AIDS?</td>
<td>• A virus called HIV causes AIDS. This germ can only live in blood, sperm and vaginal fluids and is too small to be seen.</td>
</tr>
<tr>
<td></td>
<td>• When the virus enters your body it starts to damage the cells that protect you against illness. These cells are part of the immune system.</td>
</tr>
<tr>
<td>How do I know if I am infected?</td>
<td>• It is not possible to know if you are infected with HIV unless you go for a blood test.</td>
</tr>
<tr>
<td></td>
<td>• People who are infected with HIV (known as HIV positive) can look and feel fit and healthy.</td>
</tr>
<tr>
<td></td>
<td>• The virus takes several years before any signs and symptoms begin to show.</td>
</tr>
<tr>
<td></td>
<td>• It is also possible to live for a very long time with HIV infection if you take care of yourself properly.</td>
</tr>
<tr>
<td>How can I avoid infection?</td>
<td>• A person who does not have sex and does not use injectable drugs has almost no chance of contracting HIV infection or any other sexually transmitted infections.</td>
</tr>
<tr>
<td></td>
<td>• People who use condoms correctly each time they have sex are protected from HIV and STI infections.</td>
</tr>
<tr>
<td></td>
<td>• People with one sexual partner, who also does not have other sexual partners, are safe provided both were HIV negative at the beginning of their sexual relationship and neither of them become infected from using contaminated drug needles during this time.</td>
</tr>
<tr>
<td>Who is more likely to get HIV infection?</td>
<td>• Anyone can get the HIV infection. It is not who you are but what you do.</td>
</tr>
<tr>
<td></td>
<td>• Having many different sexual partners puts you at risk of infection.</td>
</tr>
<tr>
<td></td>
<td>• Engaging in unsafe sexual acts such as sex without a condom is risky.</td>
</tr>
<tr>
<td></td>
<td>• Having sex while having other sexually transmitted infections.</td>
</tr>
<tr>
<td></td>
<td>• Sharing needles and syringes when doing drugs.</td>
</tr>
<tr>
<td>About the window period</td>
<td>• This is when an HIV test is negative but the person is infected with HIV and can transmit the infection.</td>
</tr>
<tr>
<td></td>
<td>• People taking the test are advised, if the test is negative, to repeat the test after three months. It is important to abstain</td>
</tr>
<tr>
<td></td>
<td>• or practice safer sex during this period. By this time, the antibodies to HIV are almost certain to have developed.</td>
</tr>
<tr>
<td>Is HIV spread by sex workers and their clients?</td>
<td>• Sex workers, like any other person with many sexual partners, run the risk of getting infected by their clients. They may then pass the infection to the next client.</td>
</tr>
<tr>
<td></td>
<td>• A client may be infected by the sex worker and transmit HIV to his/her spouse or partner.</td>
</tr>
<tr>
<td></td>
<td>• Use of a condom with every sexual act reduces the risk of spreading infection from one partner to the other.</td>
</tr>
<tr>
<td>What if a woman is having her period?</td>
<td>• Having sex while having periods increases the risk of getting or passing on HIV infection (if one of you is infected).</td>
</tr>
<tr>
<td>Questions</td>
<td>Answers</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| What about a baby born of an HIV positive woman? | * The baby maybe born infected with HIV.  
* The HIV positive mother can also pass the infection to her baby through breastfeeding.                                                                                                                   |
| Does breast feeding spread HIV infection?      | * Breast milk is a form of body fluid. Therefore, an HIV positive mother’s breast milk does contain HIV.  
* She can therefore pass it on to the baby while breastfeeding.                                                                                                                                         |
| What about mosquitoes and other insects?       | * It has been proven that HIV does not live in the body cells of insects. Therefore HIV infection cannot be spread by insects such as mosquitoes.                                                                                   |
| Do you need to have many sexual partners to get infected with HIV? | * Even one sexual contact with a person with HIV infection is enough to pass the infection on.  
* The risk of becoming infected with HIV increases if you have sex with many partners.  
* The presence of a sexually transmitted infection in a sexual partner e.g. (a sore on private parts) increases the risk of transmission of HIV.                                                                 |
| What is affection without sex?                 | * There are many ways of showing affection and enjoying sexual pleasure. This includes touching, massage and mutual masturbation.  
* Such acts are not wrong and therefore should not produce feelings of guilt.                                                                                                                                  |
| What is unsafe sexual activity?                | * Anal sex (without a condom).  
* Vaginal sex (penis in vagina) without a condom (for male or females.)  
* Any sex act that causes bleeding, such as dry sex.  
* Semen or blood getting into the mouth during oral-genital sex.                                                                                                                                             |
| What is safer sex?                             | * There are sexual practices, which prevent a partner’s blood, semen or vaginal fluid from coming into contact with your blood or body fluids, preventing the spread of HIV infection.  
* Masturbation, massage, and touching private parts are considered safe sexual practices.  
* Use of condoms (male or female) with every sexual act.                                                                                                                                               |
| If AIDS kills then what’s the point in knowing your HIV status? | * If you know you are infected you can make a number of good decisions such as:  
* Abstaining from sex – to avoid infecting others or getting re-infected.  
* Using a condom with every sexual intercourse.  
* Not sharing any items that come into contact with blood (e.g. razors and needles).  
* Not donating blood.  
* Thinking carefully before falling pregnant.  
* Living positively with the virus.                                                                                                                                                                      |
Session 2: Positive health, dignity and prevention

Duration: 1 HR

Learning objectives
By the end of this session participants should be able to:

• Explain what positive health, dignity and prevention is;
• Explain how one maintains positive health, dignity and prevention; and
• Know what kind of foods are needed in order to maintain a good diet.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

Note to the facilitator:
Start the discussion by asking your participants what they understand by positive health, dignity and prevention. Use the explanation below to make additions or corrections. Then take them through this section on how to maintain positive health, dignity and prevention. 20 Min

Positive health, dignity and prevention describe steps taken by people living with HIV or AIDS that enhance their lives and improve their health and self-esteem.

1. How do you maintain positive health, dignity and prevention?

• Positive health, dignity and prevention involves having a positive outlook on living. It also means living responsibly with HIV.
• Prevent re-infections with other strains of HIV and transmission of HIV to partners by using condoms.
• Use of safe drinking water or boiled water. Polluted water can cause diarrhoea and other illnesses.
• Eat well-cooked food. Heat liquids until they start to boil to kill germs.
• Cooked food should not be stored for longer than 24 hours.
• Wash food and vegetables with iodine or chlorine tablets, especially for lettuce.
• Practice regular hand washing.
Physical activity:

- Physical activity can improve health and maintain muscle tone.
- It stimulates appetite.
- It improves functioning of the digestive system.

Diet:

- Eat foods that stimulate weight gain. Meals should contain protein, fat and starch (see food examples below).
- Avoid refined sugars and sweets as they increase the risk of mouth problems.
- Squeeze fresh lemon juice over fatty foods like meat, chicken and nuts.
- Eat papaya with food to aid digestion.
- Eat many small meals per day and chew food well.
- Drink between meals, not during meals.
- Eat fermented or sour foods such as sour milk, sour porridge.
- Staple foods should be eaten with every meal. When planning meals, the staple or starchy food should be the central or main food, and the rest of the meal planned around this food.

Note to the facilitator:
Put 4 large pieces of paper on the wall, labeled as follows: 1. Starchy foods, 2. Peas, beans, lentils, nuts and seeds, 3. Milk, milk products, meat, poultry and fish, 4. Vegetables and fruit. On a separate flip chart write down all the foods in tables 1-4 on pages 157 and 158. Divide participants into 4 groups and give them sticker notes to write down the foods and paste them on the papers on the wall. Give them 10 minutes to do this exercise and then make corrections using the information from tables 1-4.

Starchy foods.

These foods are relatively cheap and provide most of the energy or fuel to make us “go” as well as some nutrients to help us ‘grow’ and ‘glow’. However, staples alone are not enough to provide all the nutrients that the body needs, so we need other foods as well.
Table 1: Example of starchy foods

<table>
<thead>
<tr>
<th>Cereals and Grains</th>
<th>Starchy Roots or Tubers</th>
<th>Starchy Fruits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rice</td>
<td>Potato</td>
<td>Plantain</td>
</tr>
<tr>
<td>Wheat Flour</td>
<td>Sweet Potato</td>
<td>Breadfruit</td>
</tr>
<tr>
<td>Maize/Corn Meal</td>
<td>Yam</td>
<td></td>
</tr>
<tr>
<td>Millet</td>
<td>Fresh Cassava</td>
<td></td>
</tr>
<tr>
<td>Sorghum</td>
<td>Cassava Flour</td>
<td></td>
</tr>
</tbody>
</table>

Peas, beans, lentils, nuts and seeds.

These foods are needed to help us ‘grow’ because they help develop and repair the cells of the body and build muscle. They also contain some nutrients to help us ‘glow’. They are a cheaper source of protein than animal foods such as beef and chicken, and should be eaten every day, if possible.

Table 2: Examples of peas, beans, lentils, nuts and seeds:

<table>
<thead>
<tr>
<th>Pulse and Legumes</th>
<th>Nuts and Oil seeds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kidney Bean</td>
<td>Ground Nut</td>
</tr>
<tr>
<td>Cowpea</td>
<td>Sesame</td>
</tr>
<tr>
<td>Chickpea</td>
<td>Peanut</td>
</tr>
<tr>
<td>Pigeon Pea</td>
<td>Soybean</td>
</tr>
<tr>
<td>Lentil</td>
<td>Pumpkin Seed</td>
</tr>
<tr>
<td></td>
<td>Melon Seed</td>
</tr>
</tbody>
</table>

Animal and milk products.

Foods from animals may be expensive but even small portions in the meal are important and should be eaten as often as you can afford them. They will help to strengthen muscles. Foods from animals help with growth and repair, as well as strengthen muscles and the immune system. Liver and other organ meats are a particularly valuable source of iron.

Fermented milk is beneficial if a person has diarrhoea because it is easily digested, may help in digestion and absorption of other foods and is a good source of energy. Fermented milk may be readily available and does not need to be stored in a refrigerator. Breast milk is a good food for infants and young children. It helps them to GROW, GO and GLOW.
### Table 3: Milk and milk products, meat, poultry and fish

<table>
<thead>
<tr>
<th>Milk and Milk products</th>
<th>Meat, Poultry and Fish</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fresh Cow’s Milk</td>
<td>Birds</td>
</tr>
<tr>
<td>Fresh Goat’s Milk</td>
<td>Rabbit</td>
</tr>
<tr>
<td>Curd</td>
<td>Deer</td>
</tr>
<tr>
<td>Yoghurt</td>
<td>Insects</td>
</tr>
<tr>
<td>Cheese</td>
<td>Cow</td>
</tr>
<tr>
<td></td>
<td>Goats and sheep</td>
</tr>
<tr>
<td></td>
<td>Pork</td>
</tr>
<tr>
<td></td>
<td>Liver</td>
</tr>
<tr>
<td></td>
<td>Eggs</td>
</tr>
</tbody>
</table>

### Vegetables and fruits.

Vegetables and fruits are an important part of a healthy diet. They supply foods that keep the body functioning and the immune system strong. They are known as protective foods because they are important in preventing and fighting infections. These foods are especially important for people living with HIV to fight infections. Aim to eat a wide variety as each one has a different way to help us “glow” with health.

### Table 4: Vegetables and fruits

<table>
<thead>
<tr>
<th>Vegetables</th>
<th>Fruits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spinach</td>
<td>Apricot</td>
</tr>
<tr>
<td>Pumpkin</td>
<td>Mango</td>
</tr>
<tr>
<td>Tomato</td>
<td>Orange</td>
</tr>
<tr>
<td>Carrot</td>
<td>Paw paw</td>
</tr>
<tr>
<td>Kale</td>
<td>Lemon</td>
</tr>
<tr>
<td>Traditional green leafy vegetables</td>
<td>Passion Fruit</td>
</tr>
<tr>
<td>Sweet Pepper</td>
<td>Banana</td>
</tr>
<tr>
<td>Okra</td>
<td>Pineapple</td>
</tr>
</tbody>
</table>

- Most vegetables and fruits can be easily grown in the garden.
- Eat vegetables and fruits that are dark-green, yellow, orange or red in colour as they are rich in vitamin A:
  - green leafy vegetables (spinach, pumpkin and cassava leaves), green pepper, carrots, papaya, apricots, mangoes;
  - Eat other vegetables and fruits rich in vitamin C to help fight infections;
  - tomatoes, cabbage, oranges, lemons, guavas, pineapples, baobab fruits;

Maintain good care of your mouth and teeth. Regular mouth cleaning and mouth rinsing can prevent the development of oral problems.
2. What can I do to help a friend who has AIDS? 15 Min

- HIV affects thousands of people in Africa. People who are infected with HIV need care and support from friends, family and the community.
- When someone you know becomes ill, especially when they develop AIDS, you may feel helpless or inadequate.

Here are some tips for helping friends living with HIV and AIDS:

- Try not to avoid your friend. Be there – it gives hope. Be the friend you have always been, especially now when it is important.
- Touch your friend. A simple squeeze of the hand or a hug can let him or her know that you care. (remember that you cannot get HIV by simply touching and hugs).
- Spend time sharing a meal.
- Call your friend and see if she/he needs anything from the shop and bring it over when visiting.
- Get a favourite cassette/CD and listen to the music together.
- Check on your friend’s partner or family. They may need a break from time to time.
- It’s ok to ask about the illness but be sensitive to whether your friend wants to discuss it or not. You can find out by asking: “Would you like to talk about how you are feeling?” Do not put pressure on your friend to talk.
- You do not always have to talk. It’s ok to sit together in silence. Listening to music, watching television, holding hands are other ways of spending quiet time together.
- Encourage your friend to make decisions.
- Be prepared for your friend to get angry with you for no obvious reason, although you may feel that you have been there and done everything you could. Remember anger or frustration is often taken out on the people most loved because it is safe and will be understood.
Session 3: Stigma and Discrimination

Duration: 1 hr 40 Min

Learning objectives
By the end of the session participants will be able to:

• Understand stigma and discrimination;
• Identify behaviours that stigmatise and discriminate against those with HIV; and
• Acquire knowledge on the rights of PLHIV.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.
• Sellotape.
• A4 papers.
• Additional information on human rights particularly with regard to HIV and AIDS.

Note to the facilitator:
Ask participants to explain what they understand by stigma and how it affects people living with HIV. Make additions using the information below.

1. What is AIDS-related stigma? 15 Min

The ways in which HIV is transmitted and the stigma related to it has unquestionably influenced the attitude of society towards the current epidemic. There is often a ‘victim-blaming’ or ‘scapegoat’ mentality, as well as stereotyping of people with HIV. This may prevent a caring response towards those affected by HIV or AIDS.

AIDS stigma refers to prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS or HIV and at individuals, groups, and communities with which they are associated. It persists despite the presence of protective legislation and disclosure by public figure-heads that they are HIV infected or have AIDS.

Before we can work effectively and deal with the emotive issues raised by HIV and AIDS, we need to identify and accept our own values and attitudes as personal rather than universal, and distinguish these from fact. It also requires us to accept that while we all have prejudices, and may not be responsible for how we acquire
them, we are responsible for what we do about them. Feeling guilty about our prejudices is generally not very helpful. What is helpful is having an opportunity to explore these prejudices and ultimately to begin to free ourselves from them. If we can do this, we may prevent our own values and attitudes interfering with our work.

2. Exercise: Who is labelling who? 25 Min

**Note to the facilitator:**
The aim of this exercise is to develop awareness of stigma and discrimination through an activity. Use the instructions below to facilitate this exercise.

**Steps:**

1. Distribute the A4 paper and markers so that each person has one, including you.
2. Divide the participants into two groups.
3. Ask one group to draw the face of people with good qualities on their page e.g. a kind person, a happy person. Ask them to label the picture e.g. doctor, nurse, police officer, etc.
4. Each participant should draw someone different.
5. Now ask the second group to draw the faces of people with bad qualities e.g. a violent person, a thief.
6. As for you, draw the face of someone ill with AIDS.
7. Allow 5 minutes for this activity.
8. After everyone has drawn their picture, ask each person to come forward, display their drawing and explain the qualities of the face they have drawn.
9. Now ask them to all pass their pages to you and you shuffle them. Leave them in a pile.
10. Ask everyone to stand up and greet each other warmly as they normally would.
11. Now ask each participant to come to you in turn. Take a page and stick it on to the back of the first person without letting him/her know what is drawn on it.
12. No-one should tell each other what the picture on their back shows.
13. Get someone to stick the last page on your back.
14. Ask everyone to stand once again and move around greeting one another, but this time, the style and manner of greeting should depend on the page stuck on that person’s back (e.g. they can show dislike for thieves when greeting someone with the corresponding label, and so on).
15. If they cannot remember what the picture on that person’s back means, they should treat the person with caution.
16. After everyone has greeted one another, ask them to sit again.
Discussion points

1. How did you feel during the first meeting?

2. How did you feel during the second meeting?

3. Was there any difference in the style and manner in which you were greeted? How? How did that make you feel?

Ask everyone to turn around and take their labels off so that they can see how they were labelled.

3. Exercise: Do you agree? 15 Min

Aim: To help us review our attitudes and behaviours that may lead to discrimination.

Description: the facilitator will read out various statements and the participants will agree or disagree. The responses will form the basis for discussion.

Steps:

• Place 2 cards labelled AGREE and DISAGREE in opposite areas of the room.

• Read out the following statements to the participants:
  • Those with HIV have only themselves to blame.
  • Prostitution should be banned to prevent the spread of HIV.
  • Those with HIV should be put in camps and locked up.
  • An HIV positive mother should not fall pregnant.

• Ask the participants whether they agree or disagree and move to the designated areas:

• Why have they agreed or disagreed? What are their reasons?

Discussion points

1. No one is to blame – many people engage in sex (protected or unprotected), some get pregnant, and others contract STIs and some contract HIV.

2. Prostitutes alone are not responsible for HIV infection.

3. PLHIV are human beings and should therefore be free to move around and associate with others.

4. An HIV positive mother can make her own decisions regarding her fertility after receiving all relevant information and in-depth counselling.

4. Exercise: Discriminatory terms 15 Min

Aim: To discuss discriminatory terms with participants.

Description: a round table discussion on discriminatory terms.
Steps:

• Write out the phrase ‘Discriminatory terms’ on a flip chart/board.
• Find out from the participants what they understand by the phrase.
• Guide the participants to define discriminatory terms as those words/phrases
  used in reference to a PLHIV that shows prejudgement or differential treatment
  or that portray them in a bad light without cause.
• Ask the participants to name a few that they know e.g. AIDS victim, AIDS
  sufferer and ‘those immoral people’.
• Discuss the negative connotations of these terms/phrases e.g. who is a victim?
  Why ‘AIDS victim’ and not ‘malaria victim’? ‘Those immoral people’ implies that
  these people had sex with anyone and everyone outside the marriage.

5. HIV, AIDS, and Human Rights 40 Min

Rights for PLHIV

Aim: To acquire knowledge on the human rights of PLHIV.

Description: Case studies on intention to marry, application for insurance, scholarship, and mandatory testing will be presented and discussed.

Steps:

• Write out the phrase “HUMAN RIGHTS”.
• Ask the participants what they understand by this phrase.

Human Rights – Rights that all human beings are entitled to

Note to the facilitator:
Ask participants to name few rights they know and write their responses on a board or large page of paper. Now divide the participants into three groups and read out the 3 case studies below. Give them 5 minutes to discuss, and 2 minutes to present to the whole group. Use the information provided in the case studies to make additions and corrections.
Case 1

Andrew and Maria finally decided to get married at their church. Before they were to marry, the church asked them to do an HIV test and bring back the results. Andrew turned out to be HIV positive whereas Maria was not. The church refused to marry them and advised them to look for another church.

What rights were interfered with/denied? Discuss these with the participants.

Suggestions

Privacy – the church did not need to know their HIV status.
Right to marry – should be the couple’s choice, not the church.

Case 2

Jester was eager to join her company’s life insurance scheme. However, she first had to go for an HIV test, which she did. Her results were sent straight to the insurance company. When she asked about the progress of her insurance, she was told that she could not be insured.

What rights was she denied?

Suggestions

Privacy – the results should have gone to her to decide whom to disclose to.
She should not have been denied insurance on the basis of her HIV status.

Case 3

Joshua was eager to study abroad. One of his visa requirements was that he had to go for an HIV test, the results of which were to be sent directly to the embassy. He tested HIV positive and his visa application was rejected. Furthermore, the university cancelled his application for admission.

What rights were interfered with?

Suggestions

Privacy – the results should have gone to him to decide whom to disclose to.
He should not have been denied an opportunity to further his education on the basis of his HIV status.

Note to the facilitator:
Ask your participants what other rights they know of? Write their responses on a board or large paper. At the end compare their information with the rights mentioned below.
The rights listed below are known as Civil and Political Rights:

- The right to life.
- Freedom from torture or cruelty, inhumane or degrading treatment or punishment.
- Freedom from slavery.
- The right not to be subjected to arbitrary arrest, detention or exile.
- The right to a fair trial.
- The right to privacy.
- The right to own property.
- Equality before the law.
- Freedom of thought, speech, religion and assembly.
- Freedom of movement – including the right to leave any country (including own) and the right to return to his/her country.
- The right to seek and enjoy asylum from persecution in other countries.

The following list indicates other fundamental human rights, known as Economic, Social and Cultural Rights:

- The right to social security, including social insurance.
- The right to work and to be protected against unemployment; the right to equal pay for equal work between men and women or different racial groups and to just and favourable remuneration, ensuring an existence worthy of human dignity.
- The right to rest and leisure, including reasonable limitations of working hours and periodic holidays with pay.
- The right to an adequate standard of living for the health and well being of self and family i.e. food, shelter, healthcare, etc.
- The right to the enjoyment of the highest attainable standard of physical and mental health, including sexual reproductive health and rights.
- The right to education.

**Note to the facilitator:**
Conclude the session by emphasising the information mentioned below.

**People living with HIV have the same rights as any other person:**

- The right to medical treatment and care.
- The right to health promotion and access to condoms.
- Children affected with HIV have the right to attend any school.
- An employee cannot be refused a job or fired because they are HIV positive.
• The right to confidentiality. No one can give out information about a person’s HIV status without their permission.

• The right to live their lives with respect, dignity and freedom from discrimination and blame.

• There is no obligation on an employee to disclose HIV status to their employer.

Summary

AIDS stigma refers to prejudice, discounting, discrediting and discrimination directed at people perceived to have AIDS or HIV and at individuals, groups, and communities with which they are associated. It persists despite the presence of protective legislation and disclosure by public figure-heads that they are HIV infected or have AIDS.

Before we can work effectively and deal with the emotive issues raised by HIV and AIDS, we need to identify and accept our own values and attitudes as personal rather than universal, and distinguish these from facts. It also requires us to accept that while we all have prejudices, and may not be responsible for how we acquire them; we are responsible for what we do about them.
MODULE 7: Gender-Based Violence (GBV) and Substance Abuse

Duration: 4 HRS 45 Min

Learning objectives
By the end of this module, participants should be able to:

• Define violence and its forms;
• Define gender;
• Understand the relationship between gender and HIV;
• Define gender-based violence & what types are found in Africa;
• Recognise various forms of gender-based violence;
• Identify myths and facts about rape; and
• Identify commonly abused drugs.
Session 1: Substance Abuse

Duration: 1 HR 25 Min

Learning objectives
By the end of this session participants should be able to:

• List the drugs that young people use;
• Identify the effects of drugs;
• Explain the risks and consequences of commonly abused drugs and substances;
• Relate drug abuse to sexual health risks and HIV infection; and
• Describe what to do to help young people involved in substance abuse.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

Introduce the topic by explaining that drug and alcohol abuse is a problem affecting everyone. It does not only affect the individual and his/her family but whole communities. For example, people steal so that they can support their drug / alcohol habits. Being under the influence of drugs and alcohol also means that you are more likely to have sex without thinking of the consequences, like unwanted pregnancies, STIs, or HIV.

Note to the facilitator:
Write on the board or large pages of paper the words: “Drug” and “Abuse” then ask your participants to define these terms. Use the definitions below to make corrections or additions. 10 Min

Ask participants to define the following terms:

**Drug** – a substance taken as medication or that can stimulate the brain.

**Abuse** – excessive and addictive use leading to clinically significant impairment.

**Drug abuse** – excessive and addictive use of chemical substances and narcotics.

**Dependence** – continued use of substance despite significant related problems e.g. continuing to smoke despite development of chest problems.
Note to the facilitator:
Ask participants to list all the drugs they have heard of in their country or community. Ask them to identify the drugs by their names, their commercial or street names and how they are administered. Write their responses on a board or large page of paper and use the information below to make corrections and additions. 20 Min

1. Commonly abused drugs

<table>
<thead>
<tr>
<th>Drug</th>
<th>Common Names</th>
<th>Administration</th>
<th>Adverse Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hashish</td>
<td>Boom, chronic, hash, hash oil</td>
<td>Swallowed, smoked</td>
<td>Euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination/cough, frequent respiratory infections, impaired memory and learning, increased heart rate, anxiety, panic attacks, and addiction.</td>
</tr>
<tr>
<td>Marijuana</td>
<td>Ganja, dagga, grass, herb, Mary Jane, weed, dope</td>
<td>Smoked</td>
<td>Euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination/cough, frequent respiratory infections, impaired memory and learning, increased heart rate, anxiety, panic attacks, and addiction.</td>
</tr>
<tr>
<td>Heroin</td>
<td>Brown sugar, H, horse, smack, white horse</td>
<td>Injected, smoked, sniffed</td>
<td>Pain relief, euphoria, drowsiness, nausea, constipation, confusion, sedation, unconsciousness, coma, death.</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Blow, bump, C, candy, coke, crack, Charlie, rock, snow, toot, flake</td>
<td>Injected, smoked, sniffed</td>
<td>Loss of coordination, irritability, anxiousness, restlessness, panic attacks, aggressiveness, addiction.</td>
</tr>
<tr>
<td>Nicotine</td>
<td>Cigarettes, cigars, smokeless tobacco, snuff, spit tobacco</td>
<td>Smoked, sniffed, taken in snuff and spit tobacco</td>
<td>Adverse pregnancy outcomes, chronic lung disease, cardiovascular disease, stroke, cancer, addiction.</td>
</tr>
<tr>
<td>Glue</td>
<td>Glue</td>
<td>Sniffed, inhaled</td>
<td>Restlessness, confusion, loss of consciousness, nose bleeding, brain damage death.</td>
</tr>
<tr>
<td>Mandrax</td>
<td>Oral</td>
<td>Loss of appetite, loss of social manners, forgetfulness, delirium, death.</td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td>Beer, booze</td>
<td>Drink</td>
<td>Liver problem, high blood pressure, diabetes, gout, ageing faster than normal, loss of coordination.</td>
</tr>
<tr>
<td>Ecstasy</td>
<td></td>
<td>Swallowed</td>
<td>Severe dehydration, exhaustion, nausea, hallucinations, increase in body temperature, tremors, and heart attacks.</td>
</tr>
<tr>
<td>Methylated spirits</td>
<td>Spirit, Meths</td>
<td>Sniffed</td>
<td>Confusion, addiction, nose bleeding, euphoria.</td>
</tr>
</tbody>
</table>
2. Steps to prevent drug and alcohol abuse

Note to the facilitator:
Divide your participants into 5 groups and allocate the following topics to each
group: 1. Steps to prevent drug and alcohol abuse, 2. How does alcohol affect the
abuse be avoided?, 5. Where can I get help?

Give each group 10 minutes to discuss and 5 minutes to present to the entire group.
After each presentation make additions using the information below. 35 Min

A. Knowledge is a powerful weapon against drugs. Young people should be told
about alcohol and drugs and their health consequences explained.

B. Help peers to develop a healthy self-image. Parents should support young people
and praise their efforts.

C. Help peers to develop a strong system of values. Good values encourage young
people to make decisions based on facts rather than on pressure from friends.

D. Young people should be taught how to deal with peer pressure. Explain that
saying ‘no’ can be an important statement about self-worth. Role-play situations for
saying ‘no’ and discuss why it is beneficial to avoid alcohol and drugs.

E. Encouraging healthy activities may help to prevent young people from using
alcohol and other drugs.

F. Ensure young people know that alcohol or drug abuse can damage their minds
and health.

3. How does alcohol affect the body?

- Alcohol is a depressant, which means it slows the functioning of the central
  nervous system.
- Alcohol abuse can result in permanent changes to the brain.
- People who overuse alcohol may stagger, lose their coordination, and slur their
  speech. They will probably be confused and disoriented.
- Reaction times are slowed dramatically — which is why people are told not to
drink and drive.
- Alcohol damages the brain, pancreas and kidneys.
- Alcohol abuse causes high blood pressure, heart attacks and strokes.
- Alcohol negatively affects the liver.

4. Why do young people drink alcohol?
Experimentation with alcohol during adolescence is common. Some reasons that
teenagers use alcohol and other drugs include:
• Curiosity
• To feel good, reduce stress and relax
• To fit in
• To feel older or more mature

5. How can substance abuse be avoided?
• Learn to say no to peer pressure.
• Avoid hanging around where alcohol is sold.
• Avoid friendships with people who drink alcohol/abuse drugs.

6. Where can I get help?
• If you think you have substance abuse problem, get help as soon as possible. The best approach is to talk to an adult you trust. If you can’t approach your parents, talk to your doctor, school teacher, clergy member (religious minister), aunt, uncle or social worker.
• In some countries there are rehabilitation centres where you can get help.

Note to the facilitator:
Ask volunteers to read the 2 case studies below and at the end of each, use the questions below to facilitate a discussion.

Case study 1: Alcohol abuse 10 Min

A group of friends are in a beer-hall one evening. It is late and all of them have been drinking heavily since early evening. David is very drunk and starts flirting with a woman sitting at the next table. She doesn’t seem very interested but David keeps buying her drinks and boasts to his friends that he’s going to take her home and have sex with her that night. Later, after more drinks, David convinces the woman, who is also drunk, to leave with him while his friends stay in the beer-hall. His friends are worried by the number of times they have seen David take different girls home after drinking too much.

Discussion questions
• How might David’s and the woman’s alcohol intake affect the risks they take?
• Why might there be an increased HIV risk in this situation?
• What might be an effective way for David’s friends to show concern about his well-being and approach him when drunk?
• In what ways might it be difficult to intervene?
Case study 2: Alcohol abuse 10 Min

*Maria is talking to a close male friend at work. She confides in him that since her partner became unemployed last year, he has started to drink heavily and that it affects their relationship. She says it is impossible to speak to him when he’s drunk. The following week the friend notices that Maria has got bruises on her arm and neck and she admits that her partner has been hitting her.*

**Discussion questions**

- Why might Maria’s partner have started to drink more alcohol when he became unemployed?
- What role has alcohol played in affecting Maria, her partner and their relationship?
- How might Maria’s colleague assist her?
- What might be some of the challenges that Maria’s colleague faces in trying to support her?

**Summary**

There are many consequences to using drugs and alcohol. Young people often experiment with drugs and alcohol. Being under the influence of drugs and alcohol means that you are more likely to have sex without thinking of the consequences, such as unwanted pregnancy, STIs, or HIV.
Session 2: Violence

Duration: 1 HR 10 Min

Learning objectives
By the end of this session participants should be able to:

- Define different types of violence;
- Recognise violence within their own context; and
- Identify the effects of violence.

Materials

- Large pages of paper or a board
- Appropriate pens and markers
- Material to stick paper up on the walls

Note to the facilitator:
This is a very sensitive topic and you need to be very careful when facilitating it. Ask your participants to define what they understand by violence and also ask them to identify different types of violence. Use the following information to make corrections or additions. 20 Min

1. What is violence?

Violence can be physical, sexual, emotional, and verbal or a combination of any or all of these. Neglect — when parents or guardians don’t take care of the basic needs of the children or people who depend on them — is also a form of violence.

Physical violence is often the most easily visible form of violence. It includes any kind of hitting, shaking, burning, pinching, biting, choking, throwing, beating and any other actions that cause physical injuries, leave marks or produce significant physical pain.

Sexual violence is any type of sexual contact between an adult and anyone under the age of 18. It can also occur between children significantly apart in age. Incest occurs when a family member sexually violates another family member.

Emotional violence can be difficult to define as there may be no physical signs. Emotional violence occurs when there is excessive shouting and anger or when parents constantly criticise, threaten or ignore children or teenagers until their self-esteem and feelings of self-worth are damaged. Emotional violence can cause as much hurt and damage as physical violence.

Neglect and deprivation are probably the most difficult types of violence to define.
Neglect occurs when a child or teenager doesn't have adequate food, housing, clothes, medical care, or supervision. Emotional neglect happens when a parent doesn’t provide enough emotional support or deliberately and consistently pays very little or no attention to a child. However, it is not considered neglect if a parent doesn’t give a child something he or she wants, like a new toy or a cell phone, but doesn’t need.

Family violence can affect anyone and can happen in any family. Sometimes parents abuse one another and this can be hard for a child to witness. Some parents abuse their children by using physical or verbal cruelty as a means of discipline.

Of course, violence and abuse do not just happen in families. Bullying is also a form of abusive behaviour. Bullying someone through intimidation, threats or humiliation can be just as abusive as physical violence. People who bully others may have been abused themselves and the same principle may be true of people who abuse someone they’re dating. However, having been abused is no excuse for abusing someone else.

Violence can also take the form of hate crimes directed at people because of their abilities, religion, gender, or sexual orientation. Gender-based violence (GBV) will be discussed in greater detail in the relevant session.

Note to the facilitator:
Divide participants into 4 groups and allocate the following topics to each group:
1. How can violence and abuse be recognised? 2. Why do abuse and violence happen? 3. What are the effects of violence and abuse? 4. What can you do if you are being abused? Allow 10 minutes for discussion and 2 minutes per group to present. Allow 5 minutes for discussion after each presentation. At the end of each presentation read the information provided below.

2. How can violence and abuse be recognised?

Sometimes people have trouble realising they are being abused. Recognizing abuse and violence may be especially difficult for someone who has lived with it for many years. A person might think that it’s just the way things are and nothing can be done about it. People who are abused might mistakenly think they bring it on themselves by not acting in a certain way or by not living up to the other person’s expectations.

Someone growing up in a family where there is violence or abuse may not know that there are other ways for family members to treat each other. A person who has only known an abusive relationship may mistakenly think that hitting, beating, pushing, shoving, or angry name-calling are perfectly normal ways to treat someone when you’re cross. Seeing parents treat each other in abusive ways might lead a child to think that’s a normal relationship. However, abuse is not a healthy way to treat people.

If you’re not sure if you are being abused, or if you suspect a friend is, it is always good to ask a trusted adult or friend.
3. Why do abuse and violence happen?

There is no single reason why people abuse others. However, some factors seem to make it more likely that a person may become abusive. Some of these factors include the following:

- Growing up in an abusive/violent family.
- People may become abusive and violent because they are not able to manage their feelings properly. For example, someone who is unable to control anger or can’t cope with stressful personal situations (like the loss of a job or marriage problems) may treat others inappropriately.
- Alcohol or drug use also can make it difficult for some people to control their actions.
- Certain types of personality disorders or mental illness might also interfere with a person’s ability to relate to others in healthy ways.

Abuse and violence can always be corrected. Anyone can learn how to stop it.

4. What are the effects of violence and abuse?

- Lack of self-esteem.
- Teenagers who are (or have been) abused often have trouble sleeping, eating and concentrating. They may not perform well at school because they are angry or frightened or because they can’t concentrate or don’t care.
- Many people who are abused do not trust others. They may feel a lot of anger towards other people and themselves and it can be difficult for them to make friends.
- Violence and abuse are significant causes of depression in young people. Some teenagers may engage in self-destructive behaviour, such as cutting themselves or abusing drugs or alcohol. They may even attempt suicide.
- It’s normal for people who have been abused to feel upset, angry, and confused about what happened to them. They may feel guilty and embarrassed and blame themselves. However, abuse is never the fault of the person who is being abused, no matter how much the abuser tries to blame others.
- Abusers may manipulate a person into keeping quiet by saying stuff like: “This is a secret between you and me,” or “If you ever tell anybody, I’ll hurt you or your family,” or “You’re going to get into trouble if you tell. No one will believe you and you’ll go to jail for lying.” This is the abuser’s way of making a person feel helpless so that he or she won’t report the abuse.
- People who are abused may have trouble getting help because it means they’d be reporting on someone they love — someone who may be wonderful much of the time and awful to them only some of the time. A person might be afraid of the consequences of reporting either because they fear the abuser or because the family is financially dependent on that person. For these reasons, abuse often goes unreported.
• Physical injuries such as bruises, and temporary or even permanent disabilities may also result from violence and abuse.

Every family has arguments. In fact, it’s rare if a family doesn’t have some rough times, disagreements or anger. Appropriate punishment and discipline — like removing privileges, grounding, or being sent to a room — are normal. Shouting and anger are normal in parent–teen relationships too — although it can feel bad to have an argument with a parent or friend. But if punishments, arguments, or shouting are excessive or ongoing, they can lead to stress and other serious problems.

5. What can you do if you are being abused?

Note to the facilitator:
Facilitators should find out what the major services are available for abused people at the community and national levels and be able to refer participants to these services. The same should be done with regard to gender based violence. Services may range from education/information/awareness raising activities, to psychosocial counselling for victims, legal support, access to the police and other forms of assistance.

• Seek help. Keeping the violence and the abuse a secret doesn’t protect anyone from being abused, it only makes it more likely that the abuse will continue.

• If you or anyone you know is being abused, talk to someone you or your friend can trust — a family member, a trusted teacher, a doctor, or family friend.

• Use the child health line if it is available in your country.

• Sometimes people who are being abused by someone in their own home need to find a safe place to live temporarily in order to be protected from further abuse. People who need to leave home for safety reasons can find local shelters or stay with a relative or friend.

People who are being abused often feel afraid, numb, or lonely. Getting help and support is an important first step towards changing the situation.

Many teenagers who have experienced abuse and violence find that painful emotions may linger even after the abuse stops. Working with a social worker or psychologist is one way to sort through the complicated feelings created by abuse. The process can also help to rebuild feelings of safety, confidence and self-esteem.
Session 3: Gender

Duration: 2 HRS 25 Min

Learning objectives
By the end of this session participants should be able to:

- Define gender;
- Explain what gender roles are;
- Identify the different social influences affecting gender development and gender roles;
- Understand how gender differences, roles and values affect behaviour; and
- Explain the relationship between gender and HIV.

Materials
- Large pages of paper or a board
- Appropriate pens and markers
- Material to stick paper up on the walls

Defining gender and gender roles 15 Min

Note to the facilitator:
After introducing the session, ask your participants to define gender and sex in their own words and write their responses down. Use the following information to add or correct their definitions as required.

1. What is gender?

Gender refers to the learned social differences between females and males throughout life. Although these differences are deeply rooted in every culture, they are changeable over time and have wide variations both within and between cultures. These differences are reflected in roles, responsibilities, opportunities, access to and control over resources, expectations, privileges, and limitations held by women and men. This means that gender is socially and culturally constructed and can be changed.

Sex describes the physical and biological differences between males and females. It is determined biologically and thus CANNOT BE CHANGED (without surgical intervention).

- Gender roles are determined for us by society. They describe what males and females are expected to do. In other words, gender roles are like a set of rules laid down by society that state what is appropriate behaviour for a man or a woman.
• Since we create gender roles, it is possible for us to change them. This happens all the time in response to changing circumstances and increasing awareness of the effects of gender on the well-being of women and men.

• Our self-esteem, relationships with others and behaviour are greatly affected by what our culture considers appropriate for a man and a woman. These are our gender values.

• Stereotyping means that people from a certain group are all expected to behave in the same way. Gender stereotyping is when women and men are always shown in the traditional roles. For example, the woman cooks and minds the children whilst the man goes to work. Gender stereotyping limits what women and men hope to do in their lives.

2. Gender exercises

A. Examining Male and Female Roles Exercise (Worksheet 10: Examining male and female roles on page 185) 20 Min

Note to the facilitator:
Put 3 A4 pages on the wall with the words “Women”, “Men” and “Both”. Explain to the participants that you will ask them a series of questions and they will be required to move to the “Women”, “Men” or “Both” signs after each statement. After each choice, ask them why they moved to a certain option. Use worksheet 10 page 185 to facilitate this exercise.

B. The Gender Role Exercise (Worksheet 11: the gender role quiz on page 186) 20 Min

Note to the facilitator:
Put 3 A4 pages on the wall with the words “True”, “False” and “Don’t know”. Explain to the participants that you will ask a series of questions and they will be required to move to “True” if they agree with statement, “False” if they do not agree with the statement or “Don’t know” if they are unsure. After each choice, ask them why they moved to a certain option. Use worksheet 11 page 186 to facilitate this exercise.

C. Famous People Exercise: 15 Min

1. Ask the group to list 10 famous people in your country.
2. Now ask them to list 10 famous women in your country.
3. Ask participants if they had any difficulty making the lists.
4. The second list is likely to include significantly more entertainers or media stars.
5. Ask what this suggests to them.
6. What qualities make these women famous?
7. How do the participants think women are valued in comparison to men?
Note to the facilitator:
Divide participants into 4 groups and allocate these topics to the groups: 1. How does gender increase women’s risk to HIV infection? 2. What are the physiological factors which make women (especially young women) more susceptible to HIV infection? 3. How do gender expectations and roles leave women and men vulnerable to STIs and HIV? 4. What are the gender norms that affect knowledge on sexual and reproductive matters? Give them 10 minutes to discuss, 2 minutes to present and allow 5 minutes for discussion after each presentation. At the end of each presentation read the information provided below.

3. How does gender increase women’s risk to HIV infection?
Talking about the gender dimension of HIV and AIDS means understanding the relationships between gender and HIV and AIDS, and analysing the gender-based economic, social, legal, cultural and physiological factors that have an impact on all aspects of the epidemic. These aspects include vulnerability, infection, access to treatment as well as stigma and discrimination. For example:

- Economic: poverty may lead women to resort to transactional sex, thus increasing the risk of infection.
- Social: women’s subordinate status in society may not allow them to negotiate condom use with their partner.
- Legal: polygamy increases the risk of infection.
- Cultural: in some countries there is the belief that having sex with a virgin could cure HIV.

HIV and AIDS do not affect all people equally. On the contrary, the spread of HIV is fuelled by biological as well as socio-cultural and gender-based factors such as women’s subordinate status in societies (gender inequality), unequal power relationships between males and females, women’s lack of economic empowerment, gender-based violence, lack of mobility and poor access to information and services.

4. What are the physiological factors which make women, especially young women, more susceptible to HIV infection?
1. HIV is more readily transmitted from male to female than vice-versa mainly because the vagina and cervix provide a larger mucosal surface for the entry of the virus than the penis.
2. Semen infected with HIV typically contains a higher concentration of the virus than the woman’s secretions.
3. Women are more likely to receive blood transfusions because of the high rates of anaemia and complications during childbirth.
4. Younger women have a higher risk of infection because their vaginal walls and cervixes are physiologically immature and tear easily thus providing easy entry for the virus. In addition, younger women have a smaller amount of vaginal secretions and this increases risk as it provide less of a barrier to HIV entry.
5. Women may resort to transactional sex (sex in exchange for money/goods/services) to provide for their families.

6. During humanitarian emergencies, women and girls are more likely to be sexually exploited.

7. In the two scenarios mentioned in 5 and 6 above, tearing and bleeding during sexual intercourse, whether from rape, rough sex, coercive sex or dry sex, increases the risk of infection.

5. How do gender expectations and roles leave women and men vulnerable to STIs and HIV?

   • Unequal power relations in heterosexual interactions. Women often do not have decision-making power and are submissive to males. For example, it may be difficult for a woman to negotiate safe sexual practices such as using condoms.

   • Women usually have less access to HIV information due to lack of education, mobility challenges and sometimes even time constraints due to childcare and daily chores (for example, women have fewer opportunities to listen to the radio).

   • Gender-based violence seriously increases the risk of HIV infection as it disproportionately affects women and girls.

6. What are the gender norms that affect knowledge on sexual and reproductive matters?

   • Gender norms in many African countries often determine what men and women are supposed to know about sex and sexuality. This limits the ability of both men and women to access the correct information to protect themselves against HIV infection. Sexuality norms may be based on incorrect information and myths. In some African countries, it is inappropriate for women to seek out or be knowledgeable on matters of sexuality as having such knowledge will often be equated with being “loose” and having had many partners. A girl’s ignorance about sex is a sign of purity and innocence.

   • Virginity is highly valued. A girl’s virginity is perceived as proof of her sexual innocence, purity, passivity, good character and worth in the eyes of her partner, family and community. This makes young girls particularly vulnerable to sexual exploitation such as early marriage, defilement and rape. Older men may coerce young girls into having sexual intercourse thinking that they are free from HIV. The myth that sex with a virgin will cure AIDS has increased child defilement and HIV infection among young girls.

   • Double standards in sexual interactions. People often believe that male sexual desires are genetically innate and therefore uncontrollable. It is also believed that they need variety and experience in order for them to satisfy their sexual desires as well as that of their partners.
• Motherhood is highly valued. It is considered a feminine quality so some women have sex with men for the sake of having children. This puts them at risk of contracting HIV.

• Harmful traditional practices such as sexual cleansing, widow inheritance, initiation ceremonies and dry sex increase the risk of contracting HIV among females.

HIV and Gender: What are the issues?

HIV infects and affects men, women, boys and girls. However, as a result of the above-mentioned reasons, evidence shows that:

• Infection and death rates are increasing faster in women and girls than in men and boys since the beginning of the epidemic.

• Women and girls carry a greater burden of care for AIDS patients than men and boys.

• Often, women are portrayed as the villains while men are seen as the victors. Consequently, blame and shame tend to fall on women and girls.

Despite this reality:

• Most HIV and AIDS policies and programmes are designed and implemented with little or no attention given to the distinct life stages and differential impact the pandemic has on women and men. The impact of gender and social relations on HIV spread and prevention has received little attention.

• PLHIV are not yet fully accepted and supported but are discriminated against and stigmatised. Some are still prisoners of their cultures, values, beliefs, customs and traditions.

• Some of the existing gender/women and development policies have not yet been fully implemented to promote gender mainstreaming in HIV and AIDS programmes.

• Some community leaders, politicians, religious leaders and policy makers are not gender-sensitive.

Exercise: 15 Min

Note to the facilitator:
Read the following case study to the entire group and engage them in a discussion. Ask them to examine the issues raised.

Jane is 4 months pregnant. When she went for her first antenatal visit she took an HIV test at her local clinic. She tested HIV positive. She knows she could only have been infected through her boyfriend James. However, James has insisted that he is HIV negative. When she told James her HIV status he beat her up and told her he does not want to see her again. Jane does not want her friends at school to know her HIV status because she fears stigma and discrimination.
Discussion questions:

1. What gender-related, cultural and social issues you could identify in this example? Please refer to the above-mentioned issues.

2. How can Jane inform James in an assertive way?

3. What are Jane’s options in dealing with the situation?

Answers

1. Jane most likely did not have the power and information to protect herself from infection, for example she did not know her partner’s HIV status. The blame and stigma fell on her, rather than on her boyfriend. In addition to infection, she was physically abused by her boyfriend and rejected by him. Now, she fears that she is going to be stigmatised and discriminated against by her school friends because the woman is culturally and socially blamed.

2. Jane should have suggested that James and her go for an HIV test together to ensure that a professional VCT counsellor prepares them for the results.

3. Jane can report James for the physical abuse, and also seek counselling on how to prevent mother-to-child transmission.
WORKSHEET 10: Examining male and female roles

W- Women    M- Men    B- Both

Please mark the person you think is best described by this statement

<table>
<thead>
<tr>
<th>Statement</th>
<th>W</th>
<th>M</th>
<th>B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intelligent</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Expressive of feelings</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A better parent</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A better home keeper</td>
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<td></td>
<td></td>
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<tr>
<td>A better worker</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Better at caring for others</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Better at building things</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A better cook</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Better at pounding maize</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Better at physical activities</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A better artist</td>
<td></td>
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<tr>
<td>Better qualified to go to University</td>
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<td></td>
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<tr>
<td>Good at acting</td>
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<tr>
<td>A better musician</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>A better speaker</td>
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<td></td>
<td></td>
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<tr>
<td>Better at running a business</td>
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</tbody>
</table>
## Worksheet 11: The gender role quiz

<table>
<thead>
<tr>
<th>Statement</th>
<th>True</th>
<th>False</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Girls are smarter than boys.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boys can run faster than girls.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men make better teachers than women.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women make better nurses than men.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intelligence is more important for boys than girls.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Good looks are more important for girls than boys.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All women want to be mothers some day.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is something wrong with people who decide not have children.</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Session 4: Gender-Based Violence (GBV)

Duration 2 HRS

Learning objectives
By the end of this session participants should be able to:

• Define what gender-based violence is;
• Recognise different forms of GBV;
• Understand the basics of prevention and response to gender-based violence; and
• Understand rape.

Materials

• Large pages of paper or a board.
• Appropriate pens and markers.
• Material to stick paper up on the walls.

1. What is gender-based violence?

GBV is an umbrella term for any harmful act perpetrated against a person’s will and based on socially ascribed (gender) differences between females and males. The nature and extent of specific types of GBV vary across cultures, countries and regions. Examples include, but are not limited to, sexual violence, including sexual exploitation/abuse by humanitarian workers, forced prostitution, domestic violence, trafficking, forced/early marriage as well as harmful traditional practices such as female genital mutilation, honour killings, widow inheritance, etc.

It is also important to mention that GBV is a serious, life-threatening issue and a human rights violation. Make reference to the previous discussion on human rights.

Note to the facilitator:
Ask participants to brainstorm examples of gender-based violence. Write their responses on a board or large pages of paper. Correct misunderstandings and add from the list below. 10 Min

GBV is abuse perpetrated against the person’s will and/or without the person’s informed (free, voluntary and having all the necessary information) consent. It can take different forms:
Sexual violence:

- Rape and attempted rape
- Harassment
- Sodomy
- Sexual exploitation and abuse
- Marital rape, intimate partner violence
- Sexual assault in children
- Forced prostitution
- Trafficking for sexual exploitation
- Sex-selective abortion, female infanticide
- Sexual violence by armed groups
- Harmful traditional practices (of a sexual nature)

Physical

- Spouse beating/domestic violence
- Harmful traditional practices

Psychological

- Verbal, emotional abuse
- Humiliation
- Discrimination
- Spouse confinement (domestic violence)
- Harmful traditional practices

Engaging men and boys has proved to be a vital strategy for ending GBV. This requires attitudinal and behavioural changes, largely on the part of the males who continue to be the main perpetrators.

2. Domestic Violence: 15 Min

Note to the facilitator:
Ask your participants to define what they understand by domestic violence. Also ask them what the different types of domestic violence are and where someone could get help from in such situations. Use the information below to make additions or corrections.
NB: Peer educators need to find out about support/services in their countries

Domestic violence refers to abuse that happens in a personal relationship. It can happen between past or current partners, spouses, or between boyfriends and girlfriends. Domestic violence happens when a person in a relationship is regularly hurt by the partner through mental or physical abuse. Most domestic violence (battered) victims are women because of their subordinate status within the household and the unequal power relationships they have with their male partners and/or male family members. For this reason, domestic violence is usually considered under the umbrella of GBV. However, there are also some men who are victims of domestic violence.

You don’t have to tolerate violence. If you are abused in your relationship, there are things you can do:

- Contact:
  - Social workers, pastors, police
  - Local counsellor, etc.

If they do not deal directly with domestic violence, they should be able to refer you to an organisation which will be able to help you.

- Find a place to stay away from the abuser if you can, so that you can think calmly about what to do next.
- Try one or all of the legal means to stop your abuser from beating you. Some methods include: laying a charge of assault or trespassing and getting an interdict/peace order.

3. Sexual violence: 20 Min

Note to the facilitator:
Divide participants into 3 groups and allocate the following topics to each group:
1. Who is most at risk of being sexually abused? 2. What are the physical signs of sexual violence? 3. What are the behavioural signs of sexual violence?

As discussed above, GBV can be sexual and can take many forms, including rape, trafficking for sexual purposes and forced prostitution (facilitator should go back to the list if necessary). Perpetrators could be: neighbours, teachers, care facility employees, family members (including spouses), family friends, strangers and others.

Who is most at risk of being sexually abused?

- Young people.
- Women.
- People with physical or cognitive disabilities.
- People who lack social support and are isolated.
What are the physical signs of sexual violence?
- Genital or anal pain, irritation, or bleeding.
- Bruises on external genitalia or inner thighs.
- Difficulty walking or sitting.
- Torn, stained, or bloody underclothing.
- Sexually transmitted infections.

What are the behavioural signs of sexual violence?
- Inappropriate sex-role relationship between victim and abuser.
- Inappropriate, unusual, or aggressive sexual behaviour.

If you feel unhappy or uncomfortable about a person or situation, do not ignore the feelings as they are valuable tools of protection.

If you are sexually abused:
- Tell a trusted adult as soon as possible.
- If the abuse is occurring within the family, a teacher, doctor, nurse, minister or social worker may be able to help.
- If the abuse is outside the family, parents or any of the above-mentioned people may be able to help.
- Professionals are trained to deal with these situations and can help if police involvement is required or necessary.

4. Rape 1 HR 10 Min

Note to the facilitator:
Brainstorm with the participants the definition of rape and date rape. Use the definition below to make additions and corrections. Divide participants into 4 groups. Allocate the following questions to each group: 1. What are the types of rape? 2. What are some of the reasons for rape? 3. What can you do if you have been raped? 4. How can rape be avoided/prevented? Give the groups 10 minutes to discuss and write down their responses on a flip chart and 2 minutes to present. Allow 5 minutes discussion after each presentation. After the presentations, read the information provided below.

What is rape?
Rape is sexual intercourse with another person without his/her consent. Rape involves penetration of the vagina or anus with the penis, other body part or foreign object such as sticks. It also includes forced oral sex. Rape can occur in marriage. Date rape is when a person is forced to have sex while on a date.
What are the types of rape?

1. **Date rape** is when a person is forced to have sex while on a date. The two people know each other and this is a form of sexual violence, even though there may be physical intimacy that is accepted and enjoyed by the couple.

2. **Spousal rape** also known as spouse, marital rape, wife rape, husband rape, partner rape or intimate partner sexual assault (IPSA), is rape between a married couple/sexual partners.

3. **Gang rape**, or mass rape, occurs when a group of people participate in the rape of a single victim. Rape involving two or more perpetrators is widely reported to occur in many parts of the world.

4. **Rape of a child/incest** is a form of child sexual abuse. Incest is sexual intercourse between blood relatives e.g. father – daughter, mother – son (rare), brother – sister, uncle – niece.
   
   • The first sexual contact usually occurs when the child is young, accepting the behaviour as permissible e.g. between the ages of 6 and 8 years.
   • It usually starts with a touch that causes the adult to become sexually aroused.
   • The first encounter is often accidental, after that it is calculated and premeditated.
   • Sexual activity becomes progressively more intimate.
   • Violence is seldom but emotional pressure is high, particularly with the secrecy involved.
   • Intercourse may take place at any age but is usually between 11 – 13 years for girls.
   • At first the child is unsure about what is happening, but as the relationship develops he or she becomes trapped.

5. **Statutory rape** is a term used in some legal jurisdictions to describe consensual sexual relations that occur when one participant is below the age required to legally consent to the behaviour.

6. **Prison rape** commonly refers to the rape of inmates in prison by other inmates or prison staff. Less commonly, both female and male corrections officers and other staff have also been victims of rape by prison inmates.

7. **War rape** describes rape committed by soldiers, other combatants or civilians during armed conflict or war. During such times, rape is frequently used as means of psychological warfare in order to humiliate the enemy and undermine their morale. War rape is often systematic and thorough, and military leaders may actually encourage their soldiers to rape civilians.

What are some of the reasons for date rape?

Stereotyping of men and women, “males are supposed to be “macho” and in control while females are supposed to be “feminine” and allow men to make decisions and when they say “no” they really mean “yes”.
Another reason may be poor communication, guessing what other people want without talking about it.

- Power.
- Myths.
- Substance abuse.
- Culture.
- Mental disorder.

Thus, it is important to know that:

- Spending money does not justify expecting sexual favours.
- Participating in other forms of sexual behaviour such as petting does not mean sexual intercourse is necessarily acceptable.
- Using sexual behaviour to prove masculinity or femininity is unacceptable.
- Being turned down for sex is not rejection.

**What can you do if you have been raped?**

- Go to a safe place. Phone or talk to a friend, your parents, a rape crisis centre.
- Do not wash yourself or change your clothes because authorities will need to see what happened. Take some other clothes to change into after the examination.
- Go to a doctor or clinic. If you are not using any contraception you can get an emergency contraception to stop you from falling pregnant. They should also be able to give you antiretroviral pills to prevent HIV transmission.
- The doctor can record and treat any injuries you have sustained.
- Report the rape to the police. At the police station they will take a statement of what happened.
- Do not try to keep it secret; remember you are NOT to blame.
- You may feel guilty, unloved, unattractive, frightened, ashamed, hurt and angry. All of these feelings are normal. Find someone to talk to, do not hide these feelings.
- Remember you do not have to go to the police if you do not want to. However, if you do not go, you will not be able to charge the rapist.
- You may need counselling.
How can rape be avoided/prevented?

1. Avoid going out alone at night.
2. Do not use dark streets at night.
3. Avoid shortcuts that you are not familiar with or that are rarely used.
4. Always let someone know where you are going, whom you are going with and when you expect to come back.
5. Avoid going out alone on dates with people you do not know well.

How can date rape be avoided/prevented?

Set limits

• Set limits for yourself and for your relationship.
• Know how physically intimate you are prepared to be with your partner.
• Think about your limits before you go out on a date.

Communication

• This is the key to a satisfying relationship.
• Discuss your limits with your partner.
• Find out what your partner’s limits are.
• Both of you are responsible for adhering to those limits.
• Do not try and guess what your partner wants - if your partner says “no” he/she means “NO”.
• Discuss where you will go on a date. Choose a mutually acceptable venue and activity.

Alcohol and drugs

• Avoid the use of substances as they alter your thinking, behaviour and effective communication.

Getting help

• If date rape has already happened to you, it is not your fault. No one asks to be raped. No-one has a right to force you to go further than you choose to go.
• Confide in someone you trust.
• Go for counselling.
• If you are a girl, be firm within your relationship. Do not let your partner make all the arrangements about where and when to go.
• Do not allow him to make all the payments. This will give him more power over you. Remember that men are more likely to take advantage of someone who looks like she cannot take care of herself.

• If you are a man you do not have to prove you are a man by making all the decisions and paying for everything. That is old-fashioned and sexist.

• If you go out with someone you do not know, stay in places where there are a lot of other people. Some men tend to think that agreeing to go with them is agreeing to sex - this is not true.

• Never let anyone force you into being alone with him. You can say NO or that you do not want to go.

• Before going out, make sure that you have a lift home. Do not accept a lift from men you do not know. Make sure you tell people when to expect you back.

Exercise: Myths and facts about rape: 10 Min

Note to the facilitator:
Put 3 A4 pages on the wall with the words “True”, “False” and “Don’t know”. Tell the participants you will ask them a series of questions and they will be required to move to “True” if they agree with statement, “False” if they do not agree with the statement or “Don’t know” if they are unsure. After each choice, ask them why they moved to a certain option. Use worksheet 12 (page 197) to facilitate this exercise.

Exercise: 15 Min

Note to the facilitator:
Use the instructions below to facilitate this exercise. At the end of the exercise explain to the participants that any man could be a rapist and any woman can be raped, regardless of their appearances, the way they are dressed or their behaviours. Nothing can justify rape; it is a crime and an unacceptable and serious violation of human rights. Explain that men and boys may also be victims of rape, although this is less common. Moreover, there is a tendency not to talk about it, thus it is less recognized.

• Ask 2 male volunteers to meet you outside the training room. Ask them to change their dressing style, e.g. 1 takes off a T-shirt, 1 to be more presentable.

• Ask them to stand in front of the whole group.

• Ask them to identify which of the 2 guys could be a potential rapist and why.

• Ask 2 female volunteers to come and stand before the group and ask who is more at risk of being raped and why?
Impact of GBV on the health of survivors: 15 Min

Note to the facilitator:
Explain to participants that there are a number of medical, psychological, and social consequences of GBV depending on the type and extent of gender-based violence. Death either through homicide or suicide is not uncommon. Trauma and depression are the most common psychological effects, while stigma, blame and exclusion are common social outcomes. Facilitate a discussion on the main effects of GBV on the health of survivors, also focusing on SRH outcomes (make the link with module 3, session 2 on sexual and reproductive organs). Make additions and corrections using the information below.

- Injury à disability or death
- Infant/maternal mortality
- Risky health behaviours
- Substance use

In particular, sexual and reproductive health:
- General gynaecological problems
- Unwanted and unsafe pregnancy: too early, too often, too many
- Unsafe or selective abortion
- Infertility
- Uterine prolapse
- Adverse pregnancy outcomes
- Pelvic Inflammatory Disease
- Irritable Bowel Syndrome
- STIs & HIV

Psychological effects:
- Depression
- Anxiety disorders
- Rape trauma syndrome, symptoms:
  - Hyper arousal ~ hyper vigilance, anger, poor concentration, aggression,
  - Intrusion ~ nightmares & flashbacks
  - Avoidance ~ social withdrawal, emotional numbing,
- Suicidal tendencies
Summary

We have relationships with many different people in our lives. We begin with our family and then make friends outside our homes. Later we interact with many other adults like teachers, our parents’ friends and other community members. When we reach puberty, we start to become sexually interested in people. Our bodies tingle, our hearts beat faster, and we feel happy to be near them and want to get closer.

Young men and women may feel pressured to enter into a sexual relationship and become boyfriend and girlfriend before they know each other well enough and feel ready for it. This can result in emotional distress, and if they do not use a condom, unwanted pregnancy and sexually transmitted infections, including HIV.

In addition, we can be subject to various forms of violence as a result of gender without even knowing this violence is an open violation of fundamental human rights, including sexual and reproductive rights. Let’s take the example of some harmful traditional practices such as forced/early marriage. (Facilitators should find out what the most common forms of violence are in the specific country context, and find a way to discuss them sensitively. Take into consideration the fact that some of them may be widely practised and accepted at the community level and may not even be recognized as forms of gender-based violence).

It may be useful to go back to the rights listed above and ask participants which rights are violated when discussing gender-based violence.

Allow time for questions and answers.
Worksheet 12: Myths and facts about rape

Respond to each statement by ticking under: True, False or Don’t know

<table>
<thead>
<tr>
<th>Statement</th>
<th>TRUE</th>
<th>FALSE</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rape is sex forced on a person who does not want it.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rape is happening in your country.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A husband cannot rape his wife.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50% of all rapes occur between people who have met before.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most rapes occur in people aged between 12 and 19.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Over 50% of rapes are not reported to police.</td>
<td></td>
<td></td>
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<tr>
<td>Studies show that rapists plan ahead and choose women who seem likely ‘victims’.</td>
<td></td>
<td></td>
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<tr>
<td>Rapists have poor social relationships with women.</td>
<td></td>
<td></td>
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<tr>
<td>Rape is an expression of anger, power and control.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Most people report rape as a violent and dangerous attack upon them that deeply affects their lives.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
APPENDIX 1: Peer education monitoring tools

Peer Educator Record Form

Each peer educator should keep a simple diary or notebook, in which the following information is recorded daily for the completion of the “Peer Educator Monthly Summary Output Report”. Whenever peer sessions are done by more than one peer educator only one peer educator will report about the session.

<table>
<thead>
<tr>
<th>Name of peer educator (s)</th>
<th>Age</th>
<th>Sex</th>
<th>Name of supervisor/coach of peer educator</th>
<th>District/Division: Location: Village:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of the sessions (dd/mm/yy):</td>
<td>Type of sessions: Group □ One-to-one □</td>
<td>Place of the sessions (village name and location):</td>
<td>Time of the sessions:</td>
<td></td>
</tr>
<tr>
<td>Number of condoms distributed:</td>
<td>Type of session:</td>
<td>Number of IEC materials distributed (specify the amount, the type of materials (i.e. pamphlets, posters, etc) and the subject of the materials (gender-based violence, PMTCT, etc)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community session □</td>
<td>One-to-one session □</td>
<td>Number</td>
<td>Type</td>
<td>Subject/Topic</td>
</tr>
<tr>
<td>School session □</td>
<td>Others, specify □</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drama □</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people reach by the session today</td>
<td>Target population of the meeting:</td>
<td>How many people have you referred (in today’s session) to VCT centres?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>5-17</td>
<td>In-school youth □</td>
<td>Pregnant mothers □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-49</td>
<td>Out-of-school youth □</td>
<td>Truck drivers □</td>
<td>How many women have you referred to PMTCT services?</td>
<td></td>
</tr>
<tr>
<td>50-64</td>
<td>Community population in general □</td>
<td>Military □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>65+</td>
<td>Inmates □</td>
<td>Other, specify □</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Commercial sex workers □</td>
<td></td>
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</tbody>
</table>
Comments (did the activity go as planned? Did you have any challenges during the implementation of the activity? etc.)

___________________________________________________________________________________________
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___________________________________________________________________________________________

Peer Educator Monthly Summary Output Report

This form is filled in by each peer educator volunteer at the end of the month. The peer educator should fill in/tick the appropriate boxes, accordingly to the activities carried out during the reporting month. This form collects information on prevention, education, life skills, stigma and discrimination and gender-based violence campaigns carries out at community and school level.

<table>
<thead>
<tr>
<th>Name of peer educator</th>
<th>Age</th>
<th>Sex</th>
<th>Name of supervisor/coach of peer educator</th>
<th>District/Division:</th>
<th>Location:</th>
<th>Village:</th>
<th>Number of days worked this month:</th>
<th>Number of hours worked a day:</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

Youth Club members

<table>
<thead>
<tr>
<th>Number of youth clubs you facilitated</th>
<th>Number of people currently enrolled</th>
<th>Number currently enrolled who have received training</th>
<th>Topic(s) of the training</th>
<th>Number of enrolled youth club members who are currently active</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Female</td>
<td>Male</td>
<td>Total</td>
<td>Female</td>
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</table>

Monthly SRH promotion session

<table>
<thead>
<tr>
<th>Session topic</th>
<th>Targeted group</th>
<th>Number of people reached by the session(s) (sum number of people reached in total during the month)</th>
<th>IEC materials distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In-school youth □</td>
<td>Pregnant mothers □</td>
<td>Age</td>
</tr>
<tr>
<td></td>
<td>Out-of-school youth □</td>
<td>Truck drivers □</td>
<td></td>
</tr>
<tr>
<td></td>
<td>General population □</td>
<td>Military □</td>
<td>5-17</td>
</tr>
<tr>
<td>Session total hours</td>
<td>Inmates □</td>
<td>Commercial sex workers □</td>
<td>18-49</td>
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<td></td>
<td>Other, specify □</td>
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<td>50+</td>
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<td>Total</td>
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<td></td>
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</tbody>
</table>
### Monthly community education

<table>
<thead>
<tr>
<th>Number of sessions held</th>
<th>Date/ Village</th>
<th>Targeted group (see from table above)</th>
<th>Topic of sessions</th>
<th>Number of people reached (sum number of people reached in total during the month)</th>
<th>Male condoms distributed</th>
<th>Female condoms distributed</th>
<th>IEC materials distributed (sum all materials distributed in all the meetings)</th>
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<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
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<tbody>
<tr>
<td>5-17</td>
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<tr>
<td>18-49</td>
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<td>50+</td>
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<tr>
<td>Total</td>
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</table>

### Schools visited

<table>
<thead>
<tr>
<th>Date /village</th>
<th>Name of school</th>
<th>Topic (s) discussed</th>
<th>Attendance of boys and girls at the meeting/session (sum number of pupils reached in total during the month)</th>
<th>IEC materials distributed</th>
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<tr>
<th>Female</th>
<th>Male</th>
<th>Total</th>
<th>Number</th>
<th>Type</th>
<th>Subject</th>
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</table>

### Other sites visited

<table>
<thead>
<tr>
<th>Number of meetings held</th>
<th>Date/ Village</th>
<th>Targeted group (see from table above)</th>
<th>Type of site (hotel, bar, markets, clinics, bottle stores, etc)</th>
<th>Number of people reached (sum number of people reached in total during the month)</th>
<th>Condoms distributed</th>
<th>IEC materials distributed (sum all materials distributed in all the meetings)</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>Age</th>
<th>Female</th>
<th>Male</th>
<th>Total</th>
<th>Number</th>
<th>Type</th>
<th>Subject</th>
</tr>
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<tbody>
<tr>
<td>5-17</td>
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</tbody>
</table>
### People referred to...

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of pregnant mothers referred to PMTCT services</th>
<th>Number of pregnant mothers that have gone to the PMTCT services as advised</th>
<th>Number of people referred to VCT services</th>
<th>Other people referred to…</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td></td>
<td></td>
<td></td>
<td>Clinic/health centre</td>
</tr>
<tr>
<td>20-49</td>
<td></td>
<td></td>
<td></td>
<td>Community counsellor</td>
</tr>
<tr>
<td>50+</td>
<td></td>
<td></td>
<td></td>
<td>Social Worker</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### Youth Friendly centre visit

<table>
<thead>
<tr>
<th>Number of youth friendly centres you facilitate</th>
<th>Number of people that visited the centre this month</th>
<th>Main reasons for people visiting the centre (indicate as many as apply)</th>
<th>Main activities conducted in the centre this month (counselling, library, sports, training - specify type, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Female Male Total</td>
<td>Age Female Male Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-19</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Red Cross supported post-test clubs

<table>
<thead>
<tr>
<th>Number of supported RC post-test clubs under your supervision</th>
<th>Number people reached by RC supported post-test clubs during this month (from post-test clubs records)</th>
<th>Main reasons for people visiting the post-test club (indicate as many as apply)</th>
<th>Main activities conducted in the post-test club this month (counselling, training - specify type, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Female Male Total</td>
<td>Age Female Male Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Health promotion sessions

<table>
<thead>
<tr>
<th>Number of SRH promotion sessions conducted this month</th>
<th>Number of people participating in the sessions</th>
<th>Type of sessions conducted</th>
<th>IEC materials distributed (sum all materials distributed in all the meetings)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Female Male Total</td>
<td>Age Female Male Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-17</td>
<td>Water and sanitation</td>
<td>Gender-Based Violence</td>
<td></td>
</tr>
<tr>
<td>18-49</td>
<td>Malaria prevention &amp; control</td>
<td>Other, specify</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>Nutrition</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Other comments
What have been the most important achievements during the reporting period? Did you implement all the activities planned at the beginning of the month? If not, why not?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What were the greatest difficulties you encountered during the reporting period?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

What can be done and what did you do to overcome these difficulties?

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

Name and signature of peer

Educator: ..............................................................................................

Date: ..............................
Peer Educator Coach/ Supervisor Monthly Summary Output Report

To be done by the Supervisor/Coach at the end of the month based on the reports received from the peer educators, and the activities he/she has carried out during the reporting month.

<table>
<thead>
<tr>
<th>Name of coach/ supervisor</th>
<th>Age</th>
<th>Sex</th>
<th>Name of programme officer</th>
<th>District/Division: Location: Village:</th>
<th>Number of days worked this month: __________________</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Number of hours worked a day: ________________</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of peer educators under your supervision</th>
<th>Number of visits to peer educators this month:</th>
<th>Number of meetings with peer educators this month:</th>
<th>Number of peer educators who submitted monthly report this month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age Female Male Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-17</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-49</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>50+</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Number of IEC materials distributed to peer educators this month

<table>
<thead>
<tr>
<th>Number of visits to peer educators this month:</th>
<th>Number of IEC materials distributed to peer educators this month:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number</td>
<td>Type</td>
</tr>
</tbody>
</table>

Youth Club members

<table>
<thead>
<tr>
<th>Number of youth clubs under your supervision</th>
<th>Number of people currently enrolled</th>
<th>Number currently enrolled who have received training</th>
<th>Topic(s) of training</th>
<th>Number enrolled youth club members who are currently active</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of youth clubs under your supervision</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of people currently enrolled</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number currently enrolled who have received training</td>
<td></td>
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<td>Topic(s) of training</td>
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<td>Number enrolled youth club members who are currently active</td>
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<tr>
<td>Age Female Male Total</td>
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<td>18-49 Female Male Total</td>
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<tr>
<td>50+ Female Male Total</td>
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</table>

Number of schools under your supervision

<table>
<thead>
<tr>
<th>Number of schools under your supervision</th>
<th>Number of schools visited this month</th>
<th>Topics discussed</th>
<th>Attendance of boys and girls at these meetings (total number of pupils reached during the month)</th>
<th>IEC materials distributed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of schools under your supervision</td>
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<tr>
<td>Number of schools visited this month</td>
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<td>Attendance of boys and girls at these meetings (total number of pupils reached during the month)</td>
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<td>IEC materials distributed</td>
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Monthly SRH promotion sessions

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<th>Total</th>
<th>Number</th>
<th>Type</th>
<th>Subject</th>
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<td>Out-of-school youth</td>
<td>Truck drivers</td>
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<tr>
<td>Inmates</td>
<td>Other, specify</td>
<td>18-49</td>
<td></td>
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<tr>
<td>Commercial sex workers</td>
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</table>
### Monthly community education sessions

<table>
<thead>
<tr>
<th>Number of meetings held</th>
<th>Number of villages reached</th>
<th>Targeted group (see from table above)</th>
<th>Topic of the session(s)</th>
<th>Number of people reached (sum number of people reached in total during the month)</th>
<th>Male condoms distributed</th>
<th>Female condoms distributed</th>
<th>IEC materials distributed (sum all materials distributed in all the meetings)</th>
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</thead>
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### Schools visited

<table>
<thead>
<tr>
<th>Date / village</th>
<th>Name of school</th>
<th>Topic (s) discussed</th>
<th>Attendance of boys and girls at the meeting/session (sum number of pupils reached in total during the month)</th>
<th>IEC materials distributed</th>
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</table>

### Other sites visited

This section must be completed when the peer educator not only targets school population, but other at risk-population such as out-of-school youth, general population, pregnant mothers, commercial sex workers, inmates, truck drivers, etc

<table>
<thead>
<tr>
<th>Number of meetings held by site</th>
<th>Targeted groups (see from table above)</th>
<th>Type of sites (hotel, bar, markets, clinics, bottle stores, etc)</th>
<th>Number of people reached (sum number of people reached in total during the month)</th>
<th>Condoms distributed</th>
<th>IEC materials distributed (sum all materials distributed in all the meetings)</th>
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<th>Total</th>
<th>Number</th>
<th>Type</th>
<th>Subject</th>
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<tbody>
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### People referred to...

<table>
<thead>
<tr>
<th>Age</th>
<th>Number of pregnant mothers referred to PMTCT services</th>
<th>Number of pregnant mothers that have gone to the PMTCT services as advised</th>
<th>Number of people referred to VCT services</th>
<th>Other people referred to…</th>
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<tbody>
<tr>
<td></td>
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<td></td>
<td></td>
<td>Clinic/health centre</td>
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<th>Female</th>
<th>Male</th>
<th>Total</th>
<th>Number</th>
<th>Type</th>
<th>Subject</th>
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### Youth Friendly centre visit

<table>
<thead>
<tr>
<th>Number of youth friendly centres under your supervision</th>
<th>Number of people that visited the centre this month</th>
<th>Main reasons for people visiting the centre (indicate as many as apply)</th>
<th>Main activities conducted in the centre this month (counselling, library, sports, training- specify type, etc)</th>
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<tbody>
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<td>Total</td>
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### Red Cross supported post-test clubs

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<th>Number of supported RC post-test clubs under your supervision</th>
<th>Number people reached by RC supported post-test clubs during this month (from post-test clubs records)</th>
<th>Main reasons for people visiting the post-test club (indicate as many as apply)</th>
<th>Main activities conducted in the post-test club this month (counselling, training- specify type, etc)</th>
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### Health promotion sessions

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<th>Number of SRH promotion sessions conducted this month</th>
<th>Number of people participating in the sessions</th>
<th>Type of sessions conducted</th>
<th>IEC materials distributed (sum all materials distributed in all the meetings)</th>
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<td></td>
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<td>SRH □</td>
<td>Number</td>
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<tr>
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<td>Water and sanitation □</td>
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<td></td>
<td>Gender-Based Violence □</td>
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<td></td>
<td>Malaria prevention &amp; control □</td>
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<td></td>
<td>Other, specify □</td>
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<td></td>
<td></td>
<td>Nutrition □</td>
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### Peer educators training

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<th>General Peer education</th>
<th>PMTCT peer education</th>
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<tbody>
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<td>Age</td>
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### Other comments

What have been the most important achievements during the reporting period? Did you implement all the activities planned at the beginning of the month? If not, why not?
What were the greatest difficulties you encountered during the reporting period?
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
What can be done and what did you do to overcome these difficulties?
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Name and signature of coach/supervisor: ________________________________
Date:  .................................................................
APPENDIX 2: Mapping

Mapping can be used to identify:

- Key populations in an area such as major stable and mobile groups (e.g. sex workers, injecting and other drug users, men who have sex with men, transgender people, and vulnerable youth), as well as the size of the group or population and the areas in which they are found. This can be done through identification of sex work neighbourhoods, truck stops, military bases, migrant worker settlements or transit points, border posts, major transport routes (sexual risk behaviour is often more common along such routes), major industrial, commercial and agricultural centres, particularly commercial enterprises related to HIV transmission, including major sources of employment, nightclubs, bars and other liquor outlets.

- Potential interactions in an area, for example, between military bases and sex work neighbourhoods.

- The visible social and sexual culture, security and crime in an area (if violent crime is common at night, this will reduce night intervention activities. If it is even unsafe in daylight, this will affect intervention design and delivery).

- Existing health, education, social and NGO services and activities in an area may help to identify potential partners, e.g. youth centres, hospitals and clinics, colleges, schools and religious centres.

Mapping process

- Study a map of the area, noting major industrial, commercial and agricultural centres. Consult with people who are familiar with the proposed area and ask them to provide further details.

- Drive slowly or walk throughout an area to familiarize yourself with the site and note its major features. Develop a plan to map the site in greater detail, by subdividing it into smaller, more manageable units and identifying key areas for further mapping.

- With maps, walk through the site if it is small enough, or drive to key areas, then walk through the site. During your walk or drive, map the major features noted above.

- Develop a detailed key (for example a symbol which represents a school, clinic, play ground, etc.) for each of the features mapped. Transfer your rough map onto a new map, complete with a key and a full list of all sites.

- Include the latest estimate of the population of the project area, note the geographic spread of the project area and the accessibility of public transport both during the day and at night.

- Note how safe the entire project area and its sub-areas are.
• Ask potential target groups questions related to:
  • Their needs in relation to HIV information, behaviour change communication, prevention commodities and SRH services;
  • Situations in which they are vulnerable to HIV transmission, perceptions of risk and risk behaviours and influences on behaviour;
  • Practices that increase their risk of HIV transmission and why they might be motivated to adopt (or are unable to adopt) safer practices;
  • Opinions about services and patterns of service use;
  • People in their peer groups who are able to adopt safer sexual and drug using practices in relation to HIV, for example sex workers who are able to persuade clients to use a condom; and
  • Their experience of stigma and discrimination.

Questions to ask after mapping

• Is it feasible to initiate a programme in the entire site or should the programme be limited to sub-sites? If the project area’s population is more than one million people, it may be advisable to limit any intervention, at least initially, to sub-sites. In widely dispersed areas, it is harder to begin a programme in the entire area.

• What is the capacity of the branch, staff and volunteers to work with the target group?

• Is it appropriate to establish a partnership with an existing NGO that already works with the target group?
APPENDIX 3: Focus group discussion

A focus group discussion is led by a skilled facilitator using a guide that contains questions relevant to the topic being investigated. It is conducted in language that is familiar to all those taking part (the respondents).

Focus group discussions can provide programme planners, implementers and evaluators with first-hand experience in observing and listening to those involved in a programme discuss issues of importance to them, e.g. the reasons behind attitudes and behaviours linked to HIV transmission and prevention. Focus groups can generate ideas that can assist in the development and implementation of a programme.

General information about a focus group discussion

Content: The focus group discussion is not used to inform or to persuade. The facilitator’s goal is to encourage a discussion in which all the respondents take part. Though the facilitator may lead the discussion in a particular direction in order to gain information, it is important that he or she encourages the respondents to feel that they are free to say and discuss anything. There are no right or wrong answers. The facilitator must listen to what the respondents have to say, and probe (ask why) for more detail. The facilitator should be neutral, and should not influence the opinions held by individuals in the group. A facilitator is not a teacher or a judge, should not look down on respondents, should not put words in the respondents’ mouths and should not argue or disagree with what is being said.

Composition: Focus group discussions are usually made up of six to ten individuals who are similar in social class, sex, age, marital status, level of expertise or education, etc.

Duration: A focus group discussion should last one to two hours.

Focus group discussion

Setting: The setting should provide privacy, so that respondents can talk without being observed by those who are not part of the group. The environment should be non-threatening and in a place that is easily accessible to the respondents, such as an empty classroom, church, or community centre. It is important to make sure that all the respondents can see and hear each other and the facilitator. This can be achieved by sitting in a circle.

Note taking: Focus group discussions can be tape-recorded with the permission of the group, or a person other than the facilitator can take notes.

Steps in facilitating a focus group discussion

Facilitator’s opening: Facilitator and recorder introduction; the general purpose of the focus group discussion is explained; the facilitator establishes neutrality, and group rules are established. Introduction: Respondents give their names
and respond to a few “non-threatening” questions. Sometimes a picture code or other stimulus is used to get the group to relax and focus on the topic, giving the respondents the opportunity to speak early on in the session. The aim is to establish a safe environment, where participants can say what they feel.

**The body of the focus group discussion:** The facilitator asks a series of open questions. These questions generally begin with “what”, “where”, “how” or “when”. For example, “How may a person react if he or she received an HIV positive test result?” A closed question usually requires a one or two word answer, such as “Would a person react badly if he or she received an HIV positive test result?” During the body of the focus group discussion, the facilitator moves the discussion from general topics to more specific topics or from a factual discussion to those related to attitudes, beliefs, or feelings. When a person responds to a question, it is important to ask other respondents “Do you agree or disagree with what has just been said? Give reasons for your answer.” This ensures that the recorded response is not that of one person but gives a summary of what the whole group felt.

**Closure:** The facilitator summarises and recaps key issues. This is to assist the facilitator, recorder, and participants in understanding what has occurred during the discussion. It allows participants to alter or clarify their positions, or to add remaining thoughts.

**Note:** It should be remembered that the transcript of the focus group discussion (from tape or notes) and the subsequent analysis of the discussion is time-consuming and requires expertise. It is important to ensure that adequate time and resources are allocated to this task.
APPENDIX 4: Pre-evaluation questionnaire (example)

NB: This form should be completed by participants at the beginning of the workshop

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
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<td>1. What is peer education?</td>
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<tr>
<td>2. Indicate the steps/activities which need to take place when planning for peer education programme implementation to a new area?</td>
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<td>7. A girl can fall pregnant before her first period.</td>
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10. What is safer sex?

11. Give the names of common sexually transmitted infections.

12. What makes a good relationship?

13. What are the dangers of teenage pregnancy?

14. How can a person live positively with HIV?

15. What can sufferers of abuse do?

16. Suggest some steps to prevent substance abuse.

17. Why are young women more susceptible to HIV infection?

18. What is gender?

19. Commercial sex workers are responsible for the spread of HIV.

Yes  No

20. PLHIV should not be allowed to have children.

Yes  No
# APPENDIX 4: Post-evaluation questionnaire (example)

NB: This form should be completed by participants at the end of the workshop

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
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<tbody>
<tr>
<td>1. What is peer education?</td>
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<tr>
<td>2. Indicate the steps/activities which need to take place when planning for peer education programme implementation to a new area?</td>
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<td>Question</td>
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<tr>
<td>20. PLHIV should not be allowed to have children.</td>
<td>Yes  No</td>
</tr>
</tbody>
</table>

Youth Peer Education Guide for Trainers
SELF-ASSESSMENT FACILITATOR MODULE EVALUATION FORM

FACILITATOR:..................................................
TRAINING:..............................................
DATE:....................................................... 

Make a tick (✓) in the appropriate box matching your opinion

<table>
<thead>
<tr>
<th>STATEMENT</th>
<th>AGREE</th>
<th>DISAGREE</th>
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<tbody>
<tr>
<td>The learning objectives are well defined.</td>
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<tr>
<td>The time allocated for this module is sufficient.</td>
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<td>The module is structured in a way that encourages active participation</td>
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<td>by participants.</td>
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<td>The length and volume of information in the module is sufficient.</td>
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<td>Each session in a day is organized around well defined themes and</td>
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<td>objectives.</td>
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<td>The language used is simple and makes it easy to follow the instructions.</td>
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<td>The content of the module is gender sensitive.</td>
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<td>Exercises and role plays instructions are clear and easy to follow.</td>
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Any additional observations of the session: ..................................................
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## NOMINATION FORM

**CONFIDENTIAL**

This form must be completed by the National Society for each person nominated to receive a grant.

### National Society Details:

<table>
<thead>
<tr>
<th>National Society:</th>
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<tr>
<td>Contact Name:</td>
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<td>Position:</td>
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<td>Contact Details:</td>
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### Nominee Details:

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<td>Gender:</td>
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<td>Male</td>
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<td>Child of RC staff member or volunteer</td>
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<td>Length of Service:</td>
<td>Years_____ Months____</td>
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<td>Large Urban Area</td>
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<td>Rural Area</td>
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### Children:

Biological and fostered children cared for by the nominee at principle residence

| Number of Children: |   |
| Ages of Children:   |   |
Humanitarian Contribution:

How does the nominee contribute to the maintenance of the National Society’s organizational capacity to deliver humanitarian assistance and/or provide leadership in the HIV response?

I have been duly authorised by the national society to submit this nomination to the Fund on its behalf. I hereby certify that the above details are correct and that any selection criteria and/or processes the National Society has created for the selection of the nominee are transparent, equitable and without conflict of interest.

Signed: ______________________________________

Position: ______________________________________

Date: ________________________________

Please attach:

Document 3 - Nominee Consent Form,
Document 4 – Grant Type and Budget Form, and
Document 5 - Medical Provider Form.
REFERENCES

1. HIV Prevention, Treatment, Care and Support: A training package for Community Volunteers (International Federation of Red Cross, SAFAIDS and WHO).

2. Greater Expectations, a source book for working with girls and young women. Szirom and Dyson.

3. Peer Education Training of Trainers, WHO.


14. Stepping Stones; MRC and PPASA.


17. FEEL! THINK! ACT!: a guide to interactive drama for SRH with young people (International HIV and AIDS Alliance).

18. One Man Can: Working with men and boys to reduce the spread and impact of HIV and AIDS. Sonke Gender Justice Network.
The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity
The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality
It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality
In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence
The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service
It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity
There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality
The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.
The International Federation of Red Cross and Red Crescent Societies promotes the humanitarian activities of National Societies among vulnerable people.

By coordinating international disaster relief and encouraging development support it seeks to prevent and alleviate human suffering.

The International Federation, the National Societies and the International Committee of the Red Cross together constitute the International Red Cross and Red Crescent Movement.