Guide for trainers

Strengthen and support CSO's to work towards:

Evidence- & Rights-based Sexual and Reproductive Health

Education and HIV Prevention for Young People

STOP
AIDS
NOW!

RutgersWPF

About this guide

This guide is developed by Rutgers WPF and STOP AIDS NOW! and is part of the **Quality of SRHR and HIV prevention programme.** In this programme we aim to support civil society organisations (CSO's) working on HIV prevention interventions and Sexual and Reproductive Health and Rights (SRHR) education for young people in 12 African countries.

In the context of the programme, trainers will be trained in 12 countries to become experts on quality criteria of SRHR education and HIV prevention programmes for young people. Once trained, trainers will support other civil society organisations to improve the quality of programmes for young people.

The training programmes are built on evidence-informed tools ("Planning and Support Tool" and "Are you on the Right Track Workbook") developed in earlier projects. Both tools and the training programme are evidence- and rights-based.

All materials that are needed to provide training sessions as described in this guide can be downloaded on our website: **www.stopaidsnow.org/prevention-youth**

Rutgers WPF
Oudenoord 176-178
3513 EV UTRECHT
The Netherlands
www.rutgerswpf.org

STOP AIDS NOW!
Keizergracht 392
1016 GB Amsterdam
The Netherlands
www.stopaidsnow.org

Rutgers WPF is a renowned expert centre on sexual and reproductive health and rights. Its activities are mainly carried out in the Netherlands, Africa and Asia. Its aim is to improve sexual and reproductive health and rights throughout the world, specifically focusing on young people, women and vulnerable groups like the disabled or chronically ill. Rutgers WPF supports partner organisations and professionals in their work, increasing their expertise on sexuality.

STOP AIDS NOW! works on expanding and enhancing the quality of the Dutch contribution to the AIDS response. Besides we stimulate and support innovative initiatives. Our projects focus on youth, children and women in countries hardest hit by the epidemic. Annually, we reach around 400,000 people who are affected by HIV and AIDS. In STOP AIDS NOW! five organisations, the Aids Fonds, Cordaid, Hivos, ICCO and Oxfam Novib have joined forces.

Funded and supported by:

Table of content

Part 1:
How to Start

1. Introduction

You are about to support other organisations in your country in order to strengthen their sexuality education or HIV prevention programmes for young people and work towards evidence- and rights-based sexual reproductive health education and HIV prevention for youth.

About this guide

How will you support other organisations? What activities can you do? In this guide we help you prepare for your training sessions. In every chapter we describe the objective, provide materials, some basic information, exercises and an agenda. Of course it is important for you to prepare for each session. This guide, but also related PowerPoints are available on a USB stick and can be downloaded on our website **www.stopaidsnow.org/prevention-youth**

Commitment

Before you start with the actual training sessions it is very important to have full commitment of the organisations, director and staff. You will learn more about this in the next chapter.

Sessions

The activities and sessions you provide to staff of CSO's are focused on: health promotion and behaviour, planning and support tool, sexual and reproductive health and rights, gender awareness, stigma and discrimination and measure effects on outcome level. After all training sessions you will conduct two follow up monitoring and support visits.

Action Plan

Together with the organisation you support, you will develop a **Plan of Action for Improvement of their Programme Activities.** After every session they will need to fill in the Plan of Action. It will be like a summary and conclusion of each session. This Plan of Action will be the entry point to discuss with the management of the organisation what changes need to be made in order to strengthen the programme activities.

2. Commitment – getting the right people on the bus

When you want to train and support an organisation it is essential to have their full commitment, from both staff members and management. We identify four phases before you have full commitment: select the right organisation, motivate staff and management, come to an agreement, and keep the commitment going. The content of the sessions for staff members depends on the amount of days available for training. If you can provide the full training, it would mean 7 training days. We realise that this is not possible for all organisations, for this reason we provide you with examples for training sessions that can take 4, 5 or 7 days.

2.1. Four steps of commitment

Select the right organisation

The first step in supporting organisations is to select an organisation that has the capacity to implement the lessons learned. Here is a full list of selection criteria. The organisation that receives the training and guidance of the trainer:
- Is interested and committed to reflect on its own programme activities and increase quality where necessary.
- Has a running programme on SRHR or HIV prevention programme for youth.
- Has basic knowledge on HIV prevention and SRHR.
- Is committed to reserve time of its programme officers.
- Is nearby (to lower transportation costs and time).
- Has available and appropriate space (e.g. board room) to use for the training.

Motivate staff and management

Once you have identified an organisation that meets the criteria, it will be important to motivate them. Provide them with the correct information: explain the benefits, be explicit what is in it for them and make sure it is clear what is expected from them. Involve your own management as much as possible. To convince the organisation to commit itself to the training, you need to:
- Involve your own management.
- Plan a meeting with the management of the organisation to:
  - Explain what the training is about, expectations and benefits (see flyer in the appendix).
  - Explain who you want to train. Important is that you train a group of staff members, not just one or two to make effective changes, you need wider support.
  - Decide on the number of available training days, 4, 5 or 7.

- Explain what is expected from management:
  - Management of the organisation signs and develops an MoU.
  - Management will identify staff members for all sessions and research.
  - Discuss and come to an agreement on travel fees, lunch and materials.
  - Participation of management during the training and support sessions.
  - Management will ensure that trained staff members have time to implement change during and after training has ended.

Come to an agreement

Develop and sign agreements in Memory of Understanding (MoU):
- To make the commitment official, you and the management of an organisation develop and sign a MoU. Develop a draft MoU (an example MoU is attached in the appendix).
- Incorporate input in MoU and sign final version.

Keep the commitment going

- An organisation will only commit itself to change if they value change. Make sure that also during the training and when you conduct support visits, you get a sense how people value the training.
- Staff members are more likely (be willing) to implement change if more organisational members value the change:
  - Encourage participants to share information and outcomes of the training with other staff members.
  - Invite management and staff members to at least one session and both monitoring and evaluation visits.

- Prepare your participants to give a short presentation to management and staff members about what they have learned and what they want to improve in the organisation.
- To put it differently, you are not training individuals, but you are training an organisation to collectively commit itself to implement the changes.
■ Show appreciation. Discuss with management that it is very important that staff members need to feel appreciated. As a trainer, you can show your appreciation after exercises and sessions. Invite management to a session or presentation and ask why they valued the training (sessions).
■ Discuss with management and staff that the training and Plan of Action is not per se about identifying NEW activities, but how to strengthen existing ones. Of course it can be concluded that new types of activities are essential. If you have that analysis and conclusion on paper, it makes it easier to talk to your donor organisations.
■ Discuss with management that implementing change costs time and support. Staff members need time and a supportive environment to change programmes effectively.

2.2. Full Programme

Session 1 – Introduction (2 hours)
■ Get to know each other & trainer
■ Ground rules and expectations
■ Background training & objectives

Session 2 – Health promotion and Planning and Support tool (10 hours)
■ Intervention mapping + planning and support
■ Analyse programme based on characteristics of effective interventions (as described in the planning and support tool)

Session 3 – Sexual Reproductive Health and Rights (11,5 hours)
■ Defining SRHR, norms and values in regards to young people and sexuality, sexuality and communication
■ Effective comprehensive sexuality education, reflection, what does it mean for your programme?

Session 4 – Stigma and discrimination (3,5 hours)
■ Naming stigma, reflection, myths and facts, testimonials, activities to address stigma and discrimination
■ Reflection what does this mean for your programme? Formulate recommendations

Session 5 – Gender inequality (5,5 hours)
■ Understanding gender and sex, gender roles and sex roles, power, gender and roles
■ Reflection what does this mean for your programme? Formulate recommendations

Session 6 – Measure effects on outcome level (8 hours)
■ Introduction measure effects on outcome level.
■ Practice and explanation on six steps

Session 7 – Finalise Plan of Action (1 or 2 hours)
■ Analysis conclusions and recommendations
■ Action Planning & endorsement of management

2.3. Decide on the programme

Discuss how many training days the organisation would like to spend. Of all the sessions we find the sessions on Health Promotion (Planning and support tool) and Sexual and Reproductive Health and Rights (SRHR) the most essential. It would mean a minimum of 4 days training to cover this. Besides we find the topics: stigma and discrimination, gender inequality and measure effects on outcome level very important. To include these three topics, you would need a total of 7 training days.

If you have 5 training days you could choose to cover one extra topic. Of course you can always decide to split the training, where you would do 3 days of training in the first week and 4 (or 2 or 1) more days in the second week.

Note – We recommend all organisations to finalise the analysis with the Planning and support tool and the Plan of Action within their own time and with support of management and other colleagues.

Complete programme – 7 days
If the organisation would like the full programme, they need 7 full days for training.

Day 1	Day2	Day 3	Day 4	Day 5	Day 6	Day 7
Introduction (2 hours) **Health promotion & Planning and support tool** (4 hours)	**Health promotion & Planning and support tool** (6 hours)	**SRHR** (6,5 hours)	**SRHR** (5 hours)	**Gender** (4 hours) **Stigma** (2 hours)	**Stigma** (3,5 hours) **Outcome M&E** (4 hours)	**Outcome M&E** (3 hours) **Plan of action** (1 hours)

Programme – 5 days
If the organisation has 5 days available, it is important to decide together if they want sessions on stigma, gender or want to focus on outcome M&E:

Day 1	Day2	Day 3	Day 4	Day 5
Introduction (2 hours) **Health promotion & Planning and support tool** (4 hours)	**Health promotion & Planning and support tool** (6 hours)	**SRHR** (6,5 hours)	**Option 1** **SRHR** (5 hours) **Gender** (1 hour) **Option 2** **SRHR** (5 hours) **Stigma** (1 hour) **Option 3** **SRHR** (5 hours) **Outcome M&E** (1,5 hours)	**Option 1** **Gender** (4,5 hours) **Plan of action** (1 hour) **Option 2** **Stigma** (2,5 hours) **Plan of action** (2 hours) **Option 3** **Outcome M&E** (5,5 hours) **Plan of action** (1 hour)

Programme – 4 days
If the organisation has 4 days available, we recommend the following sessions:

Day 1	Day2	Day 3	Day 4
Introduction (2 hours) **Health promotion & Planning and support tool** (4 hours)	**Health promotion & Planning and support tool** (6 hours)	**SRHR** (6,5 hour)	**SRHR** (5 hours) **Plan of action** (1 hour)

3. Preparation

Once you have commitment, staff members are identified, content of the training is decided on and the training days are planned, you need to prepare for the actual training sessions.

Step 1
Familiarize yourself with the content. Go through this guide at least once, especially all the exercises before you start with any activity.

Step 2
Practice in presenting. Familiarize yourself with the PowerPoint and exercises. Make changes to the PowerPoint if you feel that is needed. Is the content understandable enough for your target group (make an estimation of their experience, prior knowledge on HIV/AIDS and SRHR, terminology)? Do you understand everything yourself?

Step 3
Create a time outline for your sessions. Make changes if needed in the included agenda's for each session. Include the length of time for every activity (energizers, ice-breakers, sessions, exercises, group discussions and also plan in time for questions), total session and also what kind of activity. If you run out of time you can always write down questions on a Q&A and answer them later on.

Step 4
When preparing for a session ensure you have all materials needed and check if you can create the set-up you want to use in the chosen venue (guide of trainers, tools, PowerPoints, hand-outs, stationary).

Step 5
Read the information about facilitation skills.

4. Facilitation skills

The purpose of this chapter is to support you, as the facilitator, to learn how to use a facilitative approach when training and supporting CSOs. It includes guidelines on good facilitation and information about art of asking good questions.

4.1. The art of facilitation

What do we mean with facilitation?
Facilitation is the process of helping groups or individuals to learn, find solutions, or reach a consensus, without forcing or dictating a specific outcome.

What is the difference between being a trainer and a facilitator?
A trainer can be described as an expert of content that delivers information to its recipients. A facilitator has much more focus on the process of learning, from the beginning to the end, than on the content itself (the information). In facilitation, people are seen as participants that actively take part in the training process.

What is active learning?
Active learning is an umbrella term in which different methods are used to switch the responsibility of learning on the learners (participants). Different didactical methods need to be used to encourage active learning, such as reading, writing, discussing, presenting, analysing, evaluating, and solving problems. Active learning engages participants in two ways: by doing things (actions) and thinking about things we are doing (Prince 2004). These are the steps of active learning:

Step 1 Giving input
(presenting, lecturing, reading, case study, role play)

Step 2 Engaging in a structured activity
(feeling – thinking – doing)

Step 3 Sharing the experience
(reflecting, discussing and describing)

Step 4 Analysing the data
(critically working out options for a solution)

Step 5 Planning the solution
(deciding on a solution, looking what is needed to apply the solution)

Step 6 Plenary discussion
(presenting, discussing, and recommendations)

1. Direct Experience
(role play, case study, stories, real-world problems,...)

2. Reflection on experience
(group discussion/work)

3. Generate experience
(Generate principles in plenary discussion)

4. Implementation
(Action Plan)
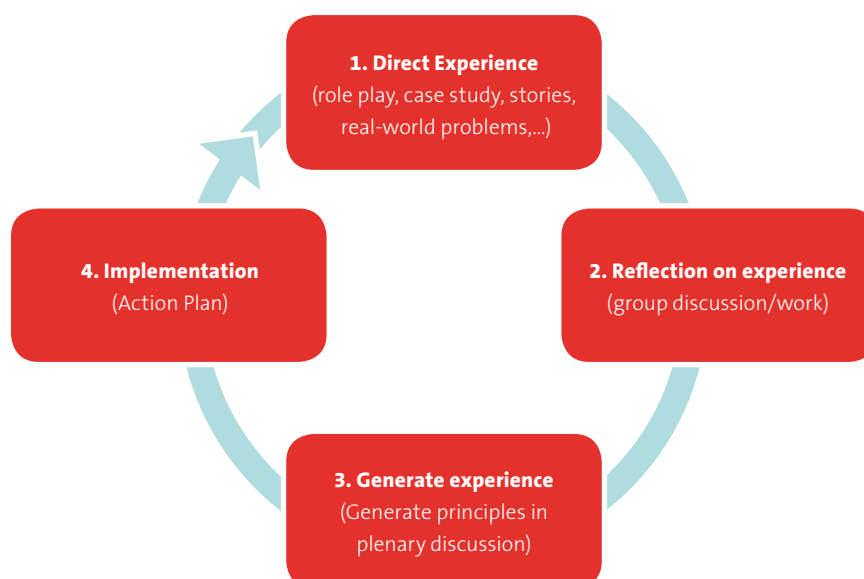
Cycle of learning process adults (Kolb)

4.2. Principles of good facilitation

Create a safe environment:
- Make ground rules together with the participants and give them ownership.
- Explain besides the process the expected output and roles of all involved.
- Help participants to commit themselves to the training.
- Give opportunities to start talking about other, not only about oneself..
- Start with neutral issues and continue to more explicit subjects.
- Organize lots of group work and ice-breakers/energizers. This gives safety and opportunities for personal exchanges.
- Work in mixed and/or single groups
- Let students choose their own groups.
- Be alert on gender in making groups.
- Promote that students help each other in tasks.
- Tell participants that feeling shame and embarrassment is normal if sexuality openly is discussed.

A good facilitator is a mirror, not a magnet. Help the participants to understand themselves, each other and the process; involve them and avoid that participants focus attention only to the facilitator. Communicate in a language of equality through collaboration, cooperation, agreement, and win-win relationships (we can all learn from each other, also you as facilitator from your participants).

Practicing "consciousness/concern of environment".
Give attention to all things to be seen directly and indirectly: see, listen and feel what happens.

Practice to be neutral, objective and non-judgmental. As a neutral and objective facilitator, you will avoid to become the target of the emotions of participants. Encourage yourself to identify the positive potential in every person and situation. Respect uniqueness and individual differences (everyone is entitled to his or her opinion!).

Focus on the process and the outcome. The main role of facilitator is to help participant to reach the objectives. Focus on this result with full involvement of participants. Perceive situations (that might be uncomfortable or complex) as challenges and opportunities' instead of problems. Commit yourself to give and receive feedback (make sure you start your sessions with exercises on expectations and hopes and end them with exercises in which participants can reflect and recommend).

Facilitation methods
1. Every person has a different style of participation: use a variety of didactical methods and means.
2. Use open questions, distancing techniques, paraphrasing, negotiate wordings and summarize.
3. Give clear instructions and enough time for group work/small group discussions. Make sure participants understand the task and the relevant concepts.
4. Systematically review what happens during the program and explain the relation between sessions
5. Systematically ask whether there are questions.
6. Provide supportive feedback and propose alternatives for solutions.
7. Let participants answer their own questions. Do not take over participants' tasks. It is more effective if participants they learn themselves.
8. Give enough time to answering questions. Count till 10 within your heart. Strive to get a correct answer.

Facilitation skills
- **Planning:** Plan your sessions and know your group before the training starts to make sure the activities are the right ones for your audience. Be aware of the situation of participants and continuously keep yourself aware.
- **Listening:** Focus on hearing/listening instead of on talking too much. However, explain and facilitate information and discussions.
- **Encourage interaction:** Encourage your individuals to participate, involve the whole group. Use humour, ice-breakers, open-questions, and give and receive supportive feedback. Create an open and safe environment. Eye contact: keep all participants involved. Use existing knowledge, experiences and skills. Encourage to share ideas and experiences and to exchange values and opinions.
- **Flexibility:** Change things to the needs of the group. Make time to answer questions or have additional discussions and/or exercises if needed.
- **Focus:** Follow the guide of trainers. Know where to go next. Do not make sessions to long or overfull. You might lose the attention of your participants. Be straight to the point.
- **Promoting ownership:** Let participants answer their own questions, lead their own discussions and presentations. However, encourage different points of views, and use examples and techniques to get the group to consider different frames of references.
- **Managing:** Facilitate participants through the process, sessions, set limits, encourage ground rules, provide examples, check on progress and reactions. Manage conflict constructively and helps the group make consensuses. Only disclosure if it has a functional meaning. Respond directly on signs of participants of being confused or frustrated; ask and talk to participants during breaks how they think the program is going.
- **Equality:** Listen to everyone's opinions, attitudes and feelings in a non-judgmental way. Respect people, be sensitive for emotions (also your own) and watch your

body language. Create relationships within the group. Be sensitive towards gender, social-economic aspects and cultures.

■ **Self-awareness:** Be genuine and yourself. Evaluate your own behaviour, skills and learn from mistakes. Be open about the limits of your knowledge and show enthusiasm. Appearance: be aware of gender, age, and the way of dressing. Body language: positive, supportive and attractive.

■ **Presenting information:** Explain the difference between facts and beliefs. Use clear and correct information; give clear instructions, and different didactical methods. Use a clear voice and intonation.

What is the role of the facilitator during workgroup?
There are different stages for working in groups:
■ Stage 1: **Forming** (Participants may feel excited, shy or insecure)
■ Stage 2: **Storming** (Participant may be insecure or unsure about roles. They start to understand the requirements)
■ Stage 3: **Norming** (Participants start to define and divide roles and start working)
■ Stage 4: **Performing** (Participants feel safe, responsibility and know what is expected)

Needed facilitation skills:
■ Stage 1: **Create a safe environment** (set ground rules, have fun, have clear aims, be personal and be confident).
■ Stage 2: **Give clear instructions and clear explanations**

(check the feasibility and relevance, encourage and support participants, especially support those who cannot find their roles and responsibilities in the group).
■ Stage 3: **Be available for support and clarification** (walk around and visit the different groups).
■ Stage 4: **Leave them alone, but check if they need help** (go to the front or middle of the room. Look around and ask how the groups are doing).

4.3. The art of asking questions

Questions are the most important tools for a facilitator. Actually, every statement you make should be in form of a question and every response you get must been seen as a valid answer. For example, do not state: **"Needs assessment is [...]"**, but instead start your session with asking **"What is a needs assessment?".**

Good questions are usually short, clear and have a single focus. However, there are different types of questions, which can be used for different purposes (see table below). Remember that asking good questions is like an art and that your skills will improve through experience, but that it is always good to reflect your habits of asking questions. Remember that it can feel frightening or uncomfortable to answer a question. Therefore, explain why you are asking questions (not to evaluate, but because you are interested or want to learn) and appreciate it if people answer your questions!

Type of question	Usage	Example
Open questions	As an invitation to talk	"Tell me about [...]?" "How is life these days?"
Closed questions	To acquire specific information	"What does health promotion mean?" "What is your program about?" "What do you mean?" "Why do you think that is a reason?" Avoid yes or no questions!
Reflective questions	To reflect your understanding of what has been said or understood	Repeat or summarize your understanding. For example: "So, you think knowledge is a determinant?" "Do you mean [...]?" "I am not sure I understood?" "Could you explain that a little more?"
Probing questions	To acquire opinions or feelings	"What is your view/opinion about [...]?" "What was it like to be young?" "Tell me a little bit more about [...]?" "Why [...]?"
Enabling questions	To encourage participants to speak openly, freely and honestly	Nod or "Mmmm-hmmss" "Right", "I see", "I understand" Sometimes a silence can also encourage people to talk. Repeat the question in a slightly different manner. Be flexible. If there is no response at all, move on. Support your participant by giving an example. Encourage your participants "I could not have said it better myself" or "Thank you for your answer".

Responding to questions participants might ask you.
During training and support sessions, participants might ask you many questions. Remember that you are not the "source of all knowledge" and that questions should be used for mutual learning. If someone asks you a question, it can be very tempting to give an answer immediately. Sometimes this is appropriate, but this is a form of consulting and not facilitating. If you have time, ask the participant what he/she thinks the answer is or if anyone else can help him/her. It is your role as a facilitator, to support participants in finding their own answers to their questions. Of course, you can enable them to sort out their thoughts, order them and raise further questions. Most of the time giving structure into a person's thinking is all they need. This enables them to solve their own problems.

What can you do if you do not know the answer?
Do not be nervous about answering questions, it is not your role to know everything. If so, ask the question to the group, say you will answer the question later on (after you have inquired more information yourself) or give it back as homework to the person who asked.

Non-verbal communication
Asking questions is one thing, but most of our communication is non-verbal. People appear to reflect your own attitude and behaviour. Therefore be open and positive.
- Tone of your voice (speak in a low, calm, open, enthusiastic, and clear tone)
- Facial expression (make eye contact, smile once in a while, laugh, have fun, but also be serious, when someone is speaking, visibly give them your attention)
- Body language (be open, do not close your arms, look around, make eye-contact, be flexible)

Part 2:
Training Sessions

Session 1: Introduction to training & support

A good start of your training is very important. It is therefore recommended to take your time to introduce the programme and make sure everyone is on the same page and knows what is expected. Also it is essential to create a nice atmosphere where all feel respected and valued. Important to emphasize is that you are not there to evaluating them, but to support them to analyse the strengths and areas for improvement of programmes. Start your training within some introduction exercises. After you present information about the programme, you can show the promotion video of this project and share the promotion flyer with participants to officially start the session.

Materials
- PowerPoint introduction (USB stick)
- Promotion video (on CD and USB)
- Flyer in appendix
- Statistics per country in appendix

Preparation
- Print or copy the flyer of the training
- Check and adapt the PowerPoint
- Check the promotion video
- Read chapter 4 on facilitation skills

After this session participants:
- Understand what the programme brings
- Feel the programme matches with expectations of each participant.
- Get to know each other.
- And trainer have built a positive relation

Agenda

Introduction	Time
1.1. Getting acquainted and expectations	30 minutes
1.2. Ground rules	15minutes
1.3. Expectations and MoU	20 minutes
1.4. Background Training and Objectives (PowerPoint + video)	30 minutes
1.5. Plan of Action for Improvement	20 minutes
	Total: 2 hours

1.1. Getting acquainted and expectations

The exercises that follow should be used at the beginning of training staff of a CSO. These activities are designed to help the group to get to know each other, to understand what is waiting for them in the session. These activities are important for you in order to get an understanding of the group, the type of people, their experiences and their expectations.

Exercise 1.1.1.

Getting Acquainted and Expectations

Preparation
Needed: Papers and markers
Time: 30 minutes

Objectives
- To provide an opportunity for the participants to get to know one another
- To understand the amount and depth of experience of the group members
- To set a nice atmosphere for sharing personal issues
- To get insight in participants' expectations

Instructions
1. Introduce yourself and welcome participants to the training.
2. Go over any logistics about timing, breaks, etc.
3. Talk briefly about the programme and what participants can expect from attending the sessions.
4. Ask the participants to get together in pairs with someone they don't know (so well).
5. Ask each participant to interview the other person sitting in the pair during 3 minutes, on questions like:
   - What is your name, function, social status (married, single, children, ….) and what is your BIG like and dislike?

- How was your sexuality education during your youth and from whom did you learn what? What was the most important thing you missed?
- What is according you personally the most interesting part of today's sexuality education for youth and what the most challenging part?

6. Gather everyone together in one big group again after six to ten minutes. Ask each person to introduce his or her partner to the group, and to share what they have learned about that person using the answers of the questions above.

7. Thank each pair after presenting each other and give each pair a big applaud.

Facilitator's Notes

The participants may be reluctant to participate in this activity at the beginning of the workshop. You may want to start this activity by being the first to share information about yourself before asking the participants to do the same. This is an approach a facilitator can use quite effectively to show an example for the participants on how to work, and is called 'modelling'. The facilitator 'models' a type of behaviour he or she would like to introduce in the group.

Exercise 1.1.2.

Making ground rules

Preparation

Needed: flipchart, marker, seizer, tape

Time: 15 minutes

Objectives

- To feel safe and confident in openly discussing the sensitive issue of sexuality
- To get aware of differences in individual participants' conditions needed for creating a safe atmosphere and to share and agree on common conditions as ground rules
- To feel encouraged to fully participate, give input and get ownership about what they want to learn
- To experience and learn a method on how they themselves can create a safe environment in their own class room (training)

Instructions

1. Write down "Ground rules" on a flipchart and invite participants to call out which conditions are needed to feel safe and confident in openly discussing the sensitive issue of sexuality and to realize full participation in the forthcoming training. Conditions can concern both rules for own and other participants' conduct and rules for facilitators' conduct as well as rules for the way of working, how to use the setting/room, et cetera.

2. If the Ground Rules are complete according the participants, check if all basic ground rules are in the list (see facilitators notes below).

3. Hang the flipchart with the Ground Rules at the wall in a way that it is visible for all participants during the training. If you move (in between) to another room, take the flipchart with you and hang it there.

4. If there anything happens during the training, which is not in line with the Ground Rules, please refer to them. If anything happens which should be a Ground Rule but is not yet defined as such, agree with participants to add a new Ground Rule in order to avoid repeating problems. In addition to Ground Rules you may appoint **per day** or for **whole** the training:
   - a time keeper;
   - a person responsible for the wrap up;
   - a person responsible for icebreakers;
   - a person responsible for the well-being on behalf of the group.

Facilitator's Notes

These are some of the basic ground rules that always should be included, such as:
- confidentiality: In case of sharing sensitive or personal issues, never disclose who said what, outside this training room.
- listen to each other and give each other enough time to speak up;
- respect differences in opinions'; 'We agree to disagree';
- be in time!;
- cell phones in silent mode;
- time management.

Exercise 1.1.3.

Expectations

Preparation

Needed: post-it papers (three colours), marker and flip chard, MoU

Time: 20 minutes

Objectives

- To establish clear expectations of what will and will not be accomplished in the training
- To be able to better tune in with the training into needs
- To decide whether the training content is complete enough

Instructions

1. Provide participants with one post-it paper of each colour and a pen. Ask them to write down the expectations they have towards a) the training methods, b) the facilitator an c) the other participants. Ask them to write one expectation per post-it paper.

2. Collect the post-it papers or invite participants to present one by one their expectations. During this, see if participants have similar expectations.
3. Cluster the expectations together with the participants on a flip chard, per category (content, method, facilitator, other participants,…).
4. Compare the answers with your agenda and objectives for the session. Point out which topics or areas of interest that you will address and those that you will not address.
5. For the topics that you will not address, you might want to offer the participants other ways to obtain the information.

MoU
6. Together with management you have developed a MoU for the upcoming training and support session.
7. Show a copy of the MoU and go through all the agreements.
8. Write down all questions that staff members have and discuss them with management.

Exercise 1.1.4.

Background training and objectives for the training

Preparation
Needed: PowerPoint Introduction + Promotion video
Time: 30 minutes

Objectives
■ Understand of why there is a need to address quality of SRHR and HIV prevention programmes for youth
■ Understand what sessions will be covered in the training

Instructions
1. Start with the promotion video.
2. Continue with the Introduction, PowerPoint introduction, explain:

> **Why is there a need for quality of programmes for young people?** – HIV prevalence rates among young people have slightly declined worldwide. But still there is a need for quality of SRHR and/or HIV prevention

programmes for young people, because: 2500 young people get infected every day with HIV. Young people (15-24 years) account for 41% of new infections among adults over the age of 15 years old in 2009. This means that an estimated of 5 million young people (15-24 years) are living with HIV/AIDS (2009). Also, an estimated of 2 million adolescents (10-19 years) live with HIV/AIDS (2009). Young women have a disproportionally high risk of infection in comparison to young men. They account for 72% of all infections in Sub-Saharan Africa (see figure 2)[1]. In 2012, 1.6 million people died from AIDS[2].

Facilitator's Notes
You can also replace the worldwide statistics on SRHR/HIV and young people with statistics explicitly for your country (see appendix). The figures focus on HIV/AIDS. Add figures on SRHR like teenage prenancy, abortion and sexual abuse.

What can we do? – Experience shows us that excellent programme's exist, however research also indicates that many organisations struggle with effectiveness (Kirby et al. 2006). The starting point of this training is that we think we all can do better on both an international and national/local level. First, we need to work together to achieve international commitment towards quality of programmes for young people. Second, we have translated what we know works into practise through the Planning and Support tool and the "Are You on the Right Track?" workbook. Thirdly, during this training the participants will be trained on how to implement quality evidence- and right based SRHR and HIV prevention programmes.

The Planning and Support tool – The Planning and Support tool is developed for organisations that already implement SRHR education for young people and want to analyse their programs, as well as those who are planning to develop a new programme. The tool can be used to identify what goes well and what needs improvement. You can strengthen your programme to become more effective. The tool is based on evidence, we learned from evidence and study's what works and what does not work. The tool is based on a study (Douglas Kirby) which analysed about 80 different programmes from countries in Sub Sahara Africa; from this study we learned what makes a programme effective. The participants will be trained on how to use the tool in session 3.

The goal of the training and support sessions – Through participating you will analyse your SRHR or HIV prevention programme for youth. Based on the analysis and evidence of what is known about effectiveness, you will be able to improve your programme. Both tools are very practical and easy to use, because it is developed by organisations like yourself. Organisations from Zimbabwe, Zambia, South Africa, Pakistan, Mali, Senegal, Ghana, Kenya, Nigeria and Ethiopia have used one or both of the tools and find it very useful and easy to use!

"We saw knowledge increasing when we evaluated our programme, but the pregnancies among young girls kept on being high. We didn't understand where we were going wrong. Now we know that behaviour is not only influenced by knowledge but also by skills and socials influences. Since we started measuring the other two determinants as well, we see where gaps are. This makes it much easier to determine our focus and improve our activities!' Enet Mukurazita, Director Young Africa, Zimbabwe.

What can participants expect?
- Training on Quality of SRHR and HIV prevention programmes for youth (7, 5 or 4 days).
- Two monitoring and support visits of your trainer/mentor.
- Analysis of quality of your programme activities for youth (Planning and Support Tool).
- Development of an Outcome evaluation Plan – to measure your programme activities on outcome level.
- Increased knowledge and skills on:
  - Sexual reproductive Health and Rights (how to communicate with youth on sexuality, norms and values).
  - Health promotion and Behaviour Change.
  - Stigma and Discrimination.
  - Gender Inequality.
  - Measure effects on outcome level.

- Availability of a Plan of Action for Improvement of your programme activities.
- All will result in improved programmes and you will be able to communicate more in-depth about the results of your programme.

Plan of Action for improvement

Together with the organisation you support, you will develop a Plan of Action for Improvement of their programme activities. After each session they will need to fill in the Plan of Action. It will be like a summary and conclusion of each session. This Plan of Action will be your entry point to discuss with the management of the organisation what changes need to be made in order to strengthen the programme activities. It is therefore very important that management is invited when you develop the final version of the Plan of Action. The Plan of Action is not per se about identifying NEW activities, but how to strengthen existing ones. Of course it can be concluded that new type of activities are essential. If you have that analysis and conclusion on paper, it makes it easier to talk to your donor organisations. Important to emphasize that STOP AIDS NOW! Or Rutgers WPF are not donor organisations

Materials
■ Copy of the Plan of Action for Improvement

Objective
■ Understand the importance and benefits of a Plan of Action for Improvement

1. Introduce the exercise and provide each participant with a copy of a Plan of Action. Explain how the Plan of Action is used:
   - After every training session, participants will reflect and analyse what goes well and what needs improvement in their programme.
   - The conclusions will be captured in a Plan of Action for Improvement.
   - The questions in the Plan of Action will guide the participants in decision making.
   - Participants will present the final plan to the management of their organisation and other staff of their organisation but also youth participating in their activities and ask their advice.
   - Make copies. Once the Plan of Action is approved by your organisation make sure that everyone has a copy of the final Plan of Action.
   - When the organisations are ready to implement the changes, you will plan the two support visits.

2. Start a group discussion. Ask the group what the benefits are of having such a Plan of Action for Improvement.

Facilitator's Notes
Remember that an organisation will only commit itself to change if they value change. Make sure that also during the training, and when you conduct support visits, you get a sense whether or not management and staff think that the training is important and beneficial.

Staff members are more likely (be willing) to implement change if more organisational members value the change:
- Encourage participants to share information and outcomes of the training with other staff members.
- Prepare your participants to give a short presentation to management and staff members about what they have learned and what they want to improve in the organisation.

Discuss with management that implementing change costs time and support. Staff members need time and a supportive environment to change programmes effectively.

1 This data is derived from the New Report on HIV Infections in Young People released, June 2011. This report, published by UNICEF with UNAIDS, UNESCO, UNFPA, ILO, WHO and the World Bank, describes the state of the epidemic in young people, the evidence for effective responses that address behavioural, social and structural challenges and prevent new HIV infections in young people (Unicef 2011). Download the report through this link: Unicef (2011) www.unicef.org/aids/index_58689.html

2 Data derived from AMFAR – Making AIDS History "Worldwide Statistics", www.amfar.org/About-HIV-and-AIDS/Facts-and-Stats/Statistics--Worldwide/ (updated 13-10-2013)

Session 2: Health Promotion – Behaviour & Planning and Support tool

Many organisations want to improve young people's quality of life and health. So, we want to implement SRHR programmes of good quality as well. However, developing high quality programmes is not easy. Experience and evidence from all over the world shows what does and what doesn't contribute to quality. In this first session on health promotion participants will get familiar and learn to work with the Intervention Mapping steps, and relate this to own SRHR and HIV prevention interventions by using the Planning and Support tool to reflect on the quality of their own work.

Materials
- PowerPoint – Health promotion
- Planning and Support tool, one for each participant
- Flipchart & markers
- Copies of the worksheet 1 to 7 for each participant
- Copies of the document: One step at a Time, one for each participant

After this session participant are able to
- Work with the Intervention Mapping steps in their SRHR and HIV prevention programmes.
- Analyse their own SRHR programme with use of the planning and support tool

Agenda

What	Time
2.1. **Introduction to our approach**	30 minutes
2.2. **Step 1: Involvement**	20 minutes
2.3. **Step 2: Needs Assessment**	230 minutes
2.3.1. What is a needs assessment (20 minutes)	
2.3.2. What are health problems in your community and related behaviours/ environmental factors? (80 minutes)	
2.3.3. What are related determinants? (130 minutes, including exercise)	
2.4. **Step 3: objectives**	115 minutes
2.5. **Step 4: Intervention Design**	110 minutes
2.6. **Step 5: adoption and implementation & Step 6 M&E**	55 minutes
2.7. **Planning and Support Tool & Plan of Action**	45 minutes
	Total: 10 hours

2.1. Introduction to our approach

Preparation
Needed: PowerPoint on Health Promotion
Time: 30 minutes

Objective
- List the six intervention mapping steps

Exercise 2.1.

Introduction to our approach

Instructions
1. Introduce the session, use the PowerPoint – Health Promotion and explain:

Introduction of the programme: Many organisations want to improve young people's quality of life and health. So, we want to implement SRHR programmes of good quality as well. However, developing high quality programmes is not easy. Experience and evidence from all over the world show what does and what doesn't contribute to quality. In this first session on health promotion and behaviour participants will get familiar and learn to work with the Intervention Mapping steps, and relate this to own SRHR and HIV prevention interventions by using the Planning and Support tool to reflect on the quality of their own work.

Objectives
- Participants work with the Intervention Mapping steps in their SRHR and HIV prevention programmes.
- Participants analyse their own SRHR programme with use of the planning and support tool.

2. Start a group discussion – Ask the group:
   - Who can explain what we mean with Health Promotion?
3. Continue with the PowerPoint and explain:

Definition of Health Promotion provided by World Health Organization: *"Health promotion is the process of enabling people to increase control over, and to improve, their health. This includes: health education, health policy making, – creating supportive environments, using social marketing approaches"*.

Intervention Mapping is a health promotion model used all over the world, including Africa and Asia. It was developed by researchers from the USA and the Netherlands. The model emphasises the use of evidence: information about the problems and needs of a target group (young people), available structures and resources to address these needs, and information about what works and what does not (effectiveness), in terms of approaches and methodology.

The Intervention Mapping model encourages programme developers to work in a systematic way. The model consists of 6 steps that are closely linked:
   - After involving all those concerned **(step 1);**
   - there is a comprehensive analysis of the problem **(step 2);**
   - this analysis results in detailed objectives **(step 3);**
   - all programme activities and materials are studied to see whether all objectives have been met **(step 4);**
   - to make sure the programme is adopted and implemented effectively, any barriers and possible structures and resources are analysed and addressed **(step 5);**
   - the end of the process is monitoring and evaluation **(step 6).**

One of the key features of the model is the behaviour change approach. Health risks and other problems are translated into the behaviour of various people. For example, the problem of large numbers of young girls with unplanned pregnancies is caused by their own behaviour (e.g. unprotected sexual intercourse) as well as by the behaviour of others (e.g. health care providers not providing young people with contraceptives).

This behaviour change approach can be used to analyse why people behave in a certain way. Why don't health care providers give condoms to young people? There are several possibilities: lack of knowledge; the attitude that young people should not have sex before marriage and therefore do not need condoms; lack of skills to approach young people in a non-judgemental way; and the influence of others or community norms. All these factors

– knowledge, attitude and skills – can be addressed in an intervention targeting the health care providers.

Benefits of the Planning and Support Tool – How has your own organisation benefited from the Planning and Support Tool? Explain how u have used it, what the effects has been? (the more concrete the better)

How the Planning and support tool will be used:
   - we will first discuss the content;
   - do different exercises;
   - we will end each session with the planning and support tool.

4. Start a group discussion. Ask the group:
   - Which steps do you take when they develop an intervention?
   Write down all the answers on a flipchart and make the link with the 6 IM steps.

2.2. Step one – Involvement

Preparation
Needed: PowerPoint Step 1 Involvement
Time: 20 minutes

Objective
■ Identify relevant stakeholders

Exercise 2.2.

Involvement

Instruction
1. Introduce Step 1.
2. Start a group discussion. Ask the group the following questions:
   - Why do you involve people when you develop and intervention?
   - Who can you involve?
   - How can you involve people?
   - What can you say about different levels of involvement?
3. Use the PowerPoint, add to the discussion and explain:

   • How you start with a stakeholder analysis: who should be involved in the project?
   • Organise involvement of all relevant stakeholders
   • Reasons to involve stakeholders:
     - create commitment;
     - improve the programme;
     - tailor the programme to the needs of target group and educators.

• Good to start a brainstorm: who are the most important stakeholders? And what is their stake/role in the project?

4. Go to the Planning and Support tool, page 21- 23. Make a start and fill it in (10 minutes).

Facilitator's notes
Many items in the Planning and Support tool are not covered in the session above. This is because the Planning and support tool also includes items that were found in the study by Douglas Kirby. This study looked at what makes Sexuality education programmes effective. Most effective programmes have included all these items.

2.3. Step two – Needs assessment

Preparation
Needed: PowerPoint Step 2 Needs assessment, flip over-makers, copy of the worksheets 1 to 5 (for each participant)
Time: ⬤ ⬤ ⬤ ⬤ 4 hours

Objectives
■ Describe how to conduct a needs assessment, using a logical model
■ Identify health problems, related behavioural and environmental factors and link with determinants

What is a needs assessment

Time: 🕐 20 minutes

Instructions
1. Introduce Step 2
2. Start a group discussion. Ask the group:
   - What is the purpose of doing a needs assessment?
3. Use the PowerPoint, add to the discussion and explain:

Needs assessment – Gives evidence for the problem. is there really a problem? And helps to understand the problem. This will help to design an intervention that addresses the actual needs of the target group.

Gives insight how the problem can be solved. Evidence can be used to convince stakeholders (donors, government) of the importance of the project.

You start with an assessment of the problem. Assess existing problems to get a clear picture of the needs of young people and their environment. Assess Sexual and reproductive health and rights (of young people) in your country/region/community. And you look at the behaviours and determinants that contribute to SRHR of young people and of others. Graph presented is a Logical Model for a needs assessment. This can be used to analysis a problem in a structured way.

Phase 4 Determinants	**Phase 3** Behaviour and Environmental Factors	**Phase 2** Health Problems	**Phase 1** Quality-of-Life

Personal Determinants → Behavioral Factors → Health Problems → Quality-of-Life

Personal Determinants → Environmental Determinants
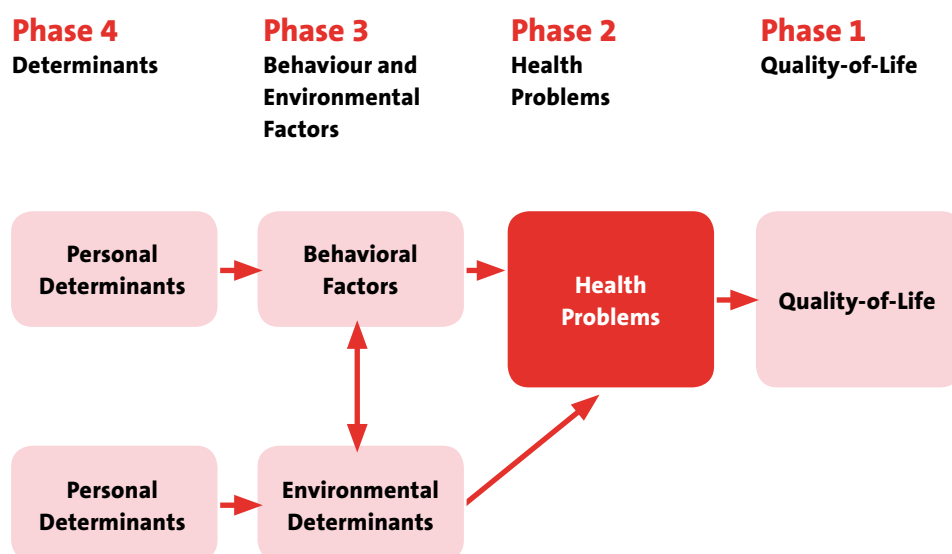
Source: Planning Health Promotion Programmes, an Intervention Mapping Approach
(L. Kay Bartholomew, Guy S. Parcel, Gerjo Kok, Nell H. Gottlieb)

4. Start a group discussion. Ask the group:
   - Who is familiar with this model (derived from PRECEDE/PROCEED model).
5. Use the PowerPoint and explain:

   When you analyse a problem you move from the right to the left. Considerations of Quality of Life include an assessment of the general hopes or problems of concern of target population. From an individual or societal perspective.

Exercise 2.3.2.

What are health problems in your community and related behaviours/ environmental factors?

Time: 80 minutes

Instructions to trainers

1. Form small groups or work in pairs.
2. Use Worksheet 1 (10 minutes). Each group writes down the health problems in their region or community.
3. Continue with worksheet 2 (15 minutes). Each group selects one health problem and answers the questions on the sheet. Let the groups present their findings.
4. Continue with the PowerPoint and explain (20 minutes):

   Which questions to ask when assessing health:
   - What is the problem?
   - Who has it?
   - What are the incidence, prevalence, and distribution of the problem?
   - What are the demographic characteristics of the population that faces the problem or is at risk for the problem?
   - Is there a community? What are its characteristics, including its resources and strengths?
   - What segments of the population have an excess burden from the health problem?
   - Where can the groups at risk, especially groups at excess risk or excess burden, be reached by a program?

   Behaviours and environmental factors:
   Identify the behavioural and environmental factors that could be linked to the health problem(s). When analysing the causes of health problems we look at:
   A. What behaviours are related to, and/or causing the problem?
   B. What environmental factors are related to, and/or causing the problem?

- Example indicators: **Behaviour:** low condom use, low uptake of STI/HIV testing, early sexual debut. **Environment factors:** medical care, social support, access to service, rules or laws, availability of resources, attitudes and behaviour of health care providers, peers, parents, employers.
- Ecological approach in health promotion.
- Emphasize that when we talk about environmental factors, we also talk about PEOPLE (also called Agents) in the environment.
- When we want to address environmental aspects that influence the health problems, we are looking at people too.

5. Continue with Worksheet 3 (30 minutes). Define behaviours- related to the problem. Which behaviours are of influence on the health problem? And define environmental factors.
6. Continue with the PowerPoint and explain (5 minutes):

   Finding the evidence:
   When you do an analysis like this it is important that you gather evidence. Secondary data collection: existing evidence, like lessons learned from other projects, literature review, reports. And you have Primary data collection: new evidence. You do this to collect data specifically for your situation and intervention/target groups. You can collect this through Quantitative research (using questionnaires) or qualitative research: (with FGDs, interviews, observations).

Exercise 2.3.3.

What are related determinants?

Time: 130 minutes

Instructions

1. Start a group discussion (15 minutes). Ask the group:
   - What are reasons for young people not to use condoms?
   Make a difference between reasons (determinants) related to the behaviour of the individual or reasons related to external factors.
2. Continue with the PowerPoint (30 minutes) and explain:

   Theory of planned behaviour – Determinants of behaviour. The list of reasons why young people may not use a condom are called determinants. All determinants together influence the behaviour. And all determinants are important to change a certain behaviour. Someone may have knowledge about risks of unprotected sexual intercourse. And at the same time not have skills to negotiate safe sex. The

more determinants you address and try to change in education, the more likely you are to be effective.

3. Use Worksheet 4 (30 minutes). Define determinants related to the behaviour of the people at risk. Provide an example:

Select a behaviour (of the people at risk):	What are the reasons why people show this behaviour?				
	Knowledge	Risk perception	Attitude	Skills/self-efficacy	Social norms
Low condom use	Lack of knowledge how to use it correctly, where to buy condoms Doesn't know condoms are safe (possible due to Myths)	Doesn't feel it to be necessary to use condoms (others are at risk of pregnancies, STIs/HIV not me)	Can't eat a sweet wrapped up in a paper – don't like the feeling of condoms	Do not know how to talk about condoms with partner	Fear of rejection when insisting on condom use Fear of being seen as promiscuous when having condoms or using them

4. Use Worksheet 5 (20 minutes). Now continue to define determinants related to (the actors within) environmental factors.
5. Plenary presentation (30 minutes). Each group gives one presentation. Ask the group who presents to think about which items would be possible/relatively easy to change and which are more difficult.
6. Go through the Planning and Support tool – step 2 (page 24 -26) and make a start (5 minutes).

2.4. Step three – Objectives

Preparation
Needed: PowerPoint on Health Promotion, Worksheet 6
Time: ⏱ ⏱ 115 minutes

Objective
■ Formulate objectives based on selected behaviours and determinants

Exercise 2.4.

Objectives

Instruction
1. Introduce Step 3, use the PowerPoint (20 minutes) and explain:

   What should change in the target group and/or the environment in order to deal with or reduce the health-related problem? Specify what should change, among whom? And, if possible, how much change within what period?

   How to make a flip. Explain that when you will develop an objective, you will make a flip – from unhealthy to healthy behaviour.

   Example: results of a needs assessment give the following info:

Behaviour	Knowledge	Risk perception	Attitude	Social influence	Skills
Low up take of health services by youth	Lack of knowledge on STI's Youth do not know where services are?	Do not see that STI's are a problem or think that STI cannot be treated	Prefer traditional healers.	Young people think that negative norms exist in regards to seeking services	Lack of confidence to attend services

   Example: objectives are related to the results of the needs assessment and can be like:

Behaviour	Knowledge	Risk perception	Attitude	Social influence	Skills
Young people seek help and support if they need this	Increasing knowledge about STIs and where they can get help and support Identify people or organisations who can assist them with SRH	Explain that STIs can be treated well if diagnosed soon enough	Express a positive attitude towards going to a health service provider	Describe how parents and peers and other community members view young people seeking help at a health service provider	Express confidence of going to a health care provider or counsellor

2. Use Worksheet 6 (40 minutes). Formulate objectives for the selected behaviours and identified causes, determinants.
3. Plenary presentation(30 minutes). Each group gives one presentation and discuss their results.

Planning and Support tool
4. Go to the Planning and Support tool (page 27 -30).
5. Each participant time (10 minutes) to get familiar with the questions in step 3 and read the related information in the back.
6. Discuss in small group or in pairs (15 minutes):
   - What stood out for you, what did you learn?
   - What will you bring back to your organization?

Facilitator's notes
Many items in the Planning and Support tool are not covered in the session above. This is because the Planning and Support tool also includes items that were found in the study by Douglas Kirby. This study looked at what makes sexuality education programmes effective. Most effective programmes have included all these items.

2.5. Step four – Evidence-based Intervention Design

Preparation
Needed: PowerPoint on Health Promotion, copy of One Step at a Time.
Time: ⏱ ⏱ 110 minutes

Objective
■ List the most effective methods to influence determinants

Exercise 2.5.

Evidence based intervention design - Step 4

Instructions
1. Introduce step 4, use the PowerPoint (15 minutes) and explain:

The main questions:
- Whether the intervention you selected is the most suitable intervention (evidence) or approach?
- Does this intervention address all the objectives? Knowledge, attitudes, self-efficacy, skills, social influence.
- Are the activities and materials of this intervention the best way to cover the objectives?
- Will you pre-test intervention with target group and educators?

How to identify Processes:
Be critical when you select interventions, approaches, activities, materials:
- does it really work and is it the most effective way? Find evidence that supports your choice. What creates the change?
- When a young person actively seeks for information, what makes that he/she learns better than when information is provided in a frontal approach?
- Why does a role play create more learning than telling someone how to practice skills?

The processes that create the change are often documented in theories of change. For example:
- Active seeking for information, makes that people are more involved, and will remember the information better than when they just hear it (theory: active learning, elaboration likelihood model).
- We learn when we observe others behaving in a certain way (theory: modelling, social cognitive theory of Bandura).

2. Form groups or work in pairs. Use worksheet 7 (30 minutes) and fill in:
   - Activities you have done to influence knowledge/ attitude/risk perception/skills/social norms.
   - How does learning take place?
   - Did it work?
3. Share the tool – One step at the time and introduce the document. Explain:

When you develop and implement an intervention, it is very important to work in a structured and planned way. Once you know:
- what the problem is;
- who your target group is ;
- what the exact behaviour is that you want to influence and;
- which determinants need to change: It is time to select the most suitable method and activity.

An example, you have seen in your environment that youth find it difficult to go to a health clinic. The behaviour you focus on is: health seeking behaviour. What are reasons for young people not to seek services? These are your determinants. For instance: youth are not able to recognize STI symptoms (knowledge), or they think they would not be at risk for getting HIV when having sex without a condom (Risk perception). Once you have done your analyses and have identified all these reasons (determinants) related to the behaviour you want to influence, it is time to select your methods.

Evidence shows us what most effective methods to influence these determinants are. For instance you can influence knowledge by providing a lecture on STI symptoms, but research tells us that people learn more when it is an interactive session.

Another example is that you can influence someone's risk perception with providing information about the risks, only if you combine this with a skill building session, so they will get the feeling they can DO something about it.

This document provides a summary on methods and theories in regards to behaviour change in general and to the determinants of behaviour, including knowledge. With this document we would like to give professionals working on SRHR and HIV prevention for youth extra support on selecting the most appropriate methods to change and influence determinants of behaviour. This summary is related to the Planning and Support Tool and derived from Intervention Mapping Toolkit, by Rutgers WPF and University of Maastricht.

4. Form small groups. Each group will discuss the final page of the document (summary of activities and methods), discuss the following questions (15 minutes):
   - Do you recognize this?
   - What is new for you? What stood out?
5. Share main findings with the whole group (10 minutes).

Planning and Support tool

6. Go to the Planning and Support tool.
7. Each participant takes 10- minutes to get familiar with the questions in step 4 and read the related information in the back.
8. Discuss in small group or in pairs – (15 minutes).
   - What stood out for you, what did you learn?
   - What will you bring back to your organization?
   - What would you like to conclude for your Plan of Action?

Facilitator's notes

Many items in the Planning and Support tool are not covered in the session above. This is because the Planning and Support tool also includes items that were found in the study by Douglas Kirby. This study looked at what makes Sexuality education programmes effective. Most effective programmes have included all these items.

2.6. Step five- Adaption and Implementation – Step 6 Monitoring and Evaluation

Preparation
Needed: PowerPoint
Time: ⏱ 55 minutes

Objective
■ Identify who to involve for the adaption phase

Exercise 2.6.

Adaption and implementation –

Step 5 and Step 6 M&E

Instruction

1. Introduce Step 5and step 6 and use the PowerPoint (20 minutes) and explain:

   Intervention Mapping step 5 addresses adoption (by facilitators or organisations) and implementation (actual use of the intervention). In other words: what should be done to make sure that the facilitators are willing and able to implement the intervention materials and activities?

2. Start a group discussion. Ask the group the following questions:
   - What should be done to make sure that the facilitators are willing and able to implement the intervention materials and activities?
   - Who needs to be involved? And when?

Planning and Support tool

3. Go to the Planning and Support tool.
4. Each participant takes time (20 minutes) to get familiar with the questions in step 5 and read the related information in the back.
5. Discuss in small group or in pairs -15 minutes
   - What stood out for you, what did you learn?
   - What will you bring back to your organization?
   - What would you like to conclude for your Plan of Action?

Facilitator's notes

Step 6 on M&E will be a separate training. We will use the Workbook, Are you On The Right Track. It is a follow up on the Planning and Support tool.

2.7. Planning and Support Tool – Plan of Action

Preparation
Needed: Planning and Support Tool & Plan of Action for Improvement
Time: ⏱ 45 minutes

Objective
■ Analyse quality of own programme with use of the Planning and Support tool
■ Express confidence to analyse programme

Exercise 2.7.

Planning and Support tool & Plan of Action

Instructions
1. Introduce the session. Repeat the goal of the tool & Plan of Action a nd discuss questions participants might have. (10 minutes), and explain:
   Goal of the tool & plan of Action:
   - Tool supports you to analyse your own programme – strengths and weaknesses.
   - Plan of Acton is there to make choices on which items you want to change.
2. Discuss in small group or in pairs the following questions (20 minutes):
   - What stood out for you, what did you learn?
   - How and when will you involve your collegues and management?
   - How and when will you finalise your Plan of Action for Improvement?
3. Look at the plan of Action for Improvement (Step 1 and 2) and make your conclusions (15 minutes).
4. Finalise your Plan of Action with your colleagues and management.

Facilitator's Notes
Discuss that the Plan of Action is not per se about identifying NEW activities, but how to strengthen existing ones. Of course it can be a concluded that new types of activities are essential. If you have that analysis and conclusion on paper, it makes it easier to talk to your donor organisations. Important to emphasize that STOP AIDS NOW! and Rutgers WPF are not donor organisations, and therefore cannot fund any programme activities.

❝ **Young people in my community lack access to youth friendly health services, the majority do not want elderly people to know about their SRHR problems. They visit crappy doctors for unsafe abortions and self-medicate to test STIs. Youth friendly services save lives!** ❞

Martin, Nigeria

Worksheet 1 – brainstorm Health problems

What are

health problems

young people face in your area?

Worksheet 2 – describe a health problem

Choose one health problem	
Describe the problem	
Whose problem is it?	
Is it a serious problem?	
What behaviours are related to it? And or causing the problem?	
What environmental factors are related? And or causing the problem?	

Worksheet 3 – behaviours of youth and environmental factors/agents

Health Problem	Health Problem
What behaviours (of youth) are of influence on this health problem?	What behaviours – of the actors in the environment – are of influence on this health problem

(ACTORS are for instance: policy makers, parents, teachers, health care workers, directors of a health care setting, friends, journalists) |

Worksheet 4 – determinants

Select a behaviour (youth)	What are the reasons why people show this behaviour?				
	Knowledge	Attitude	Risk perception	Social norms	Skills/self efficacy
1.					
2.					
3.					
4.					

Worksheet 5 – determinants environmental factors/agents

Actors in the environment (for instance: policy makers, parents, teachers, health care workers, directors of health care setting, friends, journalists) and what they DO	What are the reasons why people show this behaviour?				
	Knowledge	**Attitude**	**Risk perception**	**Social influence**	**Skills/self efficacy**
Example Actor: Health care worker Behaviour: (what do they do) Do not provide condoms to young people	Lack of knowledge on young people's right to services (more reasons can be added)	Think that providing condoms promotes sexual activity/ promiscuous behaviour	Do not think that young people are at risk of pregnancy/ STI/HIV as they are not having sex	Think/fear that colleagues will judge them if they provide condoms to youth	DO not know how to talk about sexuality with young people
Actor: Behaviour:					
Actor: Behaviour:					
Actor: Behaviour:					

Training Sessions

Worksheet 6 – objectives

Objective for the selected behaviour (youth) What is the desired behaviour you want to see?	Objectives in relation to the identified causes. (Determinants) What do they have to DO to show this behaviour (measurable and active) Example: list two health care centres in their own community				
	Knowledge	Attitude	Risk perception	Social norms	Skills/self efficacy
1.					
2.					
3.					
4.					

Worksheet 7 – determinants – activities

	What activity did you do to make a change? For example: folder or role play	How does learning take place?	Why did it work (or why not)?
Knowledge			
Risk perception			
Attitude			
Skills/selfefficacy			
Social norms			

Session 3: Sexual Reproductive Health and Rights

Sexual and reproductive health and rights (SRHR) is in almost all cultures surrounded by taboo. The main traditional message shared by almost all cultures is that sexuality is something for heterosexual adults, dominated by males, to be practiced within marriage and meant for reproduction. Based on this bias SRHR of young people is often limited to abstinence messages which not acknowledge the practical reality and the right to choices of young people to practice and enjoy sexuality whenever they are ready for it.

However, worldwide today's young people practice premarital sex, sometimes with someone of the same sex or a transgender. They need comprehensive sexuality education, not only to fight the HIV epidemic and SRH problems, but even more to meet their real needs and rights to complete information and to enjoy a happy, safe and joyful sexual life whenever that will start.

These two days on SRHR for young people make you familiar with tools and methods you can use to discuss or train quality SRHR education and HIV prevention programs for young people with the organization you will support.

Materials
- PowerPoint – SRHR day one (USB)
- PowerPoint SRHR day two (USB)
- Plan of Action for Improvement

After this session participants
- Accept and are willing to promote young people's sexual reproductive health and rights
- Openly communicate about sexuality including sensitive issues related to SRHR of young people
- Have the intention to promote and support young people in their role as decision makers and agents of change
- Have the intention to design and implement evidence- and right-based sexuality education programs

Agenda

Session	Time
3.1. **Introduction (objectives & agenda)**	20 minutes
3.2. **Defining SRH and SRHR**	
3.2.1. **Defining Sexual Reproductive**	75 minutes
3.2.2. **Human rights and young people Health**	75 minutes
3.3 **Reflection on who are young people**	
3.3.1. **How do we look at young people?**	75 minutes
3.3.2. **From minimum participation to meaningful decision-making**	60 minutes
3.3.3. **Statements on young people and sexual health**	45 minutes
3.4. **Sexuality and communication**	
3.4.1. **Define sexuality**	60 minutes
3.4.2. **Communicating sexuality with young people**	60 minutes
3.4.3. **Carousel game**	45 minutes
3.5. **Effective Approaches in Comprehensive Sexuality Education (CSE)**	90 minutes
3.6. **Reflection & Plan of Action**	45 minutes
Closing and evaluation	15 minutes
	Total 11 hours

3.1. Introduction

Preparation
Needed: PowerPoint SRHR day one
Time: 20 minutes

Instructions

1. Introduce the session and use the PowerPoint SRHR day one and explain:

   - The programme of the two day session on SRHR and related objectives.
   - After the session on SRHR participants:
     - Accept and are willing to promote young people's sexual reproductive health and rights.
     - Openly communicate about sexuality including sensitive issues related to SRHR of young people.
     - Have the intention to promote and support young people in their role as decision makers and agents of change.
     - Have the intention to design and implement evidence – and right-based sexuality education programs.

3.2. Defining SRH and SRHR

Exercise 3.2.1.

Defining Sexual Reproductive Health

Preparation
Needed: 3 papers (half A4) and one marker per person
PowerPoint slides on WHO definition of Reproductive Health (ICPD) and the draft definition of Sexual Health
Time: 75 minutes

Objective

■ Define Sexual and Reproductive Health

Instructions

1. Give each participant three papers (half A4 format) and a marker. Do not explain the purpose of the exercise yet. Let, the participants think they have leisure time and try to get in a relaxed and informal mood.
2. Ask participants to individually write spontaneously in capitals one word per paper, that pops into their minds when they hear the term SRH without (too much) thinking.
3. Form a circle with participants, in which SRH will commonly be defined by clustering participants' papers on the ground in the form of a pyramid. Appoint the place at the ground which represents the top (here fit spiritual, philosophic, abstract terms like health, rights, love, ...) and which place represents the more concrete basis (where words in related order will be laid down like STIs, pregnancy, safe sex, et cetera (60 minutes).

4. Invite one participant who would like to share as first his/her thought with the group. This person lays one of his/her papers down on the ground and explains why this word relates to SRH.
   Participants can pose clarifying questions:
   - What do you mean with this word and how does it relate to SRH according to you?
   - Is it a gender difference or a practice?
   - What kind of practice?
   - et cetera...
5. Start a group discussion. Discuss and arrange with the participants the exact place of the paper in the imaginary pyramid.
6. Invite participants to join papers with a similar or same word. Be critical about this similarity and ask them about the similarity.
7. Invite a new participant to share his/her view with a new aspect of SRH and repeat the procedure of explaining, clarifying questions, defining the exact place and joining with similar words. Cluster the different words/aspects of SRH and arrange them during the procedure with participants (as displayed in figure 1).
8. Discuss the overall pictures as a definition of SRH and look at important or missing aspects like relationships, interaction, intimacy, love, gender, pleasure, excitement, et cetera. Consider with participants together if there are differences in the input of both genders. Conclude with participants together on their own definition by making an overall summary of the different aspects of SRH, brought forwards by participants themselves.
9. End the exercise with comparing participants' definition with the definition of WHO on reproductive health and the draft definition on sexual health; use the PowerPoint slides on Defining Sexual Reproductive Health.
10. Conclude on a final definition to be further used in the training and in the development and implementation of sexuality education, so also used for young people without skipping the aspects such as rights, gender and pleasure.
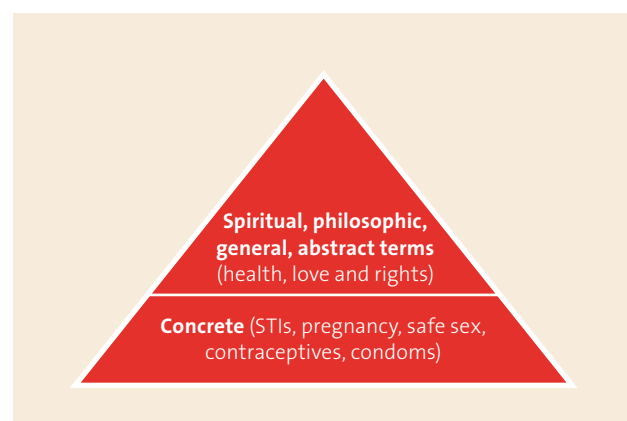

Figure 1: SRH pyramid

Exercise 3.2.2.

Human Rights and young people

Preparation
Needed: PowerPoint slides on Human Rights, Hand-out "the UN Convention on the Rights of the Child" (a copy for each participant), flipchart and markers
Time: 75 minutes

Objectives
- Identify (SRH) rights of young people
- Identify possible barriers for implementation and strategies (using opportunities) to overcome barriers

Instructions
1. Introduce the chapter on human rights and young people and use the PowerPoint on Human Rights (15 minutes) and explain:

   The rights for young people:
   - To be yourself – self-determination, own decision making, self-expression.
   - To information and education – on sexuality, sexual health, prevention of and support and on rights.
   - To accessible, affordable and confidential sexual and reproductive services.
   - To protect – towards sexual health problems and discrimination and be protected (e.g. sexual abuse).
   - To participate – in the design, implementation and evaluation of policies, programs and services.
   For more information go to: SRR Charter of IPPF
   www.ippf.org

   Optional: invite participants to individually read the hand-out with the rights and the instructions how to discuss these rights.
2. Form small groups. Appoint each of the rights to one of the groups in order to discuss this right.
3. Discuss the appointed right (between 15 to 20 minutes) and ask them to appoint someone within the group to write answers on the flip chart and someone, who will lead the discussion and who will present the outcomes of the discussion in the plenary. Answer the following question:
   - What does this right mean for you, your work and your environment?
   - In how far do you meet this right? What are barriers, what are opportunities?
   - Which suggestions do you have to overcome these barriers?
   - Which support do you need to remove these barriers and to improve these opportunities?

4. Close the discussion with a plenary presentation and discussion by all groups on the five rights. Conclude which action points have to be taken into account for planning to be taken up in the near future and who will be responsible for what. Share the leaflet (see hand-out) on the sexual and reproductive rights for young people according the UN Convention on the Rights of the Child in 1989.

3.3. Reflection on Who are Young People?

Exercise 3.3.1.

How do we look at young people?

Preparation
Needed: PowerPoint slides on how do we look at young people, hand-out Statements
Time: 75 minutes

Objectives
- List the differences between supporting and controlling young people
- Are aware of different opinions in regard to supporting and controlling and develop an own opinion on the most effective strategy
- List benefits of supporting people instead of (only) controlling them

Instructions
1. Introduce the exercise. Invite participants to individually judge each statement of the form (see hand-out) in how far they agree. Let them cross the numbers in the form which meet their judgment at the best (5 minutes).
2. Form small groups. Appoint the statements to each group. Ask them to discuss (15 minutes):
   - The differences in judgments and why these differences are there.
3. Discuss each statement in plenary. Focus on differences in opinions and the main issue in the subgroups. Check whether everybody agrees or not and why. Try to demonstrate views on the difference between support and control and how important support is instead of control.
4. Close the discussion with a presentation; use the PowerPoint slides on young people and decision making, referring to the UN Convention on the Rights of the Child in 1989.
5. Start a group discussion. Ask the group:
   - Why it is important to support young people as decision-makers?

6. Use the PowerPoint and explain:

> • Experience shows that young people learn best when they are involved in an activity, because a young person becomes interested, often remembers what has been done and why it was important.
> • Young people often feel more ownership of an activity when involved. This could make an activity more needs-based and thus more effective as well as sustainable. Research shows that young people will easier accept information or activities if introduced or facilitated by their peers.
> • Young people can help you gain entry into (difficult) target communities and build up trust relations.
> • Young people understand themselves and their needs best. Through participation you can strengthen their abilities and empower them to meet these needs. Also they know how it should be presented and what can be improved in activities.
> • Through their participation young people learn how to make own, thoughtful decisions and gain new experiences. Research shows that young people stick more to decisions made by themselves than to prescribed and imposed decisions.
> • Your organization will gain greater credibility with both young people and adults.

Exercise 3.3.2.

From minimum participation to meaningful decision-making

Preparation
Needed: PowerPoint slides on meaningful youth participation, Copy of the Checklist Participation (end of this chapter), the manual "Hear our Voices – Making sure Young People's Voices are heard!" and Dance4Life document "Meaningful Participation".
Time: 60 minutes

Objectives
■ Express the importance to see young people as decision makers and agents of change in relation to SRH
■ Discuss and select activities that can be done to support young people in their role as decision makers in relation to SRH

Instructions
1. Introduce the exercise (10 minutes). Give each participant a copy of the Manual. Introduce the manual shortly and explain:

> **❝ I believe that sexual health is a human rights issue and it is not negotiable. This has to be emphasised by policy makers. ❞**
>
> Namakando, Zambia

• This manual will show you how easy it can be to give the young people you work with, a voice in your policies, programs and interventions of an organisation. This could happen on different levels in your organisation – anything from asking for input on programme content to including young people on your Board.
• Meaningful Participation of young people is simply about giving space to the voice of the young people and taking what they are saying seriously. Experience shows that people learn best when they are involved in an activity, since an involved person becomes interested and more often remembers what they have done and why it was important. In addition, it will ensure that policies, programs and interventions are based on the real (and not the perceived) needs of young people and thus more effective.

2. Ask each participant to fill in the Checklist in a few minutes (added in this chapter).
3. Start a group discussion (15 minutes). Ask the group:
   - Can you share an example of meaningful participation?
   - Can you share examples how young people participate in your own organisation?
4. Use PowerPoint slides on meaningful youth participation and add to the discussion (hand out for more information) (10 minutes).
5. Form small groups. Look at the following questions and discuss (20 minutes):
   - Which activities are appropriate for your organization to involve young people (pages 33-35)?
   - How can you integrate this in your work with young people?
   - Who needs to be involved to make this happen?
   - What will be the result when you have made the changes?
   - What barriers do you foresee? How can you address these barriers?
7. Ask each group to share their main discussions (10 minutes).

Exercise 3.3.3.

Statements on young people and Sexual Health

Preparation
Needed: Statements on Young People and Sexual Health on flip chard, paper or PowerPoint
Time: 45 minutes

Objectives
- Explore different norms, values, and opinions in regard to young people and sexual health
- List the differences between opinions and facts
- Discuss sensitive issues related to sexuality

Instructions
1. Introduce the exercise and explain (5 minutes):
   Norms and opinions on young people and sexual health
   - We all have grown up with norms, values and opinions on life issues, especially when it comes down to young people and sexual health. As time flows, live issues change and cultural norms need to be adapted. Opinions can be rooted traditionally or can be adapted to today's young people. Remember that opinions are never wrong or right. However, they can be reasoned by people, based on incorrect information and not on evidence.
   - Evidence and facts can never be wrong or right. It is important to make the distinction between norms/values/opinions at one hand and facts at the other hand.
   - Norms/values/opinions should be based on facts and evidence. Talking about young people and sexual health might be a sensitive issue for most people.
   - An important step in talking openly about sexuality is to analyse our own norms and opinions on sexual behaviour: Where do they actually come from?
   What we perceive as socially accepted sexual behaviour is influenced, for example by:
   - Health – Is the behaviour healthy (does evidence exist?), seen from the perspective of the individual (and his partner)?
   - Rights – Is the behaviour in line with the human rights?
   - Cultural/Societal/Religious norms – Is the behaviour in line with social norms (religion, society, culture)?
   - Law – Is the behaviour in line with the law?
2. Define three corners in the training room; one is the corner ''AGREE'', one is ''DISAGREE'' and the third one is ''I DOUBT or DON'T KNOW'. Tell participants that you will read statements about young people and sexual health one by one and that they should choose after each statement read out, to go standing in the corner that is most fitting with their opinion about the statement which has been read out.

3. Share the first statement (see below) on the flip chard, paper or PowerPoint with the participants and read it out loud.
4. Ask participants to choose to go standing in the corner that is most fitting with their opinion. When all participants have chosen a corner, then ask them to convince participants standing in the other two corners, to join them in their own corner by using as valid as possible arguments. The statements about young people and sexual health are:
   - It is healthy for young people to experiment with sexuality and their sexual feelings.
   - Masturbation is not unhealthy.
   - Premarital sex is so common that we should accept it as healthy.
   - Sexuality has a different meaning for men and women.
   - Homosexuality is a disease or mental disorder.
   - Everything you learned in your youth about sexuality is determinant for your sexuality in the rest of your life.

5. Summarize after each statement the way how participants think about it and which facts and evidence are supportive to the differences in opinions.

Facilitator's Notes
Guide the debate in a way that everybody speaks only one by one and that everybody listen to each other. Correct arguments which are based on misconceptions or myths and give, if needed, facts and evidence. Be aware and remember participants on the fact that an opinion never is wrong; facts can only be wrong or right. Stress that each one respects personal opinions form other, but be clear that these never can be imposed to others when you are working in a rights-based way.

3.4. Sexuality and Communication

Exercise 3.4.1.

Define sexuality

Preparation
Needed: PowerPoint slides on sexuality
Time: 60 minutes

Objectives
- Are aware of the broadness of the concept of sexuality
- Can relate concrete sexuality issues to the different aspects sexuality entails: sensuality, intimacy, sexual identity, sexual and reproductive health and sexualisation
- Express confidence to discuss openly and explicitly with others about SRHR of young people
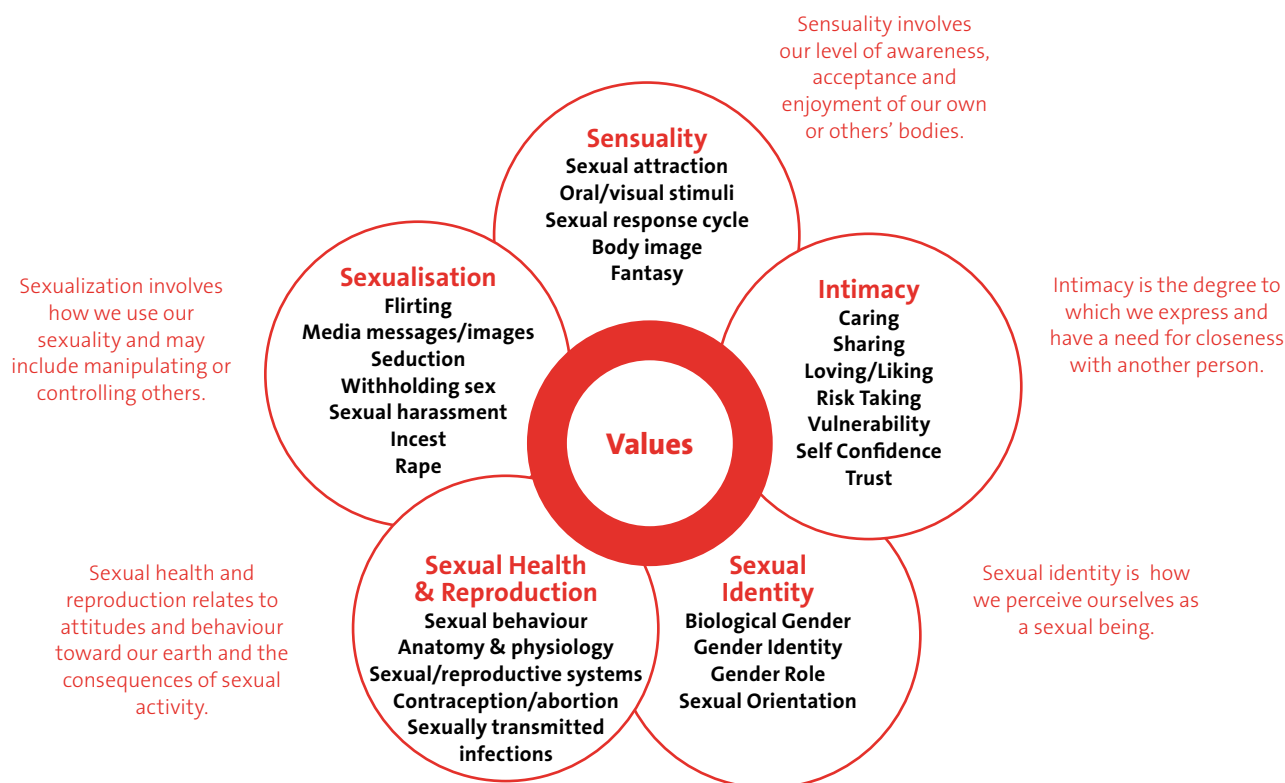
Sensuality involves our level of awareness, acceptance and enjoyment of our own or others' bodies.

Sensuality
Sexual attraction
Oral/visual stimuli
Sexual response cycle
Body image
Fantasy

Sexualization involves how we use our sexuality and may include manipulating or controlling others.

Sexualisation
Flirting
Media messages/images
Seduction
Withholding sex
Sexual harassment
Incest
Rape

Values

Intimacy
Caring
Sharing
Loving/Liking
Risk Taking
Vulnerability
Self Confidence
Trust

Intimacy is the degree to which we express and have a need for closeness with another person.

Sexual health and reproduction relates to attitudes and behaviour toward our earth and the consequences of sexual activity.

Sexual Health & Reproduction
Sexual behaviour
Anatomy & physiology
Sexual/reproductive systems
Contraception/abortion
Sexually transmitted infections

Sexual Identity
Biological Gender
Gender Identity
Gender Role
Sexual Orientation

Sexual identity is how we perceive ourselves as a sexual being.

Figure 2: Sexuality Circle

Instructions

1. Introduce the session and use the PowerPoint SRHR day two (20 minutes). Explain:

   The programme of session two on SRHR and related objectives.
   After the session on SRHR participants:
   - Accept and willing to promote young people's sexual reproductive health and rights.
   - Openly communicate about sexuality including sensitive issues related to SRHR of young people.
   - Have the intention to promote and support young people in their role as decision makers and agents of change.
   - Have the intention to design and implement evidence and right-based sexuality education programs.

2. Introduce the chapter and use the PowerPoint slides on sexuality and communication.
3. Start a group discussion. Ask the groups:
   - Write at a flip chart all words that pop into your mind when hearing the word sexuality.
   Provide the information in the PowerPoint, showing the different aspects of the broad concept of sexuality.
4. Ask the groups to indicate of each word they have written on their flip chard to which aspects of sexuality it belongs by adding the appropriate letter: a, b, c, d or e:
   a. sensuality
   b. intimacy
   c. sexual Identity
   d. sexual and reproductive health
   e. sexualisation

Exercise 3.4.2.

Communicating sexuality with young people

Preparation
Needed: three pieces of paper (half A4) and a marker (for each participant)
Time: 60 minutes

Objectives
- List different intimate and sexual acts in order of the degree of intimacy as well as the risk on SRH problems each act might be related to
- Express confidence to discuss openly and explicit with others about SRHR of young people

Instruction
1. Give each participant three papers (half A4) and invite them to write with a marker in capitals on each of the three papers, one intimate act/behaviour that young people perform if they have a love relationship.
2. Make a circle, in which participants will make an order of sexual acts according the degree of intimacy they represent: on top the less intimate behaviours like dating and writing letters and at the bottom the most intimate like vaginal and anal intercourse.
3. Invite the first one who is willing to share thoughts about a sexual act and the degree of intimacy it represents. This person describes in detail what you exactly do when you perform that act, explains his/her view in relation

to intimacy and lays his/her paper down at that place on the ground, which represents the degree of intimacy. Participants may ask questions about the act, what you exactly do and/or discuss the degree of intimacy.

Facilitator's Notes

Pose clarifying questions, e.g. what do you mean with watching blue movies, is it fun?, what do they exactly do during watching?, how intimate is it?, et cetera and encourage participants to pose such questions as well. Create a relaxed atmosphere by making jokes and encouraging everybody to laugh and have fun.

4. Join papers with a similar or same word. Be critical about this similarity by posing questions like 'Does petting exactly mean the same as we already discussed?'
5. Ask for another participant to share his/her view with a new intimate instead of sexual act and repeat the procedure of clarifying questions, placing the act on the ground and joining with similar words.
6. Cluster with the participants the different intimate instead of sexual acts in a row; from hardly intimate up to very intimate.
7. Finish ordering intimate sexual behaviours and ask participants which intimate instead of sexual acts represent a risk in SRH problems (STIs, HIV, unintended pregnancy) and discuss per act if and which education is needed.
8. Group discussion – Discuss with participants which acts young people can still perform while they practise abstinence and define together what abstinence means, what virginity means and what penetrative sex means.
9. Conclude with participants on what they have learned.
10. Present and discuss the definition of sexuality of the WHO and use the PowerPoint slides on sexuality.

The Carousel Game

Preparation

Needed: envelopes (1 envelope per couple), sets of cards
Time: 🕐 45 minutes

Objectives

■ Discuss sensitive issues related to sexuality through personal, open and explicit communication

Instructions

1. Have enough envelopes: 1 envelope per couple. Per envelope you need the copies of all questions in the hand-out below. Cut the copies of all questions in a way that you have each question separate at paper. Put in each envelope a set of all questions.
2. Have enough chairs: 1 chair per person. Make an inner and outer circle of chairs, in which chairs are placed opposed to each other. Be sure that there is enough space between the couples of chairs to provide privacy.
3. Ask participants to choose a partner and to sit as couple opposite each other at the chairs. Give the outer circle an envelope with the set of all questions in it and ask them to wait looking into the envelope till the instruction is clear.
4. Explain that they are going to discuss the sensitive topic of sexuality, but in a personal way.

Facilitator's Notes

Repeat the ground rules and especially the one about confidentiality: what is said in this training is confidential and you are not allowed to disclose a personal issue of somebody outside this training. Add also the ground rule:

nobody should be pushed to speak out; everybody has the right to speak and to be silent.

5. Explain the rules of the game:
   - The ones having the envelope take one question out the envelope and judge whether they want to talk about that question with heir partner. If not, they put the question back and judge a new one till they find a question they want to talk about.
   - If they have such a question, they should give the question to their partner who judges whether he/she wants to talk about the question. If not, put that question back in the envelope and continue the procedure till both partners agree about a question they want to talk about.
   - The couples wilt have the opportunity to discuss as many questions as they agree for about 7 to 10 minutes.
   - After 7 to 10 minutes the game leader says Stop, 1 (or 2 or 3) chair(s)!, meaning that the outer circle has to take the envelope with all questions with them and move clockwise 1 (or 2 or 3) chair(s) to the right. The inner circle sticks to their chair.
   - The new couples start the procedure again of finding those questions both agree about to talk, et cetera
   - Depending of the time, after 3, 4 or 5 rounds the game is over.
6. Start the game and depending of the time, continue for 3, 4 or 5 or more rounds. Stop the game and ask the participants to form and sit in a circle.
7. Start a group discussion. Discuss the game by first inviting participants to share their experiences:
   - How was it? How did it feel? Was it safe to discuss sexuality in such an open and personal way? Does it make a difference when you know your partner/you have the same gender/a lot younger or older/a different hierarchic position in the organisation?
   - Why was it possible to discuss sexuality in such an open, personal and explicit way?
8. Conclude the session with the following remarks:
   - Ground rules about a safe atmosphere are crucial as a condition.
   - Each question was agreed upon by both of the couple before talking, stressing that everybody has the right to talk about a question or not.
   - Rights and respect are necessary conditions for discussing sexuality in an open, personal and explicit way in spite of the taboo culture.
   - A safe atmosphere with ground rules about confidentiality, rights and respect are needed to be able to conduct any sexuality education program or training and end with qualities of a good educator/facilitator.

3.5. Effective Approaches in Comprehensive Sexuality Education

Exercise 3.5.

Effective approaches in comprehensive sexuality education

Preparation
Needed: PowerPoint slides Effective approaches
Time: 90 minutes

Objectives
- List the differences of effectiveness between comprehensive sexuality education and abstinence-only messages to improve young people's SRH
- Identify principles of evidence- and right-based comprehensive sexuality education
- Recognize benefits of evidence- and rights-based CSE
- List the requirements of an educator of comprehensive sexuality education, including the objectives of a training of educators
- know that the implementation of comprehensive sexuality education goes beyond the classroom and needs a policy on SRHR in schools

Instructions
1. Introduce the chapter and use the PowerPoint slides on effective approaches (15 min.).
2. Form 5 groups and ask each group to appoint someone who will write the group outcomes at a flip chart and someone who will present the outcomes (15 min.).
3. Give each group one of the following questions (25 min.):
   - What are the main differences between abstinence-only and comprehensive sexuality education programs?
   - What does the concept of comprehensiveness means in comprehensive sexuality?
   - What are principles of a rights-based comprehensive sexuality education program for young people?
   - Which issues should be included in comprehensive sexuality for young people, aged 12 to 19 years old? And what would be a logical sequence of issues?
   - Which behaviours and determinants do educators need to perform in order to effectively facilitate comprehensive sexuality?
4. Ask the groups to present their outcomes and discuss the issues in a way that the content of all slides of the PowerPoint are covered. If needed use the PowerPoint on effective approaches for more explanation (20 min.).
5. Conclude and share a copy of the slides (9-24) of the PowerPoint with each participant (5 min.).
6. Introduce the topic school policy on sexual health and use the PowerPoint slides on school policy (10 min.).

3.6. Reflection & Plan of Action

Exercise 3.6.

Intention to implement activities to support young people as decision makers

Time: ⏱ 45 minutes

Objectives
- ■ Discuss and select activities that can be done to support young people in their role as decision makers in relation to sexuality, SRH and Rights
- ■ Express confidence to implement activities to support young people in their role as decision makers and agents of change in relation to SRHR

Instructions
1. Form small groups or work in pairs.
2. Ask each group to answer the following questions:
   - Think about all the SRHR session you have just done. What you have learned or what has been an eye opener?
   - How can you integrate this in your work regarding interventions for young people?
   - Who needs to be involved to make this happen?
   - What will be the results when you have made the changes?
   - What barriers do you foresee? How can you address these barriers?
   - What else would you need to make the changes a success?
3. Ask each group to share the most important outcomes of the discussions with the whole group.
4. Fill in the Plan of Action for Improvement. Select activities based on the reflection above.

Facilitator's Notes
Discuss that the Plan of Action is not per se about identifying NEW activities, but how to strengthen existing ones. Motivate participants to be as concrete and specific as possible.

❝ Let's talk about sex – cause the more we talk, the more we know. The more we know, the more we be open and we decrease stigma! ❞

Tshepiso, South Africa

Hand-out 3.2.2.
The UN Convention on the Rights of the Child

The UN convention on the rights of the child and sexual and reproductive health and rights

A Young Person's Guide

All children are born with fundamental human rights. Rights define what you are free to do, as well as the information and services to which you are entitled.

What is the Convention on the Rights of the Child (CRC)?
The CRC (1989) is a set of legal rules. The CRC has 54 different paragraphs (called articles) that cover the rights of children and young people. Some of these rights apply to your sexual and reproductive health.
191 Governments around the world have signed and approved the CRC. They have promised to make sure that all children and young people below the age of 18 years, survive, grow, are protected and participate as active members of society.

What is this leaflet all about?
In this leaflet you will find out how some of the articles in the CRC relate to your sexual and reproductive health. The articles taken from the CRC are in quotes, in the coloured boxes below each article you will find information on how this article can be interpreted to protect and/or advance your sexual and reproductive health.

What are Sexual and Reproductive Health and Rights?
These rights include being able to:
- have a happy life and personal relationships
- decide yourself whether to be sexually active or not
- enjoy a safe and healthy sex life in which you protect yourself and are protected by your partner against disease and illness
- feel completely well and happy in your body and your mind
- decide if, when and how many children to have
- make sure that women and girls stay healthy while pregnant
- make sure that babies are born healthy

Based on the Programme of Action of the International Conference on Population and Development Paragraph 7.2

Article 2
States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status…

All the rights set out in the CRC apply to all children and young people under the age of 18.

All Children Have Rights
These rights belong to you and no one can take them away from you, no matter whether you are a girl or a boy, rich or poor, married or unmarried, whatever your religion, colour, nationality, sexual orientation, disability, or health status, for example, being HIV-positive.

The Right to Life

Article 6
1. States Parties recognize that every child has the inherent right to life.
2. States Parties shall ensure to the maximum extent possible the survival and development of the child.

Every child has the right to live, grow up and have a healthy life.
Some sexual and reproductive health problems, such as HIV/AIDS and unsafe abortion, can lead to illness and death. With information, skills and services that help you to make informed choices, you can protect yourself and others from unwanted pregnancy, HIV and other sexually transmitted infections.

The Right to Health

Article 24
States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.

Every child has the right to be as healthy as possible and to be able to access the best possible health-care services.
For example:
You can visit a doctor or nurse to receive the full range of sexual and reproductive health services that are available and legal in your country, including contraceptives, abortion services and understandable advice about your sexual and reproductive health.
When you visit a health centre you are made to feel welcome, safe and comfortable.
Services should be affordable for you.

No one should turn you away or stop you from receiving services, or demand that you get someone else's permission first (e.g. the permission of a parent or spouse, if you are married.)

The Right to Privacy and Confidentiality

Article16
No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation...

A child's private life should remain private.
If you tell a medical person or a teacher something that you don't want anyone else to know, then he or she should respect your privacy. If you have been abused, adults may have a duty to inform others who can help protect you or help you protect your and your interests.

The Right to be Protected from Harmful Practices

Article 24
...States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children...

Practices that are bad for children's health should be stopped.
Some traditional practices are bad for your health and against your rights, such as early and forced marriages; female genital mutilation (FGM) which is also called female circumcision or female genital cutting and killing girls in the name of honour. You have the right to know about the dangers of such practices and be protected against them.

The Right to Freedom from Abuse and Exploitation

Article 19
State parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child...

Article 34
States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse...

No one, including people who care for children, should physically, sexually or mentally hurt a child. The government should make sure that all children are protected from abuse and must also take action to help abused children.
This means no one, including the people who take care of you, should force you to do things with your body that you do not wish to do. You have the right to say no to sex or any other unwanted act such as being touched or being forced to touch other people. Child trafficking, child pornography and prostitution are against your rights.

Article 39
States Parties shall take all appropriate measures to promote physical and psychological recovery and social reintegration of a child victim of: any form of neglect, exploitation, or abuse; torture or any other form of cruel, inhuman or degrading treatment or punishment.

If a child has been hurt, abused or neglected, support services should be provided to help the child deal with his/her experiences, feelings, and physical health needs.

The Right to Education

Article 24
... States Parties... shall take appropriate measures:
(e) To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;
(f) To develop preventive health care, guidance for parents and family planning education and services...

All children and young people have the right to information on good health practices.
You should be given wide-ranging and easy to understand information on sexual and reproductive issues that will let you feel comfortable with yourself, your body and your sexuality. This information should enable you to make your own decisions about your sexual and reproductive health. You should be given this information without being judged or being made to feel embarrassed or guilty.

Article 28
States Parties recognize the right of the child to education. With a view to achieving this right progressively and on the basis of equal opportunity, (a) Make primary education compulsory and available free to all;...

All children should have full access to free primary education.

Everyone has the right to receive an education. You should not be denied education simply because you are a girl, are poor or have a disability. If you become pregnant or have children you still have the right to go to school.

Article 29
... the education of the child shall be directed to .....
b) The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;...

Education should help you to understand your rights and also to respect the rights of others.

The Right to Participation

Article 12
State parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views, of the child being given due weight in accordance with the age and maturity of the child...

Every child and young person has the right to express his or her views.
When decisions are made about you and your sexual and reproductive health, you have the right to be a part of making that decision. Your feelings and opinions should be listened to and taken into consideration.

Article 13
The child shall have the right to freedom of expression; this right shall include freedom to seek, receive, and impart information and ideas of all kinds...

Every child has the right to find out, receive, and pass on information.
You have the right to learn about sexual and reproductive health matters, for example, how your body works, pregnancy, contraception and sexually transmitted infections, and to talk to friends about what you learned.

Article 14
State parties shall respect the right of the child to freedom of thought, conscience, and religion...State Parties shall respect the rights and duties of the parents and... legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacity of the child.

Children and young persons have the right to freely think and believe what they like as long as it does not harm anyone else.

You have the right to form your own views about sexuality and reproductive health issues. As you grow older your views about your sexual and reproductive health should be taken more seriously into consideration.

Article 15
State parties recognise the rights of the child to freedom of association and to freedom of peaceful assembly...

Children have the right to meet friends and form groups to express ideas, so long as it does not break the law.
You have the right to publicly demand what you are legally entitled to. Some ways of doing this include meeting with friends and discussing issues or forming groups.

Your government is responsible for making sure you can enjoy all of your rights protected by the CRC. By agreeing to the Convention on the Rights of the Child, governments must make sure you are safe, happy and healthy keeping in mind your 'best interests'. A United Nations 'Committee on the Rights of the Child' makes sure that governments are protecting your rights. How these rights apply to you will vary according to how old you are. This means that rights are important to you in different ways at different ages. Governments, parents and adults should keep in mind that as you grow up they need to respect your capabilities and encourage you to act and think for yourself. Exercising your rights responsibly means that you must understand that other people have rights, too, and you have to respect them. We only have space here to put some parts of the CRC articles. You can read the full text of the Convention at www.unicef.org/crc/crc.htm The IPPF Charter gives you more information on your sexual and reproductive rights at www.ippf.org/charter/index.htm

Hand-out 3.3.1.
Statements on how do we look at young people?

How do you look at young people?

1. Things are much better for young people then they were 20 years ago				
Agree				**Disagree**
1	2	3	4	5
2. Young people need more freedom and less interference from adults				
Agree				**Disagree**
1	2	3	4	5
3. Young people should be encouraged to enjoy themselves				
Agree				**Disagree**
1	2	3	4	5
4. Young people should be allowed to choose their own religion				
Agree				**Disagree**
1	2	3	4	5

Hand-out 3.3.2.
Checklist Youth Participation

Your checklist:
Ensure young people can participate

You can use this checklist to make sure young people are able to participate.

1.	Is the workshop or meetings at times when young people can attend?	☐ Yes ☐ No ☐ Does not apply
2.	Is the workshop/meetings venue accessible to young people OR is transport available?	☐ Yes ☐ No ☐ Does not apply
3.	Is food provided at the meetings or workshop?	☐ Yes ☐ No ☐ Does not apply
4.	Is equipment access and support available for the young people, if needed?	☐ Yes ☐ No ☐ Does not apply
5.	Does the organisation have clear policies and procedures about how young people are treated at workshops or in meetings?	☐ Yes ☐ No ☐ Does not apply
6.	Is appropriate training to reach the workshop or meetings' aim accessible by young people?	☐ Yes ☐ No ☐ Does not apply
7.	Is the decision making process in the meetings or clear and understood?	☐ Yes ☐ No ☐ Does not apply
8.	Are the young people in the meeting or workshop representative of the programme's target population?	☐ Yes ☐ No ☐ Does not apply
9.	Do young people have access to different ways of expressing themselves in the workshop or meetings?	☐ Yes ☐ No ☐ Does not apply

Training Sessions

Hand-out 3.3.2.
Participation Flower

The Flower of Participation is developed by CHOICE in order to give a better understanding of youth participation. The flower is based on 'the ladder of participation' which can lead to a focus on hierarchy, where the highest level is the ultimate goal. Instead, the flower is based on the acknowledgement of young people's rights in relation to the different needs and realities of youth participation.

The lowest steps of the ladder are the leaves, because these forms are not meaningful participation. The flower petals represent the different variations of responsibility that young people can have or take but all are based on equality. This shows that there are different forms of participation that in practice, work differently and lead to different results. The form of participation must fit the program/project and the objectives of the program/project. Even more important: it must fit the needs of the involved young people. Because of this the different forms of participation can even take place simultaneously within one organisation or program. The form of participation and the amount of responsibility of the youngsters depend on several factors. The most important factors are:

- Level of training (knowledge is power)
- Available time
- If these people are volunteers or getting paid for their work
- Available funds
- The level of investment of adult organizations in all of the above

The different forms of participation

1. **Manipulation** (adults use young people to support a good cause and at the same time they pretend the good cause is inspired by young people).
2. **Decoration** (young people are being used to support a good cause, or give it more zest, even though the adults don't give the impression as if the good cause is inspired by youth).
3. **Tokenism** (young people seem to have a voice, but in reality they have little to no choice in what they do or how they get involved).
4. **Assigned but informed** (young people get a specific role and get informed on how and why they are involved in the program or project).
5. **Consulted and informed** (young people give advice on projects or programs developed and executed by adults. Young people are informed about how their advice will be used and what the outcome is of the decisions the adults have made).
6. **Initiated by adults, shared decisions with young people** (this happens when projects or programs are initiated by adults, but decisions are shared with young people).
7. **Initiated and executed by young people** (this happens when young people initiate and execute a program or project. Adults are only involved in a supporting role).
8. **Initiated by young people, shared decisions with adults** (this happens when programs or projects are initiated by young people whilst decisions are shared with adults and young people. These projects are supportive and motivational for young people, while, at the same time, young people can profit from the experience and expertise of adults).

Information is copied from www.choiceforyouth.org/

Hand-out 3.4.3.
Questions of the Carousel Game

RutgersWPF

How much do you masturbate, and how do you feel about it?

RutgersWPF

Did you ever have sex with more than one partner? How was that for you?

RutgersWPF

Do you feel guilty when you imagine making love with someone other than the partner you have sex with at that moment?

RutgersWPF

Are you attracted to persons of your own sex?

RutgersWPF

Are men who do the housekeeping less masculine?

RutgersWPF

Can you completely "wrap up" in someone?

RutgersWPF

Are you jealous?
What happens if you are?

RutgersWPF

Do you think sex is important?

RutgersWPF

Do you dare to masturbate in the presence of your partner?
Did you ever do that?

RutgersWPF

How was your first sexual experience?

RutgersWPF

If your partner would want to have anal intercourse with you, what would you do?

RutgersWPF

When having sex, do you ever have fantasies about having heterosexual sex (while your preference is homosexual) or homosexual (while your preference is heterosexual)?

RutgersWPF

When making love, do you sometimes feel that there seems to be an obligation to come?

RutgersWPF

Do you think men like to talk more about their sexual adventures than women do? Why?

RutgersWPF

What do you like or/and dislike about pornography?

RutgersWPF

Did you ever consider that you were homosexual?

RutgersWPF

Did you ever feel used in a relationship? Did you ever "use" someone yourself?

RutgersWPF

Do you get sexually aroused very quickly? When?

RutgersWPF

Do you think your ideas about sexuality are different than your actual behaviour?

RutgersWPF

Does someone's voice have a sensual influence on you?

RutgersWPF

Do you think you are sexy?

RutgersWPF

Do you keep private parts as clean as your hands and face?

RutgersWPF

Did you ever fake an orgasm?

RutgersWPF

Did you ever keep your relationship a secret (e.g. from your parents or partner)? How did you feel about that?

RutgersWPF

Do you like it when someone of the same sex touches you?

RutgersWPF

When do you find someone erotically attractive?

RutgersWPF

Are you proud of your sexual "equipment"?

RutgersWPF

What do you dislike most about sex?

RutgersWPF

What do you most like about sex?

RutgersWPF

Did you ever regret having a steady relationship?

RutgersWPF

Were you ever upset because your partner wanted to make love to you while you wanted to sleep?

RutgersWPF

How many sexual relationships can you handle at the same time?

Session 4: Stigma and Discrimination

Discrimination of and stigma against people living with HIV and populations at risk, such as young people, are important rights-related obstacles hindering an effective AIDS response. HIV related stigma has long been recognized as one of the main obstacles to HIV prevention, care, support, treatment and yet little has been done on a large scale to combat the HIV stigma (ICRW, 2004). Stigma is a complex social phenomenon or process that results in a powerful and discrediting social label and/or radically changes the way individuals view themselves and are viewed by others. Although many adults exhibit tolerance toward HIV positive individuals, stigma is still a problem that affects the everyday lives of PLHAs (People Living with HIV/AIDS). For this reason we find it very important to include a session about stigma and discrimination in this training. Sessions are derived from the Toolkit for Action: Understanding amd Challenging HIV stigma (ICRW).

Materials
- Guide addressing needs of young people living with HIV
- PowerPoint exercises Stigma and discrimination
- Plan of Action for Improvements

After this session participants:
- Express need to address stigma and discrimination in their work with young people
- Intend to implement activities to address stigma and discrimination in their work with young people

Agenda

Session		Time
4.1	**Introduction**	10 minutes
4.2	**Naming stigma**	
4.2.1	**Define stigma**	15 minutes
4.2.2.	**Stigma problem tree**	60 minutes
4.3	**Reflection on stigma and Discrimination**	20 minutes
4.3	**Personal stigma experience**	
4.4	**Test "Myths and Facts"**	30 Minutes
4.5	**Activities that can be implemented – Plan of Action**	70 Minutes
Evaluation		5 minutes
		Total 3,5 hours

4.1. Introduction

Exercise 4.1.

Introduction

Preparation
Needed: PowerPoint on Stigma and discrimination
Time: 10 minutes

Instructions
1. Introduce the session. Use the PowerPoint on Stigma and discrimination and explain:
   The objectives
   - Participants express need to address stigma and discrimination in their work with young people.
   - Participants implement activities to address stigma and discrimination in their work with young people.

4.2. Naming stigma

Define stigma and discrimination

Preparation
Needed: PowerPoint slides on define stigma and discrimination, plenary
Time: 15 minutes

Objectives
- Define stigma

Instructions
1. Start a group discussion. Ask the group:
   - What do we mean with stigma and discrimination?
2. Use the PowerPoint slide on stigma, add information to the discussion and explain:

> **Stigma** is a complex social process with many different forms, causes and effects. It can be described as a mark of disgrace or discredit, a distinguished mark or characteristic (spoilt identity) to label someone as inferior because of an attribute they (a group of people) have in common, such as an illness, deformity, colour, nationality, religion, sexual orientation, gender identity and so on. Stigma can be described as unfavourable attitudes and beliefs directed towards someone or something, which is usually culturally constructed. Stigma is often accompanied by discrimination, but discrimination is not the same thing as stigma. Rather, discrimination must be defined as a possible effect of stigma. Remember, HIV does not discriminate people. It is not who you are, but what you do determines whether you are at risk of getting infected by HIV. HIV related stigma can be described as a process of devaluation of people living with or associated with HIV and AIDS.

3. Start a group discussion. Ask the group:
   - What makes HIV related stigma different from other forms of stigmatization.
4. Use the PowerPoint on HIV related stigma, add information to the discussion and explain:

> **HIV related stigma** refers to a real or perceived negative feeling to a person or a group of persons (in this case the PLHA) by virtual of his or her HIV positive status. Stigma has become a major reason why HIV epidemic continues and millions of young people are still infected. It's a situation where a person is ignored, socially excluded and treated differently from others because of their HIV positive status. Although, you could say that HIV stigma differs from other forms of stigma (such as religious

> or nationality related stigma, you can't hide your skin colour!), physical symptoms of HIV/AIDS or taking ARVs can (not always and sometimes different) occur. This makes it possible to identify and stigmatize non-disclosed PLHAs as well. Stigma or self-stigmatization can also be a reason for young people not to disclose their status or not to seek treatment and support (as physical symptoms can be hidden).

Factors that contribute to HIV and AIDS-related stigma:
- AIDS is a life-threatening disease.
- People are scared of contracting HIV.
- The virus is associated with behaviours (such as sex between men or injecting of drugs) that are stigmatised in many societies.
- People living with HIV are sometimes thought of as being responsible for becoming infected.
- Religious or moral beliefs that lead some people to believe that having HIV is the result of moral fault (such as promiscuity or 'deviant sex') that deserves to be punished.

Stigma Problem Tree

Preparation
Needed: PowerPoint slide with exercise, pens, cards, flipchart, markers and tape
Time: 60 minutes

Objectives
- Participants define causes and consequences of HIV
- Participants identify different forms of stigma

Facilitator's Notes
Purpose of this exercise is to help participants reflect on and analyse the many layers of stigma and discrimination that exist in society and their implications in the context of HIV/AIDS.

Set up the structure for the problem tree on the wall or use a picture of a tree (see PowerPoint). Put up a few example cards especially for the forms of stigma, e.g. gossip, segregation. Or ask participants to draw a problem tree, showing forms of stigma (main trunk), effects (branches) and causes (roots).
Explain the purpose of the stigma problem tree to the participants.

Instructions

1. Introduce exercise and use the PowerPoint slide on Stigma Problem Tree.
2. Form small groups or work in pairs. Think about the forms of stigma. Write one point per card and tape them on the wall diagram to make a problem tree showing forms of stigma (main trunk). Then move on to the effects (branches) and causes (roots). Different effects, causes and forms of stigma are described below this exercise to be used by the facilitator to support participants and to add on stigma problem tree if missing.
3. Help participants see different levels in a plenary discussion. For example, immediate effects, impact on people living with HIV (e.g. isolation), spin-off effects (e.g. loss of jobs) and wider effects on the economy (e.g. loss of employment, lack of productivity, no development).
4. Look at the causes and dig deeper, asking "But why?"
5. Form two groups. Participants can further analyse the cards.
   One group looks at effects:
   - What are the effects on the family, the community, the nation?
   - How can we as programmers minimise the effects of stigma?

   The other group looks at causes:
   - Why is this a root cause? Can you explain, using examples?
   - What can you do to change or challenge this cause of stigma?

Facilitator's Notes

Causes of HIV stigma could include:
- Poverty; lack of or incorrect knowledge; fear of disease; poor health care; fatalism; media; gender; misconceptions; inferiority and superiority complex; government policy.
- Morality: view that PLHA are sinners, promiscuous, unfaithful, "sleeping around".
- People's beliefs about pollution, contagion, impurity.
- Fear: fear of infection, fear of the unknown, fear of death.
- Ignorance: lack of knowledge makes people fear physical contact with PLHA.
- Gender and poverty: women and poor people more stigmatised than men/rich people.
- Prejudice: tendency to judge others.

Forms of HIV stigma could include:
- Name-calling; Scapegoating. Finger pointing. Teasing. Ridicule. Labelling.
- Blaming; Shaming. Judging. Back biting. Rumour. Gossiping. Making assumptions. Suspecting.
- Neglecting; Rejecting. Isolating. Separating. Not sharing utensils. Hiding. Staying at a distance.
- Harassment; Physical violence. Abuse.
- Self-stigma; blaming and isolating oneself. Stigma by association – whole family or friends also affected by stigma.
- Stigma by looks and appearance; Associated stigma – family and friends also affected by stigma.
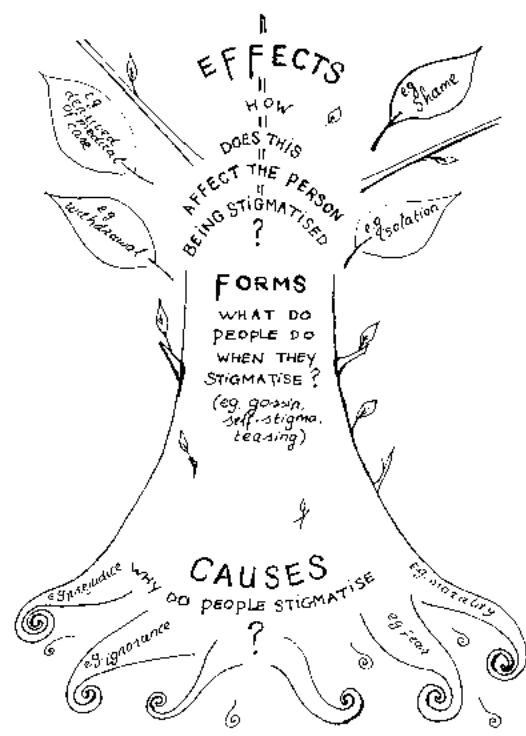

Figure 3: Examples of Stigma Problem Trees

Effects of HIV stigma could include:
- Shame. Denial. Self-isolation. Loneliness. Neglect. Loss of hope. Depression. Death. Alcoholism. Isolation. Self-rejection – give up on yourself. Self-blame. Self-pity. Self-hatred. Anger. Violence.
- Withdraw from public activities (church membership). Become very quiet. Commit suicide or start thinking about suicide. Die alone – without love. Feel useless. Forced to leave community. Family disruption. Divorce or separation. Kicked out of family. Fired from work. Loss of promotion, education, accommodation. Decline in school performance or dropout from school. AIDS orphans and street kids. Abuse or poor treatment by relatives.
- Deprived of medical care, health staff argues this is a "waste of resources". Sent back to the village and property grabbing. Quarrels within the family – argue over who is responsible for this situation and who will take care of the sick PLHA. Stop making use of clinics, VCT programme, and HBC programme. Reluctance to take medication. No treatment. Spread of infection.

4.3. Reflection on Stigma and Discrimination

In this second exercise participants are asked to express the feelings that lie behind their attitudes. It is a reflection exercise on stigma. In this exercise participants are asked to reflect on their own experiences of being stigmatised. This might bring out some strong feelings. These feelings help participants see how hurtful stigma can be. However, self-reflection exercises need strong ground rules and a safe environment (see chapter 4). Also, it might help if you start with telling a personal experience with stigmatization to encourage your participants to do the same.

Exercise 4.3.

Reflection on stigma and discrimination

Preparation
Needed: outside space
Time: 20 minutes

Objective
■ Analyses own attitude and value towards people living with HIV

Facilitator's Notes
The next exercise is very important, because it makes the discussion of stigma more personal. It asks participants to reflect on their own experience of being stigmatised and

how it felt. These feelings help participants get an insider's view of stigma – how it hurts and how powerful those feelings are.

The exercise looks at stigmatisation in general, not HIV-related stigma. This is why the instructions are, "Think of a time in your life when you felt isolated or rejected for being seen as different from others."

If you can, use outside space for the reflection. You might have to push people a little to sit alone for Step 1. Participants may automatically sit together.

The sharing should be voluntary – no one should be forced to give his or her story.

Instructions
1. Introduce the exercise and say: "Spend a few minutes alone thinking about a time in your life when you felt isolated or rejected for being seen to be different from others."
2. Explain that this does not need to be about HIV. It could be any form of isolation or rejection for being seen to be different (think of bullying, gossiping, feeling rejected by friends, family or colleagues, and so on).
3. Ask participants to find some space alone, at a distance from other participants.
4. Ask them to think about, "What happened? How did it feel? What impact did it have on you?" Tell participants to spend a few minutes reflecting alone, and then when they feel ready they can share their experience with someone with whom they feel comfortable.
5. Arrange chairs in a close circle.
6. Start a group discussion. Ask the group:
   - How was the exercise?
   - What kind of feelings came up?"
   Invite participants to share their stories in the large group. Give people time. There is no compulsion – people will share if they feel comfortable.

4.4. Myths and Facts on HIV and its Transmission

Exercise 4.4.

Facts and myths

Preparation

Needed: PowerPoint slide results, a copy of Myths and Fact test (for each participant)

Time: 🕐 30 minutes

Objective

■ Recognize the difference between facts and myths in regards to HIV transmission

Facilitator's Notes

Participants will take this test individually and do not have to reveal their results, if they do not feel comfortable doing so.

Explain that this is not an external evaluation, but merely a self-assessment test to correct your information or see which myths are common among other people.

Instructions

1. Introduce the exercise and explain:

   From its beginnings, HIV/AIDS and its transmission have been covered in many myths and misconceptions. In some cases, these mistaken beliefs have encouraged the very behaviours that cause more people to become HIV-positive. Myths and misconceptions can also be at the very roots of stigmatization and discrimination. Evidence shows that knowing the facts (knowledge) is not enough to change someone's risky or stigmatizing behaviour (as we already learned in the previous sessions). But before we take a deeper look to some effective types of activities to address stigmatization, we will first assess what we actually know about HIV and its transmission. The difficulty with addressing myths and misconceptions is that we think our beliefs are facts. This means that only asking someone about common beliefs and myths does not help us in discovering our own misconceptions. Therefore, we have developed a little test to see whether we know all the facts.

2. Give each participant a copy of the test "Myths and Facts" and a pen.
3. Fill in the test individually.
4. Start a group discussion. Discuss each myths/facts plenary after everyone is finished. Ask the group: Myth or fact.
5. Ask people to share something about their results, for example on which item were they not so sure in the beginning, what was new for them, People will share if they feel comfortable. Start by sharing a myth that was new to you. This can make participants more comfortable.
6. Summarise the feelings expressed, and thank participants for their honesty.
7. Form small groups. They select one myth to analyse on the questions:
   - Where does this belief (myth) come from?
   - What are some of the reasons or thinking behind the belief (myth)?
   - What are the known facts on this myth?
   - Do you know any other common beliefs or myths?
8. Ask participants to give a short presentation on their analysis of their myth.

4.5. Addressing Stigma and Discrimination

Exercise 4.5.

Addressing Stigma and discrimination

Preparation
Needed: PowerPoint, the guide "Addressing needs of YPLHIV" (for each participant)
Time: 60 minutes

Objectives
- List relevant activities that can be implemented to address stigma and discrimination
- Express confidence to implement activities within own work that address stigma and discrimination

Instructions to participants
1. Introduce the exercise. Give each participant a copy of the Guide. Introduce the guide shortly and explain:

Life skills and sexuality education programmes usually only focus on HIV negative young people. And HIV prevention seems to be the main target of many of such programmes. However, HIV positive youth also need our attention and care. Fact is that worldwide 40% of all new HIV infections are among young boys and girls, while every day 2,500 other young people are infected. To address the specific needs and stigmatization of young people living with HIV (YPLHIV), the practical guide "Addressing the needs of young people living with HIV" has been developed, by organisations in Zimbabwe. The Guide provides a checklist to analyse how your organization addresses stigma and also multiple examples of appropriate activities to address stigma.

3. Each participant fills in the checklist individually on page 7-8. Discuss the results with your neighbour.
4. Read through the relevant chapters (where the score is "No" or "Not really").
5. Discuss in small groups or work in pairs. Discuss the following questions:
   - Discuss examples how you already address the needs of YPLHIV/and specifically address stigma
   - Which activities are appropriate for your organization to address stigma?
   - Who needs to be involved to make this happen?
   - What barriers do you foresee? How can you address these barriers?
   - What else would you need to make the changes a success?
6. Ask each group to share the most important outcomes of the discussions with the whole group.
7. Now fill in the Plan of Action for Improvement. Select activities based on reflection above.

Facilitator's Notes
Discuss that the Plan of Action is not per se about identifying NEW activities, but how to strengthen existing ones. Motivate participants to be as concrete and specific as possible.

66 No more stigma, cause I want each and every one to be loved equally. 99

Nurhaun, South Africa

Hand-out 4.4.
Facts and Myths

Please, answer for each item if you think it is a myth or fact.

Item	Myth	Fact
Diarrhoea and vomiting can cause the contraceptive pill to be ineffective		
Wearing two condoms is safer as using one		
I'm receiving treatment; therefore I can't spread the HIV virus		
HIV positive women can have healthy babies		
You cannot get infected with HIV or a STI if you have sex during the night		
It's safe to have unprotected sex if you and your partner are HIV positive		
The chances of getting infected with HIV are very small if you wash your vagina or penis after having sex		
If you never had sex you cannot be HIV positive		
HIV can evolve differently in each person's body; if it mutates, a different train can emerge		
The first time having sex a boy does not need to wear a condom, because he is protected by a skin covering the top of his penis (his membrane)		
Birth control does not protect me against getting HIV infected		
Using condoms can make you infertile		
HIV is a punishment from God		
I can't get HIV by hugging, kissing, or shaking hands with someone who is HIV-positive		

Session 5: Building Gender Awareness

Gender inequality refers to unequal treatment or perceptions of individuals based on their gender. Women often lack access to education and knowledge of sexual and reproductive health including HIV, especially if they live in isolated areas. In this chapter on gender awareness we will discuss concept of gender, roles and sex roles and focus on power and transactional relationships. Most importantly we will reflect on current programmes for young people on SRHR and HIV prevention and how gender can be integrated. Sessions are derived from the Handbook "Healthy Woman, Healthy Man, Healthy Family".

Fast Facts

Women and girls continue to be affected disproportionately by HIV in sub-Saharan Africa. In sub-Saharan Africa as a whole, about half of the people who acquire HIV become infected before they turn 25 years. Women account for approximately 60% of estimated HIV infections.

Women's vulnerability to HIV in sub-Saharan Africa stems not only from their greater physiological susceptibility to heterosexual transmission, but also to the severe social, legal and economic disadvantages they often confront. Data from the UNICEF/UNAIDS report (2004) illustrate that girls are much more likely than boys to be removed from school to provide health care or additional household help when AIDS affects a family. In sub-Saharan Africa, girls aged 15-19 typically have sexual partners who are 6 or more years their senior. This limits their power to resist unsafe sexual practices. More than four-fifths of new infections in women result from sex with their husband or primary partner.

Materials
- ■ PowerPoint building gender awareness
- ■ Plan of Action for Improvement

After this session participants
- ■ Express the need to address gender inequality in their work with young people
- ■ Implement activities to address gender inequality in their work with young people

Agenda

Session		Time
5.1	Introduce building gender awareness	5 minutes
5.2	Understanding gender and sex	45 minutes
5.3	Gender roles and sex roles	105 minutes
5.4	Power, gender and roles	130 Minutes
5.4.1	Power, gender and roles	
5.4.2	Power, gender and transactional relationships	
5.5	Intention to implement activities	40 Minutes
		Total 5,5 hours

5.1   Introduction building gender awareness

Exercises 5.1.

Introducing gender

Preparation
Needed: PowerPoint on building gender awareness
Time: 5 minutes

Instruction
1. Introduce the session and use the PowerPoint on building gender awareness and explain:
   The objectives:
   - Express the need to address gender inequality in their work with young people.
   - Implement activities to address gender inequality in their work with young people.

5.2. Understanding gender and sex

Exercises 5.2.

Understanding gender

Preparation
Needed: PowerPoint, Pens, paper, flipchart and the hand-out: "Case study: Understanding the word 'gender'"
Time: 🕐 45 minutes

Objective
- Participants recognize the difference between gender, gender roles in society and sex

Instructions
1. Invite the participants to sit in a circle and introduce the exercise (5 minutes).
2. Read out the case study (hand-out) to the participants (5 minutes).
3. Use PowerPoint and ask the participants (5 minutes):
   - if you were in this situation, which would be your choice, a boy or a girl?
4. Note on the flipchart how many participants say 'boy' and how many say 'girl'.
5. Ask those who chose a boy why they did so, and do the same for the girl (10 minutes).

Take a clean flipchart, and make a table and record the participants' reasons as follows:

BOY: I would like to have a boy because		GIRL: I would like to have a girl because	
1.	☐	1.	☐
2.	☐	2.	☐
3.	☐	3.	☐
4.	☐	4.	☐
5.	☐	5.	☐

6. Once all the reasons are on the flipchart, go through all the reasons. Start with the boy and ask if a girl can do the things stated in the boy's column. Tick all 'yes' responses and where the response is 'no', mark with an 'X'. Do the same for the girl column (10 minutes)

Facilitator's Notes
The outcome of this exercise will be that all the reasons marked 'X' will be directly related with sexual roles of a girl or a boy. Where there is a tick, those will all be social roles of a boy or a girl.
Roles in the society are either biological (sexual) or social. An example of a biological role is that a woman can give birth while a man cannot. Also, men break their voices.

An example of a social role could be, that in patriarchal societies the man would continue the family name while a girl would get married and lose the family name.
Biological roles cannot be changed and are permanent, while social roles can be changed and are not necessarily permanent.

7. Ask the group first how they define sex and gender. After use the PowerPoint and explain (10 minutes):
   Sex – Refers to the biological characteristics that make us male or female (anatomical, physiological and genetic). These biological differences are determined at birth and are universal. Sex also refers to sexual activity, including sexual intercourse.
   Gender – Gender refers to the widely shared ideas and expectations (norms) held about women and men. It refers to the roles we learnt in our societies and responsibilities for women and men that are created and learned in families, communities and cultures.[A]

A   Adapted from: Ipas and Health and Development Networks 2001; Gender or Sex: Who Care. www.gender.org.uk. www.unescobkk.org

5.3. Gender roles and sex roles

Exercise 5.3.

Gender roles and sex roles

Preparation
Needed: PowerPoint, pens, paper, and flip charts for each group
Time: 1 hour 45 minutes

Objectives
- ■ Participants recognize the difference between gender, gender roles in society and sex
- ■ Participants list causes of gender-based discrimination/ violence

Part A | Gender roles and sex (50 minutes)

Instructions
1. Invite the participants to sit in a circle and introduce the exercise Part A.
2. Use PowerPoint (20 minutes) and divide the participants into small groups and ask them to answer the following questions:

How are women portrayed in:	How are men portrayed in:
Religion	Religion
Education	Education
Culture	Culture
Media	Media

Give each group a flip chart and ask them to record all their answers.

3. Let each group present to the whole group (15 minutes).
4. Use PowerPoint and ask the participants to recall and mention some sayings about men boys and women/girls in their society/culture. Go through all the sayings by identifying the positive and the negative ones. Ask the participants to carefully observe upon whom the positive and the negative ones reflect. The reflection will show how the community perceives women/girls and men/boys (15 minutes).

Examples may include:	
Women/girls should not inherit property	Men must slaughter animals
Girls should not be taken to school since they will get married anyway	Wedding days are about women
It is right to hit a woman especially when she provokes a man	Men can have more than one wife
Women/girls should not eat chicken	Men don't talk about their feelings
Women must cook	Women should stay at home and look after children
Men should work	

Facilitator's Notes
Messages about women/girls are often portrayed negatively. There is need to examine and understand whether these messages are valid. Most cultures show:
- Women/girls are inferior to men;
- Women/girls are not treated with respect;
- Women/girls do not take up leadership positions; and
- Women/girls are discriminated against.
Use the guiding questions to process the activity.

Part B | Questions on gender for reflection (25 minutes)

1. Introduce exercise part B, use PowerPoint. Allow the participants to reflect on the following (20 minutes).:

- How do you feel about the cultural sayings?
- Are the cultural sayings fair?
- Is it right for your daughter/sister/mother to be disinherited after the death of her husband just because she is a woman?
- Is it right for your daughter/sister/wife to be denied a right to education?
- Is it right for your daughter/sister/mother to be sent away from her home just because she tested HIV positive?
- Is it right for your daughter/sister/mother to be hit by her partner after a disagreement?

5. Use PowerPoint and ask for volunteers to tell a story or write about what they like about being male or female (5 minutes).

Part C | Gender feelings (15 minutes)

1. Have a girl/woman walk in front of the group and ask a boy/man to tap the girl/woman's bum (5 minutes).
2. Introduce exercise Part C, use the PowerPoint and take the participants through the following questions (10 minutes):

- Ask the girl how she felt when the boy did that?
- Ask the group why they think men/boys do this?
- What would you do if you were in the girl's position?
- What would you do if a man/boy did that to your daughter/sister/wife/mother?

Part D | Define gender roles (15 minutes)

1. Now ask the group first how they would define gender roles (10 minutes)
2. After, use the PowerPoint (5 minutes) and explain:

> **Gender roles** refer to the behaviours, attitudes, values, responsibilities and expectations that are defined through our interactions and our cultural practices, and which are then seen as 'right' or appropriate for women and men. This is how gender stereotypes are formed and different activities and behaviours are then given and expected of women and men.[B]

5.4. Power, gender and roles

Exercise 5.4.1.

Power, gender and roles

Preparation
Needed: PowerPoint, pens, paper, and flip charts for each group. Write on pieces of papers (the same amount of participants) that provide descriptions of different (young) people in society, for example: Member of Parliament, 12 year old girl and/or boy, HIV positive 16 year old boy and/or girl, college student, 17 year old mother and/or father, a gay young person and so on.
Time: 60 minutes

Objectives
- Participants recognise that men and women are treated differently in society
- Participants list different groups that have power, and the groups that are targeted for unfair treatment

Instructions
1. Invite participants to sit in a circle and introduce the exercise (5 minutes), explain:
   - This exercise will help to understand how gender and people's access to resources can contribute to positive or negative reproductive health outcomes.
2. Use PowerPoint and ask the participants to stand in one straight line. Give each of the participants one of the pieces of paper that you prepared earlier that provide descriptions of different people in society.
3. Introduce the activity by asking all the participants to read out the 'role' that has been given to them (10 minutes).

4. Explain to the participant:
   - For this activity you want them to assume the 'role' that has been written on the piece of paper you gave them. You will read a series of statements.
   - For each statement, you would like them to consider whether that statement applies to the role they have been given. If it does, they should move forward one step. If it does not, they should stay where they are. For example, one of the participants has been asked to assume the role of a Member of Parliament. You then read the following statement, "I can protect myself from HIV."
   - Since it is likely that the Member of Parliament can protect himself or herself from HIV, the person playing this role would move forward one step.
5. Continue reading each of the following statements (15 minutes):
   - I can negotiate for safer sex with my sexual partner.
   - I can comfortably discuss sex with my partner.
   - My partner takes care of the children while I do the washing.
   - I can leave the relationship if my boyfriend/husband becomes violent.
   - My boyfriend/husband respects me and consults me in decision-making.
   - I can decide the spacing and number of children that I would like to have.
   - My girlfriend/wife will never pay for the bill when we go out for a date.
6. After looking at all the statements, ask the participants the following questions (15 minutes)
   - Do you agree with the steps that different people took? Why or why not?
   - How do the participants who did not move or moved very little feel about where the rest of the participants are?
   - How do the participants who took several steps feel about where they are in comparison to the other participants?
   - Ask different people to explain if the character they assumed would be at high risk of HIV infection or violence.

7. Bring the group together again and explain that our role in society, which is determined by gender and gender roles, access to resources, and educational levels, can have a detrimental impact on an individual's rights and health decision-making (10 minutes).

8. Now, ask participants first how they would describe gender inequality and gender equity. After plenary discussion, use PowerPoint and explain (10 minutes):

> **Gender equity** is the process of being fair to men and women. To ensure that it is fair, compensation measures must often be in place to help men and woman play on a level playing field. Without these measures, disadvantages created by history and social practices can prevent that everyone is starting out equal. Equity is a means. Equality and equitable outcomes are the results.
>
> **Gender equality** means that men and women have equal conditions for realising their full human rights for contributing to, and benefiting from, economic, social, cultural and political development.
>
> **Gender-based inequality** refers to situations in which women and men do not have access to information, decision-making power, household and community resources and social and health services, or situations in which they are not treated respectfully because of their sex.[C]

Preparation
Needed: PowerPoint, Hand-out "Taxi Queens"
Time: ⏱️ 1 hour 10 minutes

Objectives
- Participants list different groups that have power, and the groups that are targeted for unfair treatment
- Participants speak about different groups in society that have higher risk on HIV/AIDS or violence in a non-judgmental way
- Participants acknowledge the existence and complexity of transactional sexual relationships between men/boys and women/girls

Instructions to participants
1. Introduce the exercise. Start a group discussion (5 minutes). Ask the group:
- what do we mean with transactional sex relationships?
2. Use PowerPoint (5 minutes), add to the discussion and explain:

> **Definition:** Transactional sexual relationships are sexual relationships where the giving and receiving of gifts and/or services is an important aspect. The women/girls and men/boys who have transactional sexual relationships do not label themselves in term of prostitutes or clients, but rather as girlfriends/boyfriends, sugar babies/sugar daddies or mommies (Hoefinger 2013).[3] The girls and boys who offer or receive the sexual acts may or may not feel attraction for the other.
>
> **Transactional sex relationships is not the same as prostitution, because:**
> - the exchange of gifts/services for sexual acts include multiple (generally non-marital) commitments, which are not necessarily predetermined payments or gifts,
> - Instead, there is a definite motivation to benefit materially or socially from the sexual exchange.
>
> **Transactional sex, power, and gender roles:** Transactional sex relationships are common in all income categories (in different forms!) and are dependent on dominant images of gender roles in society, in which men act as (non-)material providers for their sexual partners and the receiving women in turn need to compensate their partners with sexual acts (Hunter 2002).[4]

3. Invite participants to read the article on Taxi Queens (see hand-out) (10 minutes)
4. Start a group discussion. And discuss the following questions (20 minutes):
- How do you recognise what happens with this girls, with situations in your community/region?
- Are the transactional relationships fair?
- What would you do in the girl's position, and you finally had enough money to pay for your school fees, but your school is so far away that walking would take over an hour?
- Why do you think men/boys do this?
5. Ask for volunteers to share other forms of transactional sexual relationships that are common in their region (10 minutes).

Facilitator's Notes
Tell participants that these relationships can be so accepted that at a first sight they are not labelled as transactional sex relationships (e.g. it can also occur in marriages). Acknowledge that transactional relationships happen everywhere and can happen to anybody. Have a few examples of other transactional sexual relationships ready to encourage participants, such as:

3   Heidi Hoefinger. Sex, Love and Money in Cambodia: Professional Girlfriends and Transactional Relationships, London, Routledge, 2013.
4   Mark Hunter. "The Materiality of Everyday Sex: Thinking Beyond 'Prostitution'", African Studies, 61(1): 99-120.
C   Adapted from: Ipas and Health and Development Networks 2001; Gender or Sex: Who Care. www.gender.org.uk. www.unescobkk.org

- Male students in colleges/universities have sexual relationships with freshmen female students in exchange for higher social status, gifts, and social network (also called "gold rush").
- Married men who have sexual relationships with their wives in exchange for pocket money, food, cloths,...
- Young boys who have transactional sex relationships with truck drivers over a longer period of time (sometimes the ride from place A to B), in exchange for gifts, safety, or money.

6. Discuss in small groups: give three examples of how you would address transactional relationships in activities for young people? Ask participants to share their examples (20 minutes)

66 Empowerment helps us women to negotiate sex. 99

Adeola, Nigeria

5.5   Addressing gender inequality

Exercise 5.5.

Addressing gender inequality

Preparation
Needed: PowerPoint slide with exercise
Time: 40 minutes

Objectives
- List activities relevant activities that can be implemented to address gender inequality
- express confidence to implement activities within own work that address gender inequality

Instructions to participants
1. Introduce the exercise and discuss in small groups or work in pairs (20 minutes). And discuss the following questions:
   - What you have learned or what has been an eye opener?
   - How can you integrate this in your work with young people?
   - Who needs to be involved to make this happen?
   - What will be the result when you have made the changes?
   - What barriers do you foresee? How can you address these barriers?
   - What else would you need to make the changes a success?
2. Each group shares the most important outcomes of the discussions with the whole group (10 minutes).
3. Now fill in the Plan of Action for Improvement. Select activities based on your reflection above that you would like to do (10 minutes).

Facilitator's Notes
Discuss that the Plan of Action is not per se about identifying NEW activities, but how to strengthen existing ones. Motivate participants to be as concrete and specific as possible.

Hand-out 5.2.
Understanding Gender

Case Study: Understanding the word gender

There is a couple that has been married for the last ten years. All their efforts to get a baby have been fruitless. They have visited all famous traditional medicine experts, and they have not been able to get any help. They have seen famous doctors who have tried to assist them but have failed. However, there is an old religious prophet who has long returned to his village, who assisted couples long ago with similar problems. The couple finds this prophet in his village, and they tell him their problem. He examines them both, and he tells them that they can only have one child. He tells them that they must choose to have a boy or a girl.

Hand-out 5.4.2.
Taxi Queens

Taxi Queens "Swapping sex for free rides to school? Some South African girls think it's a good deal"

In some of the roughest neighbourhoods of Cape Town (South-Africa), as minivan taxis line up to pick up kids and take them to school in the morning, drivers or their assistants routinely select a pretty school girl — some as young as 12 years old — who would be their *"queen"* for the day. She'll sit in the passenger seat, act as eye candy and be in charge of the stereo, which is widely considered to be a high-status gig. Once declared taxi queen material, the girl is allowed to ride the minibus for free, saving the equivalent of about $1 a day, not an insignificant amount of money for children from impoverished urban neighbourhoods. The girls may feel indebted, which is about the point where the problems with seemingly mutually beneficial *"transactional relationships"* begin to unfold. Howard, 41 year old, who used to work as an assistance driver, said the relationship between drivers and taxi queens is based on a simple formula. *"The drivers are used by the girls to get free rides and the girls are used by taxi drivers for sex. Everyone uses everyone,"* he said. *"Life is a vicious cycle."*

Very little academic research exists about taxi queens in South Africa, yet experts agree that the cross-generational and transactional nature of these relationships makes it a problem of massive proportions. In the country's latest HIV/AIDS report, inter-generational sex was highlighted as one of the main sources of HIV transmission in the country, said Anna Strebel, a gender and sexuality researcher. *"Young women have the highest rate of infection,"* Strebel said. *"Their concern is mainly about getting pregnant, not about AIDS, even among university students, which is staggering."* Strebel recently interviewed a large number of taxi queens in the Western Cape area for a study. She was surprised to find how widespread the practice of a transactional relationship between older drivers and young girls was. *"Wherever there are taxi drivers, it exists,"* she said. While girls from poor families might engage in the practice, sometimes referred to as *"survival sex,"* to get essentials such as food and free rides, other girls do it to be able to afford designer clothes. Strebel said the phenomenon isn't linked directly to poverty. Today, the term *"taxi queen"* is considered derogatory because it's now generally agreed the practice stigmatizes and exploits women, most of whom are too young to make informed choices.

Howard, explained the process by which a schoolgirl becomes a taxi queen without a speck of emotion. The key is getting them hooked on tik (crystal meth), and since taxi drivers are widely known to be the city's most prominent dealers of *"straw,"* or hits of tik packaged in cut up, inch-long transparent straws, the opportunities for school girls to sample the drug are endless. Before things turn ugly,

however, the young women enjoy a period of intense courtship, which can arguably be just as addictive as tik. *"You don't have to pay today for the bus, sweetheart. It's on me,"* Howard said he or his driver used to tell the schoolgirls, inviting them to sit up front and asking them what they were doing later. Some girls got lured quickly by the status that becoming a taxi queen brings, especially if it is a new car with a loud stereo system. But many girls were well aware of the slippery slope and rejected free fares and romantic proposals.

Patrik Solomons, director of Molo Songoglolo, a children's rights foundation, said teenage girls are often sexually abused by taxi drivers or their assistants. But many don't see it as abuse because they were raised in a culture where violence, sexual abuse and injustice are the norm. *"Teenagers don't just wake up one day and think 'I think I'll become a taxi queen.' Children are groomed into these scenarios,"* he said, adding that some teens are encouraged by their families to get as many material gifts as possible and be friendly with taxi drivers — who are typically gang members — to assure gang protection for all of them. The roots of the taxi queen phenomenon, however, go beyond economics and crime. Solomons said that in South African society, men are given a license to do anything they please. *"These kids develop very strange ideas of what love is,"* he said. *"Teenagers are very vulnerable. Like everywhere else in the world, teenagers here like to be treated as adults. And taxi drivers are treating them as adults."* – Source: Iva Skoch (Global Post), 17-12-2010

Session 6: Measure Effects on Outcome Level

The "Are You on the Right Track?" Workbook demonstrates the step by step design of an outcome Monitoring and Evaluation Plan. Monitoring refers to the tracking of programme activities by measuring on a regular, ongoing basis whether planned activities are being carried out according to the schedule or plan. Evaluation is a process that measures whether programme outcomes are achieved, and determines the impact of the programme in the target population.

The Workbook we will use in the training is a hands-on instruction manual for developing an outcome monitoring and evaluating plan (outcome M&E Plan) that fits your organisation's specific situation. The Workbook demonstrates the six steps you need to take to create your own tailor-made plan. Your outcome M&E Plan enables you to measure the achievements of your organisation's activities related to Sexual and Reproductive Health and Rights and HIV prevention (SRHR/HIV prevention). An M&E plan is the entire design of monitoring and evaluation, including methods and timing. It also contains decisions such as whether to include a comparison group or not, to do a pre-test and/or post-test, which groups and how many will be involved, and how to select the respondents.

The results will give you insights in the effects of your work and possible programme changes. The hub of the workbook is the Outcome M&E Worksheet (page 18-26), which is the actual framework of your outcome M&E plan. Also a number of practical tools, such as questionnaires and interview guides, are provided in the Workbook.

Materials:
- PowerPoint – Measure effects on Outcome Level
- The "Are You on the Right Track?" Workbook (copy for each participant)
- Plan of Action for Improvement

After this session participants
- List differences between output and outcome level
- List advantages of measuring programme activities on outcome level
- Develop an Outcome M&E plan

Agenda

What		Time
6.1.	Introduction	15 minutes
6.2.	**Outputs and outcomes**	
6.2.1.	**Understanding outcome measurement**	
6.2.2.	**Advantages of outcome measurement**	
6.2.3.	**Exchange of experiences**	45 minutes
6.3.	**Health promotion and behaviour**	30 minutes
6.4.	**Introduction of the 6 Steps to develop M&E plan**	10 minutes
6.4.1.	**Step 1: Select indicators**	90 minutes
6.4.2.	**Step 2: Select the M&E Design**	45 minutes
6.4.3.	**Step 3: Design tailor made tools**	90 minutes
6.4.4.	**Step 4: Data collection**	30 minutes
6.4.5.	**Step 5: Data analysis**	30 minutes
6.4.6.	**Step 6: Write a report**	20 minutes
6.5.	**Finale M&E Plan**	60 minutes
		Total 8 hours

6.1. Introduction

Introduce the programme and explain the objectives
After this training participants:
- List differences between output and outcome level
- List advantages of measuring programme activities on outcome level
- Develop an Outcome M&E plan

Explain:
- Why this workbook?
- Development of workbook
- Experiences with the workbook

6.2. Outcome versus Output Measurement

Exercise 6.2.1.

Understanding outcome measurement

Preparation
Needed: PowerPoint
Time: 🕐 30 minutes

Objective
- ■ Participants list differences between outcome and output measurement

Instructions
1. Introduce the exercise.
2. Invite the participants to sit in small groups or in pairs/ discuss these three questions shortly:
   • How do you define measuring on outcome level?
   • What is difference with output measurement?
   • Why is it important to measure on outcome level?
3. Ask each volunteers to present.
4. Show the PowerPoint and add to the discussion and explain:

What is the difference between output and outcome?
Output – numbers of people who have participated, trainings provided, etcetera.
Outcome – change in people's lives, as a result of all these trainings and participation in sexuality education

Change in young people's life and behaviour as a result of HIV prevention/sexuality education programmes.

Exercise 6.2.2.

Exchange of experiences

Preparation
Needed: PowerPoint slide 14
Time: 🕐 15 minutes

Objective
- ■ To understand the amount and depth of experience on outcome measurement
- ■ To set a nice atmosphere for sharing experiences
- ■ To get insight in participants' expectations on developing an outcome M&E Plan

Instructions
1. Group discussion- Ask participants if they have any experience with outcome measurement.
2. Invite participants to share their experiences with the group:
   - How do you measure on outcome level in your programme activity?
   - Why does your organization measure on an outcome level?
   - What do you still want to learn?
3. If, none of the participants has any experience with outcome measurement, ask if someone has experiences with M&E in general.

6.3. Health Promotion and Behaviour

Exercise 6.3.

Health promotion and behaviour change

Preparation
Needed: PowerPoint
Time: ⏱ 30 minutes

Objective
■ Participants understand the relation between needs assessment, objectives and outcome evaluation.

Instructions
1. Use the PowerPoint, introduce the exercise and explain:

Needs assessment
- what are health problems?
- which behaviours are causing these problems?
- Which determinants are related to the behaviour (lack of knowledge, attitude, low risk perception, lack of skills, negative social norms).

Objective for your intervention:
- Address these problems/behaviours/determinants (example: Increased health care seeking behaviour and – know where to find at least two health care clinics).

Design of your intervention – select the most suitable method/activity – that focuses on determinants (example: to increase knowledge/skills etc.

2. Go back to the worksheets (1 to 7) that were developed in the first training sessions. And explain each sheet, involve the group.

Example – result of a needs assessment

3. Continue with the PowerPoint and explain:

What you measure on short term (determinants) and long term (behaviour).Results will tell you where you can improve your intervention to influence the behaviour (long term).

The focus of this workbook: Workbook focus on young people's behaviour change in relation to sexual and reproductive health and rights (SRHR) and HIV prevention.

Examples of health promoting behaviours of young people to prevent HIV or STI's, unplanned pregnancies, sexual abuse:
- Young people make their own decisions about sexual and reproductive health, sexuality and growing up.
- Young people who never had intercourse, delay their first sexual intercourse.
- Young people abstain from sexual intercourse or from sex in general.
- Young people who are sexually active, use a condom every time they have sexual intercourse.
- Young people only have consensual sex and never force their partner to have sex.
- Young people seek help and support if they need this.

6.4. The "Are You on the Right Track?" Workbook – Six steps

Exercise 6.4.1

Introduction

Preparation
Needed: PowerPoint, workbook
Time: ⏱ 10 minutes

Example – result of a needs assessment

Behaviour	Knowledge	Risk perception	Attitude	Social influence	Skills
Low up take of health services by youth	Lack of knowledge on STI's Youth do not know where services are?	Do not see that STI's are a problem or think that STI cannot be treated	Prefer traditional healers	Young people think that negative norms exist in regards to seeking services	Lack of confidence to attend services

Example – define objectives for the intervention

Behaviour	Knowledge	Risk perception	Attitude	Social influence	Skills
Young people seek help and support if they need this	Increasing knowledge about STIs and where they can get help and support Identify people or organisations who can assist them with SRH	Explain that STIs can be treated well if diagnosed soon enough	Express a positive attitude towards going to a health service provider	Describe how parents and peers and other community members view young people seeking help at a health service provider	Express confidence of going to a health care provider or counsellor

Objective

■ Participants understand how to use the workbook

Instruction

1. Introduce the workbook and explain how to use it (page 7 in the workbook).
2. Give participants some time to go through the workbook themselves before you start with explaining each step.

Exercise 6.4.2.

Step 1: Select indicators

Preparation

Needed: workbook
Time: 90 minutes

Objectives

■ List behaviours and determinants they want to change or achieve in their programmes
■ Select topics of the process evaluation

Instruction to participants

1. Use the PowerPoint and present step 1 on Indicators.
2. Invite participants to form small groups or work in pairs. Discuss the following questions:
   - What are the health problems you address in your programme?
   - Which behaviours do you want to change that are causing these health problems?
   - Which determinants that are causing this behaviour, or part of your programme activities?

4. Invite participants to go to the **Are You on the Right Track Workbook** and fill in step 1 of the Worksheet (pages 19-20).
5. Each group or pair presents their findings.

Facilitator's Notes

In the first and most important step of your outcome M&E Plan, the focus of the programme will be identified:
- Select the behaviours (pages 28-29).
- Select the determinants (pages 28-29).
- Common examples of behaviours and determinants that influence those behaviours are provided on pages 50-54 in the Are You on the Right Track Workbook.

Exercise 6.4.2.

Step 2: Select the M&E Design

Preparation

Needed: workbook
Time: 45 minutes

Objective

■ List differences between qualitative and quantitative research and methodologies
■ List different ways to measure change (pre-, post-test, comparison group)
■ Select a suitable M&E design

Instruction

1. Use the PowerPoint and present step 2: Select the M&E Design.
2. Invite participants to go to the **Are You on the Right Track Workbook** and fill in the checklist to identify the organisation's capacity for M&E (page 55).
3. Invite participants to compare and discuss their results in small groups or in pairs.
4. Invite participants to fill in page 21, step 2 of Worksheet.
5. Each group presents their findings.

Facilitator's Notes

- In the second step of the outcome M&E Plan, participants will select the suitable M&E design for their organisation. To figure out which M&E design is best for their organisation fill in the checklist on page 55. The options are: minimal, good, or optimal design.
- Furthermore, they will decide on the target group and how to select the respondents. It will be helpful to involve the management when deciding about your M&E Plan (read pages 30-35 in your Workbook for more information).

Exercise 6.4.3.

Step 3: Design tailor made tools

Preparation
Needed: copy of questionnaires
Time: 90 minutes

Objective
- List differences between qualitative and quantitative tools
- Select the tools needed to measure their indicators
- Are able to design own tools

Instruction
1. Use the PowerPoint and present step 3: Design tailor made tools.
2. Start a group discussion. Discuss the existing tools, qualitative tools: page 57, and quantitative tools: page 70.
3. Invite participants to go to the **Are You on the Right Track Workbook** and fill in page 22, step 3 of Worksheet.
4. Print one of the questionnaires for qualitative data collection and one for quantitative data collection. Together with the participants go through the questionnaire and see which questions are most suitable for your intervention (step 1).
5. Ask a few volunteers to present which questions they will use and why.

Exercise 6.4.4.

Step 4: Data collection

Preparation
Needed: Workbook
Time: 30 minutes

Objective
- Understand how to collect data using their own tools
- Make a data collection plan (by whom, when and how)
- Are able to communicate openly about sexuality and create a safe environment for data collection

Instruction
1. Use the PowerPoint and present step 4 on Data collection.
2. Discuss in small groups or in pairs how to collect the information:
   - Decide who will collect the information.
   - Train data collectors.
   - Make a data collection plan.
   - Create a safe environment for data collection.

3. Invite participants to go to the **Are You on the Right Track Workbook** and fill in page 23, step 4 of Worksheet.

Facilitator's Notes
- In this fourth step, participants will reflect on who will collect the data. Perhaps, they can link up with other organisations and ask them to assist them. Or they need to select and train data collectors (e.g. teachers, health service providers or young people).
- Furthermore, they have to decide on the logistical arrangements. It is also important to think about how to create a safe environment for data collection.

Exercise 6.4.5.

Step 5: Data analysis

Preparation
Needed: Worksheet and Workbook
Time: 30 minutes

Objective
- List difference between quantitative and qualitative data analysis
- List different steps of quantitative and qualitative data analysis

Instruction
1. Use the PowerPoint and present step 5: Data analysis.
2. Plenary discussion: on how to analyse information (both quantitative as qualitative). Cover topics such as:
   - When will you use quantitative and/or qualitative analysis?
   - How to enter data?
   - How do you draw conclusions?
   - What are elements of a good conclusion?
   - Discuss validity and reliability.
3. Go to the Are You on the Right Track Workbook and fill in page 24, step 5 of Worksheet.

Facilitator's Notes
- We have arrived at Step 5. So, we are nearly finished with the outcome M&E Plan. Actually, this would be the most interesting part, because it provides participants with new valuable insights.
- On pages 43-46 of your Workbook participants can find tips and advice on how to enter data.
- Always involve others in this process, because together you see and understand more. You might even want to involve a consultant with analytical skills to do the data analysis.

Exercise 6.4.6.

Step 6: Write a report

Preparation
Needed: Worksheet and Workbook
Time: 🕐 20 minutes

Objective
- ■ List creative ways to share collected data
- ■ List different purposes of usage of data
- ■ List elements of a clear and readable report

Instruction
1. Use the PowerPoint and present step 6: Write a report.
2. Go to the Are You on the Right Track Workbook and fill in page 25-26, step 5 of Worksheet.
3. Invite each group to presents their work.

Facilitator's Notes
We have arrived at the final step. Now participants would compose a report on the data you collected. This document contains all the information you have collected, how it was collected, the conclusions and recommendations. A report is only useful when it is clear and readable, and the findings and recommendations are accessible for others (see pages 46-47 of the Workbook).

6.5. Finalize M&E Plan & Plan of Action

Exercise 6.5.

Intention to implement M&E Plan

Preparation
Needed: M&E Plan, Plan of Action,
Time: 🔴 60 minutes

Objectives
- ■ Finalize M&E Plan
- ■ Express confidence to implement M&E Plan

Instruction
1. Discuss in small groups or work in pairs the following questions:
   - What you have learned or what has been an eye opener?
   - How can you share this with your colleagues and management?
   - How will you implement your M&E plan?
   - Who needs to be involved to make this happen?
   - What will be the result when you have made the changes?
   - What barriers do you foresee? How can you address these barriers?
   - What else would you need to make the changes a success?

2. Each group shares the most important outcomes of the discussions with the whole group.
3. Now fill in the Plan of Action for Improvement. Select activities based on your reflection above that you would like to do.

Session 7: Plan of Action for Improvement

Together with the organisation you support, you will develop a Plan of Action for Improvement of their programme activities. After each session they will need to fill in the Plan of Action. It will be like a summary and conclusion of each session. This Plan of Action will be the entry point to discuss with the management of the organisation what changes need to be made in order to strengthen the programme activities. It is therefore very important that management is invited when the final version of the Plan of Action is developed. The Plan of Action is not per se about identifying NEW activities, but how to strengthen existing ones. Of course it can be concluded that new type of activities are essential. If you have this analysis and conclusion on paper, it makes it easier to talk to your donor organisations.

7.1. Finalizing the Plan of Action for Improvement

Preparation
Needed: The Plan of Action for Improvement
Time: ⬤ ⬤ 120 minutes

Materials
◼ Plan of Action
◼ Evaluation form

Objectives
◼ Participants have developed a Plan of Action for Improvement of programme activities, based on all sessions
◼ Participants present Plan of Action to management of the organisation

Agenda

Finalise Plan of Action	Time
Finalise Plan of Action with staff	60 minutes
Prepare a presentation/meeting for management and other staff	60 minutes
	Total 2 hours

Instructions to participants
1. Continue with the development of your Plan of Action for improvement. Ask one of the participants to fill in the Plan of Action in word (if not done yet). The document becomes more official and it becomes easier to read for management.
2. Together with your team who received training, prepare how you will present the plan of action and ask for their input and involvement. Discuss:
   - What are our main conclusions?
   - What will be the result when we make desired changes?
   - What barriers do we foresee? What solution do we have?
   - What else would we need in order to make the change a success?
   - How will you present your Plan of Action?
3. Present the Plan of Action to management and ask for feedback.
4. Incorporate feedback and finalise the Plan of Action.
5. Ask for approval of the. Plan of Action by management of the organisation.
6. Use the evaluation form to evaluate your training sessions.

Monitoring and Support visits

Once each organisation has developed their Plan Of Action For Improvement of Programme Activities they will start to implement and make changes to their programme. It is very important that you will assist them and conduct support visits to the organisation. We have developed a format you can use for your visits.

When
- The first visit takes place 6 weeks after they finalised the Plan of Action for Improvement
- The second visit, 6 weeks after that
- You can hand out certificates during the second monitoring and support visit

Preparation
- When you plan a meeting, ensure you will be able to meet with management and staff of the organisation that has been involved. Best is if you can meet them in a group
- Make sure you have 3 hours with the group to meet
- Make sure you have their specific Plan of Action available
- Re-read the chapters in the Planning and Support tool that are relevant for the organisation

Format of monitoring and support visit

Preparation
Needed: Format support visit, finale Plan of Action for Improvement, Planning and Support tool, notebook and pen or laptop (to write down conclusions).
Time: ⬤ ⬤ ⬤ 180 minutes

After this support visit participants
- Have listed possible barriers for implementation
- Have listed solutions to deal with barriers
- Are encouraged to implement the Plan of Action for Improvement
- Express confidence to implement Plan of Action for Improvement

Instructions
1. Introduce your visit: You are here to provide support (not to evaluate them!) Opportunity for them to ask questions and to make possible and necessary changes to the Plan of Action for Improvement.
2. Use the following format for the support visit and ask these questions to the group.
3. Try to capture all answers in the document
4. At the end of your first visit you and the team can come to the conclusion that changes are needed for the Plan of Action. It is ofcourse oke to make changes. However, it is important to make them specific and concrete. Write the suggested changes down on the Plan of Action and involve the management.
5. Have fun! And dont forget to give your team lots of compliments for their work!

Format for your monitoring and support visit

Questions for your team	Answers (capture the main findings)
What went well, where are you proud of? 15 minutes **Instruction** - Each member writes it down on a piece of paper. - Stand in a circle and invite participants to share.	
What is your view on the Plan of Action For Improvement? 15 minutes **Instruction** Ask the group: - What is your view on the Plan of Action? - Is it clear for all involved? - Do you feel it is important to continue and follow up on the Plan of Action?	
Look at the Plan of Action. **Health Promotion & Behaviour Change** **(if relevant)** 15 minutes **Discuss with the group:** - Did changes (already) occur? - What changes were made to existing activities? - If not: why not - If yes please be specific - Do people have knowledge and skills what is needed to change (and implement) these items effectively?	
Look at the Plan of Action. **Section on: characteristics of effective interventions (if relevant)** 15 minutes **Discuss with the group:** - Did changes (already) occur? - What changes were made to existing activities? - If not: why not - If yes please be specific - Do people have knowledge and skills what is needed to change (and implement) these items effectively?	

Look at the Plan of Action. **Section on: SRHR (if relevant)** 15 minutes **Discuss with the group:** - Did changes (already) occur? - What changes were made to existing activities? - If not: why not - if yes please be specific - Do people have knowledge and skills what is needed to change (and implement) these items effectively?	
Look at the Plan of Action. **Section on: Stigma/ Gender (if relevant)** 15 minutes **Discuss with the group:** - Did changes (already) occur? - What changes were made to existing activities? - If not: why not - If yes please be specific - Do people have knowledge and skills what is needed to change (and implement) these items effectively?	
Look at the Plan of Action. **Section on: Measure effects on outcome level (if relevant)** 15 minutes **Discuss with the group:** - Is a plan available? - Are data collected/analyses/ report available? - If not: why not - Do people have knowledge and skills what is needed to change (and implement) these items effectively?	
General	
Discuss with the group: What are barriers for implementation? Do you have solutions? 20 minutes	
Discuss with the group: When do you plan to finalise with implementation of this Plan of Action? 10 minutes	
Discuss with the group: What do you need to fully implement the plan of action? (discuss how to make it possible) 15 minutes	
How is management and how are other colleagues involved? (discuss ways to involve them) 15 minutes	
What questions do you still have? 15 minutes	
180 minutes	

Part 3:
Appendices

Facts and figures per country

These statistics are based on the findings of the report "Opportunity in Crisis: Preventing HIV from early adolescence to young adulthood", published in June 2011 (Unicef). They can be used in the introduction of the Training to motivate trainees why there is a need for quality programmes.

Ethiopia
HIV prevalence rates among young people have slightly declined in Ethiopia
…but still:
- 2,6% of young people (15-24 years) was HIV positive in 2009[5].
- In Ethiopia 20% of girls and 33% of boys do have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Ethiopia:
- 73% of girls do not have prenatal care on regular basis;
- 66 % of girls do not know where to get a condom;
- 5 % of boys got tested and received their results.

Ghana
Decline in HIV prevalence among youth
….but still:
- 8300 new infections among young people a year.
- In Ghana 28% of girls and 34% of boys do have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Ghana:
- 26 % of girls do not know where to get a condom;
- 7 % of boys got tested and received their results.

Kenya
Decline in HIV prevalence among youth
….but still:
- 42,000 new infections among young people a year.
- In Kenya 48% of girls and 55% of boys have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Kenya:
- 35 % of girls do not know where to get a condom;
- 31 % of boys got tested and received their results.

Malawi
Decline in HIV prevalence among youth
….but still:
- 26,000 new infections among young people a year.
- In Malawi 42% of girls and 42% of boys do have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Malawi:
- 35% of girls do not know where to get a condom;
- 31% of boys got tested and received their results.

Mali
Decline in HIV prevalence among youth
….but still:
- 1600 new infections among young people a year.
- In Mali 18% of girls and 22% of boys do have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Mali:
- 75% of girls do not know where to get a condom;
- 5% of boys got tested and received their results.

Nigeria
Decline in HIV prevalence among youth
….but still:
- 120,000 new infections among young people a year.
- In Nigeria 22% of girls and 33% of boys do have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Nigeria:
- 63% of girls do not know where to get a condom;
- 7% of boys got tested and received their results.

Senegal
Decline in HIV prevalence among youth
….but still:
- 2200 new infections among young people a year.
- In Senegal 19% of girls and 24% of boys do have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Senegal:
- 54% of girls do not know where to get a condom;
- 2% of boys got tested and received their results.

---

5   Statistic based on "Country Progress Report on HIV/AIDS Response, 2012", published by Federal HAPCO incorporation with UNAIDS Country Office and WHO. Downloadable at: www.unaids.org/en/dataanalysis/ knowyourresponse/countryprogressreports/2012countries/GAP%20 Report%202012.pdf

South-Africa

Decline in HIV prevalence among youth

....but still:

- 160,000 new infections among young people a year;
- 930,000 young people (15-24 years) are HIV positive,

In 2009 in South-Africa:

- 13,6 % of all girls in South-Africa are HIV positive;
- 4,5 % of all boys in South-Africa are HIV positive[6].

The United Republic of Tanzania

Decline in HIV prevalence among youth

....but still:

- 40,000 new infections among young people a year.
- In the United Republic of Tanzania 39% of girls and 42% of boys have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in the United Republic of Tanzania:

- 41 % of girls do not know where to get a condom;
- 19 % of boys got tested and received their results.

Uganda

Decline in HIV prevalence among youth

....but still:

- 46,000 new infections among young people a year.
- In Uganda 32% of girls and 38% of boys have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Uganda:

- 30 % of girls do not know where to get a condom;
- 12 % of boys got tested and received their results.

Zambia

Decline in HIV prevalence among youth

....but still:

- 27,000 new infections among young people a year.
- In Zambia 38% of girls and 41% of boys have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Zambia:

- 24 % of girls do not know where to get a condom;
- 14 % of boys got tested and received their results.

Zimbabwe

Decline in HIV prevalence among youth

....but still:

- 22,000 new infections among young people a year.
- In Zimbabwe 53% of girls have comprehensive knowledge on HIV. UNGASS Target for 2010 was 95%.

In 2009 in Zimbabwe:

- 30 % of girls do not know where to get a condom;
- 31% of boys do not know a place to get tested;
- 12 % of boys got tested and received their results.

---

6   Source: State of the World's Children, UNICEF, 2012. Downloadable at:
     www.unicef.org/sowc2012/pdfs/SOWC%202012-Main%20Report_
     EN_13Mar2012.pdf

Determinants of Behaviour

Determinants	Behaviour	
Behaviour	Delay the onset of sexual intercourse.	Seek help and support for SRH needs.
Intention	Young people have the intention to delay first sexual intercourse.	Young people have the intention to seek health services when needed.
Knowledge	- Understand that a girl can get pregnant when she has unprotected sex, even if it is only once or the first time she has sexual intercourse. - Understand the routes of HIV transmission. - Are able to identify the factors that influence one's ability to resist partner pressure to have sexual intercourse (e.g. financial independence, self-esteem, communication skills). - Understand what safe sex means. - Understand what delay means. - Are able to list criteria for being "ready" to have a sexual relationship.	- Know the symptoms of STI's and that STI's can be treated well. - Know places where youth friendly health services are provided. - Know people or organizations that can assist them with SRH.
Risk-Perception	- Identify themselves as vulnerable to pregnancy, abortion, STIs, and HIV when having unprotected sexual intercourse. - Understand that boys and girls might have different expectations of being private with someone of the other sex. - Understand that having occasional sex within a steady relationship can both lead to health risks.	- Understand that if they suspect to have a STI or HIV, they must seek health services and testing. - Understand that if they have unprotected sex they must get tested for STI's and HIV. - Understand that waiting to get tested can lead to increase of risks of HIV or knows that it can increase problems with STI's. - Understand that STI's can be treated well if tested soon enough.
Attitude	- Know perceived benefits of delay at their age. - Express a positive attitude towards the delay of sexual intercourse. - Are in the opinion that boys and girls can be friends without a sexual relationship or having sex.	- Express a positive attitude towards going to health service providers. - Understand that young people have the right to good health provision.
Social Influence	- Are aware of the perceptions of the norms of significant others (peers, parents) related to sex and delay of sex. - Are able to discuss the norms that enable or make it difficult to say no to sex. - Have a majority of friends who do not have sexual intercourse. - Know two people in society that support the delay of sexual intercourse.	- Know how parents, peers, and other community members view young people seeking help at a health service provider. - Have positive experiences with or believe that healthcare providers are friendly and approachable for young people.
Self-Efficacy & Skills	- Have confidence in own skills to resist sexual intercourse - Are able to avoid and get out of a situation that could lead to sexual intercourse. - Are able to refuse and persuade a partner not to have sexual intercourse.	- Have confidence to go to a health care provider or counsellor.
External factors	- IEC materials or peer groups on the delay of sexual intercourse are available at school, clinic or nearby CSO's. - There are fun or edutainment activities to do for young people.	- Health services are nearby. - Health services provide services to young unmarried people. - Health services are youth friendly. - Health services are affordable.
The cultural, religious and societal context	- Important religious or societal figures value the decision of delaying sexual intercourse.	- Important religious or societal figures value youth friendly health services.

Training & Support

Do you want to increase quality of your SRHR or HIV prevention intervention for youth and show the results to others?
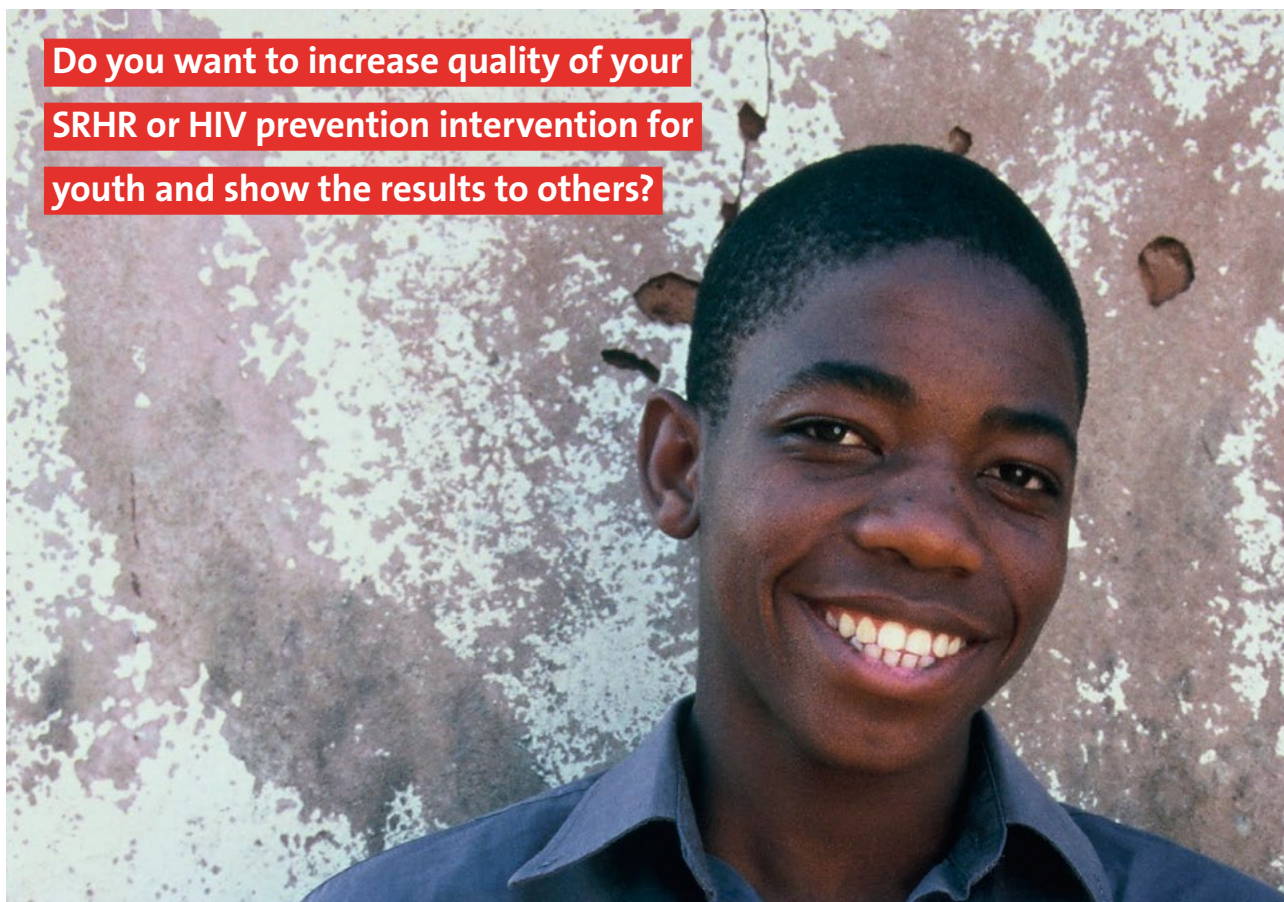
Through research studies we know a lot about the effectiveness of comprehensive sexual and reproductive health and rights (SRHR) education and HIV prevention programmes for youth.[7] Even though strong programmes exist, this knowledge is not widely used and applied. Many programmes do not fully address the needs of young people or only focus on a few aspects that contribute to behaviour change. These programmes have limited chances of success and are not as effective as they could be.

Capacity building organisations seek to support civil society organisations (CSOs) in 12 African countries to increase the effectiveness of their SRHR education and/or HIV prevention programmes for young people. Trainers are available in Kenya, Ethiopia, Zimbabwe, Nigeria, Senegal, Mali, Uganda, and Ghana, to support civil society organisations. In 2014 also trainers from Tanzania, South Africa, Malawi and Zambia will be available

The aim is that by the end of 2015, at least 150 CSOs from these 12 different African countries will benefit and at least 80% of them have adapted their programme activities to increase effectiveness, or developed a plan of action for improvement.
UNESCO, as the leading UN agency in the field of sexuality

"This was totally new for me. I never analysed the behaviour of young people so thoroughly. You just assumed and tried your best to change them. Now we know it is much more complex and before you get young people to use condoms, they first need to be able to buy them, use them properly and have communication skills".
Participant of MEADOT, Ethiopia

education and HIV prevention for young people in educational institutions, is the advisor of this initiative and contributes to the quality of the programme

The project is based on experiences of a pilot project (2011/2012) and research study in Zimbabwe (university of Amsterdam) funded and supported by: Rutgers WPF, Oxfam Novib, ICCO, Cordaid, HIVOS, Educaids, Dance4Life, STOP AIDS NOW! and UNESCO

---

7   Kirby, D., Laris, B.A., & Rolleri, L. (2006). The Impact of Sex and HIV Education Programs in Schools and Communities on Sexual Behaviors among Young Adults. Research Triangle Park, NC: Family Health International.

What will be addressed in the training on SRHR education and HIV prevention for youth?

Health promotion and behavi**ur programme & Planning and Support tool** – Many organisations want to improve young people's quality of life and health. So, we want to implement SRHR programmes of good quality as well. However, developing high quality programmes is not easy. Experience and evidence from all over the world shows what does and what doesn't contribute to quality. In this first session of the training we focus on health promotion. Participants will get familiar and learn to work with the Intervention mapping steps, and relate this to own SRHR and HIV prevention interventions by using the Planning and Support tool to reflect on the quality of their own work.
Sexual reproductive health and rights is in almost all cultures surrounded by taboo. Based on this bias SRHR of young people is often limited to abstinence messages which not acknowledge the practical reality and the right to choices of young people to practice and enjoy sexuality whenever they are ready for it. In the sessions on SRHR for young people make you familiar with tools and methods you can use to discuss or train quality SRHR education and HIV prevention programs for young people.
Gender inequality – Gender inequality refers to unequal treatment or perceptions of individuals based on their gender. In our sessions on gender awareness we will discuss concept of gender, roles and sex roles and focus on power and transactional relationships. Most importantly we will reflect on current programmes for young people on SRHR and HIV prevention and how gender can be integrated.
Stigma and discrimination – HIV related stigma has long been recognized as one of the main obstacles to HIV prevention, care, support, treatment and yet little has been done on a large scale to combat the HIV stigma. Stigma and discrimination need to be addressed when we talk about SRHR and HIV prevention programmes for youth. In the sessions we will reflect on ways CSO's can integrate this in their work.
Measure effects of programme activities on outcome level – is our final topic in the training and support sessions. We will use the workbook: Are you on the right track,

Two practical tools

Planning and Support Tool
The study of Kirby and colleagues in 2006 presents the characteristics of effective interventions. Programmes, for instance, should be based on the real needs of young people and need to use a mix of messages. When organisations integrate the characteristics in their programmes, the chances of actual behaviour change among youth are assumed to increase. The characteristics are incorporated in the *Planning & Support Tool for SRHR/ HIV Prevention Interventions for Young People* (2009), a tool that can be adequately used for developing, implementing, monitoring, and evaluating SRHR education and HIV prevention programmes for youth. The *Planning & Support Tool* translates useful academic models, evidence, theories and other information into practical use and was developed by Rutgers WPF, STOP AIDS NOW! and organisations in South Africa, Pakistan and Zimbabwe. Academic knowledge and practice are thus linked. Non-governmental organisations (NGOs), community based organisations (CBOs) and faith based organisations (FBOs) in Ethiopia, Kenya, Nigeria, Pakistan, South Africa, Zambia and Zimbabwe made use of the tool and concluded that it is practical and user-friendly.

Are You On The Right Track?
Are You On The Right Track? (2011) has been developed by STOP AIDS NOW! and Rutgers WPF in close collaboration with CSOs in Zimbabwe. The workbook is a hands-on instruction manual to develop an outcome monitoring and evaluating plan that fits the organisation's specific situation. It demonstrates six steps organisations need to take to create their own tailor-made plan to measure effects of their programme activities on outcome level. It assists organisations to go beyond counting numbers and start to measure the actual change on the lives of youth. Programme activities that focus on behaviour change concentrate on influencing determinants of behaviour: attitudes, knowledge, risk perception, skills, self-efficacy, and social influences. The changes in these determinants will be measured by using the workbook. The results will give insight in the effects of interventions, and will suggest necessary programme changes. The actual linkage between social scientists and organisations that implement the programmes makes the *Are You On The Right Track?* Workbook successful and user-friendly. The work is used and tested in Zimbabwe, Kenya and Senegal and Mali in 2012.

"Working with this Workbook really opened our eyes. So far we were only measuring the effect of our activities on one level, being knowledge. We saw knowledge increasing, but the pregnancies among young girls kept on rising as well. We didn't understand where we were going wrong. Now we know that behaviour is not only influenced by knowledge but also by skills and socials influences. Since we started measuring the other two determinants as well, we see where gaps are. This makes it much easier to determine our focus and improve our activities!"
Enet Mukurazita, Director Young Africa, Zimbabwe

Appendices

Practical Information for Organisations who Work with Young People on SRHR Education and or HIV Prevention

Why Participate?
- The tools help you to understand which factors determine the behaviour of youth. Based on these insights you can adapt and strengthen your activities.
- The tools are evidence based, yet very practical and easy to implement at the same time. Implementing them doesn't require a lot of extra time, money or knowledge.
- There is no need to redesign your programmes. The tools can be implemented in your current way of working. By following the steps described in the tools you can work towards an increased impact of your activities right away.
- It helps you to show what you have achieved with your programme activities on lives of youth, you can go beyond counting numbers.

Would you like to be involved? Then this is what you can expect:
1. 7, 5 or 4 day training on Quality of SRHR and HIV prevention programmes for youth.
2. Two monitoring and support visits of your trainer/ mentor.
3. Development of a self-reflection/analysis on your programme activities for youth.
4. Development of an Outcome evaluation Plan – to measure your programme activities on outcome level.
5. Increased knowledge and skills of staff of your organisations on:
   - Sexual reproductive Health and Rights (how to communicate with youth on sexuality, norms and values);
   - Health promotion and behaviour- use of the Planning and support tool;
   - Stigma and discrimination and gender inequality;
   - Measure effects on outcome level.
6. Availability of a Plan of Action for Improvement of your programme activities.
7. All will result in improved programmes and you will be able to communicate more in-depth about the results of your programme.

The content we offer is flexible; we can make adjustments based on your organisational needs.

If you have an interest, what do we expect from you?
1. Interest to work on quality of your SRHR and HIV prevention programme for youth.
2. Participate in 4, 5 or 7 day training and be available for two monitoring visits.
3. Involve colleagues and management after the training.
4. Analyse your running and already funded programme (using the Planning and Support tool) with colleagues and management After the training (between 4 to 8 hours).
5. Participate and be available for monitoring and support visits.
6. Willingness to follow up on your Plan of Action for Improvement.
7. Be part of an evaluation study.

Memorendum of Understanding

Between [your organisation's name] and **[organisation name of participants]** *Working towards Evidence and Right based SRHR/HIV prevention interventions for young people 2013.*

1.   About this document
1.1.   This document articulates the terms of collaboration between **[your org.]** and **[their org.]** both from **[your country]**, by means of this document, invites **[director name]** and staff members to arrange for and participate). In a training; *Working towards Evidence and Right based SRHR/HIV prevention interventions for young people.*
1.2   **[Director name]**, director of **[their org.]**, accepts this.

2.   Parties to this MoU
2.1   **[name of your org.], [short description of your organisation and register number],** legally represented by **[name of your director]** and practically represented in the context of the Project, by **[trainer name], [position of trainer]**, at **[name of your organisation].**
2.2   **[name of participants org.], [short description and register number]** legally represented by **[director of organisation]** and practically represented in the context of the aforementioned project, by **[all names of participating staff members].**

3.   Principles of cooperation
3.1   The training is for staff and management of **[their org.]** and takes **[fill in numbers of]** days.
3.2   The training results in a Plan of Action for improvement of the programme.
3.3   After the training, **[your org.]** will provide two more support visits and assists **[their org.]** in implementation of this Plan of Action during those two visits.

4.   (Financial) responsibilities
4.1   **[your org.]** provides **[fill in number of days]** training days **[fill in data]** and two support visits **[fill in data]**.
4.2   **[their org.]** arrange for the venue, and lunch for facilitators and staff during the training.
4.3   **[your org.]** agrees to support **[their org.]** with material books and information to use in all the training sessions.
4.4   **[your org.]** and STOP AIDS NOW! will deliver an evaluation report of the project.
4.5   **[their org.]** will ensure that **[names of all participating staff]** will be available for all agreed training sessions:
4.6   **[their org.]** will participate within the evaluation of the project.

5.   Intellectual property
5.1.   The Parties agree that all rights related to the concept, format, and products of the Project and outcomes of the training belong to **[your org.]** and STOP AIDS NOW! and Rutgers WPF.
5.2.   In **[fill in data]** and at the end of the project, **[fill in data]**, **[director's name]** and **[staff members]** will be evaluated.
5.3   The intellectual property rights of the Planning and Support Tool lies with its developers, Rutgers WPF and STOP AIDS NOW! During the course of this training no changes may be made to the tool. Suggestions for improvement of the tool will be part of the evaluation process.

6.   Duration of this MoU
6.1   This MoU is valid from **[DD/MM/YY]**, until **[DD/MM/YY]**.

7.   Termination of this MoU
7.1.   Each party is entitled to terminate the MoU unilaterally. This is to be accomplished by registered letter with immediate effect if the other party is in material breach of this MOU, and after having received a written notice to remedy the breach within one month, and the other party fails to remedy the breach within said the aforementioned time period.
7.2.   This MoU is automatically terminated under the following conditions:
    a. A party has filed a petition for its own bankruptcy, is declared bankrupt, has adopted a resolution to enter into liquidation, or for whatever reasons has become too heavily indebted or insolvent to take on activities within the Project.
    b. A party is prevented from performing its obligations under this MoU because of force majeure during a continuous period of 30 days or more. Force majeure includes acts, events, omissions or accidents beyond the reasonable control of the Party, such as strikes, natural calamities, war or civil unrest, or refusal of a competent authority to provide the necessary permits or consents.

8.   Final provisions

8.1.   Each party to this MoU will be responsible for paying its own taxes, social security premiums or any other levies or duties that (may) directly or indirectly relate to the Project.

8.2.   This MoU does not intend to form any form of joint venture between the parties.

8.3.   The Parties will not be entitled to enter into agreements or perform any legal acts on behalf of the other party or any third parties in relation to the training without the other party's explicit agreement.

8.4   This MoU and all activities performed in relation to the contract are subject to Ugandan law.

8.5.   In case of conflict, this contract will be interpreted under the laws of **[your country].**

_____

[Name of your director], Executive Director **[name of your organisation]**

_____

[Name of your director], Executive Director **[name of your organisation]**

By: **[Fill in names of others involved]**

1.

2.

3.

Factsheet: Youth Participation

This factsheet presents the evidence and facts on the question: *How can you encourage CSOs to involve young people meaningfully by using benefits of youth participation, practical examples and suggestions?* The current generation of young people is the largest in history. Nearly half of the world's population is under the age of 25 years. It is important that young people participate in the development decisions of today, because research shows (among other reasons) that young people can be of asset to your organization to develop more effective and sustainable quality programs. Moreover, it is their right to participate in interventions that affect them.

Some definitions of young people

Young people can be defined by age (number of years old), 2) by biological/psychological development (developmental stage), 3) or socially constructed (social position and role capabilities & entitlement).

Some definitions of meaningful youth participation

1. The active, informed and voluntary participation of young people in all phases and all layers of decision-making: research, design, planning, implementation, monitoring and evaluation, including youth leadership and ownership, empowerment youth, fully informed, guidance and support and recognition of diversity of youth (Choice 2014).
2. Youth participation means working with and by young people, not only working for them. The young people's rights approach to development acknowledges that young people have the right to participate (Convention on the rights of the Child 1989, Article 12).

Important considerations when involving young people

1. **Youth participation is an ongoing process.** Youth participation goes beyond collecting young people's needs and opinions through surveys or involving only a limited number of representatives (although also important!). Consulting young people about projects is important to make quality programs, but it should be part of a wider and ongoing process in which young people are also involved in project planning and implementation.
2. **Train young people.** It takes time, effort and sometimes also financial resources to involve young people meaningfully. For example a young person and adult facilitator both need training, for example they need

to build on self-esteem, communication skills and knowledge. Especially if you involve young people as decision-makers they must receive training on analytic skills and problem solving. This is not done overnight. However, you can be creative, by involving youth researchers from local universities or volunteers to be more cost-effective. Remember that involving young people does not cost more than involving adults. There are also a lot of benefits to involve young people that, in the end, might be very cost-effective (see the benefits below).

3. **Define participation.** Before involving young people, an organization must discuss what participation means for them. How, when and whom is going to participate. How can staff support young people and how can they ensure their safety?
4. **Train adult staff members.** Youth participation does not mean that knowledgeable adults (like staff members) should not be involved anymore or as much. On the contrary, it is very important that adults are involved. However, facilitators (CSO staff) also need training to ensure opportunities for young people to participate, to listen give support and learn how to make a safe non-judgmental environment in which young people's rights are recognized and advocated for. Most important is to invest in a trustworthy relationship between the involved young people and staff members.
5. **Youth participation policy.** A CSO can develop a policy to ensure what has been learned becomes practice. There are many free youth participation guides (including case-studies) available online (see complete worksheet).
6. **Analyse.** There are different forms and levels of youth participation (a list of different forms can be found in the complete factsheet). Many times these forms co-exist, but with different levels of participation (see the Flower of Participation of Choice for Youth and Sexuality, in the session 3 on SRHR). These forms should be analysed and addressed separately, for example a young person involved as a peer-educator needs different training and support than a committee member.

Benefits for CSOs to involve young people

1. Experience shows that young people learn best when they are involved in an activity, because a young person becomes interested, often remembers what has been done and why it was important.
2. Young people often feel more ownership of an activity when involved. This could make an activity more needs-based and thus more effective as well as sustainable.
3. Research shows that young people will easier accept information or activities if introduced or facilitated by their peers.

4. Young people can help you gain entry into (difficult) target communities and build up trust relations.
5. Young people understand themselves and their needs best. Through participation you can strengthen their abilities and empower them to meet these needs. Also they know how it should be presented and what can be improved in activities.
6. Through their participation young people learn how to make own, thoughtful decisions and gain new experiences. Research shows that young people stick more to decisions made by themselves than to prescribed and imposed decisions.
7. Your organization will gain greater credibility with both young people and adults.

Benefits for young people

1. To get a voice in important decisions;
2. To network with CSOs and NGOs;
3. To work on their CVs (future employment);
4. To learn more about SRHR and HIV/AIDS;
5. To make friends;
6. To live out passion or ambition;
7. To feel belongingness;
8. To receive materials (like free T-shirts, food, handy time, information, condoms).

Some tips to involve young people meaningfully

1. Young people are a diverse group of people. Make sure you also involve a diverse group of young people. Think about: gender, education, age, sexuality, socially excluded groups and so on, such as young people living on the street, young people addicted to alcohol/drugs, gay, lesbian, bisexual, and transgender and intersex young people, young people with mental or physical disabilities, and so on. Define your target group to understand who should be involved, where and how?
2. It is important to ensure gender equality in participation. Involve both boys and girls in gender inequality activities, because research shows that activities become more effective and sustainable. Not only in numbers, but also in decision-making opportunities!
3. Be accountable towards your target group (young people) and not only to donor agencies. Make sure that you use understandable language and appealing platforms for young people, such as Facebook, texting, or a magazine.
4. Research and publicize the effects of involving young people through outcome evaluation. You can use these results to encourage donor agencies to invest in improving youth participation within your organization.

You could arrange a meeting with donor agencies and the young people that are involved to make sure they continue to promote these young people.
5. Practical ideas and needs. If you want young people to participate, you must choose the appropriate time and place to do so: outside work or school hours and close to the young people's homes or schools. Arrange transport money, or have a meeting in a school. Make sure you can give food, equipment and support. People think better when fed and they need materials (just like staff members) to be able to take action, such as pencils, notebooks, computers, flipcharts, materials, flyers and so on.
6. Have clear guidelines for both young people and adults on confidentiality, conduct and respect. They need to know what they can and cannot do. What their responsibilities and tasks are?
7. Make sure there is also time for fun and entertainment. Watch a video, play sports, games or listen to music. This helps you create a safe environment, trust and stimulates creative thinking!
8. Avoid the "youth star" phenomenon. Discuss with both staff members and young people that it is important to have equal opportunities for all young people to participate. Young people can rotate to share opportunities of decision-making. Develop several criteria (on gender, age, education and region) to make sure that young people have equal chances of participation, include this in your youth participation policy.

Do you want to learn more about youth participation, access free materials and/or guides?

Go to our website: **www.stopaidsnow.org**
or go to SHARE and login: **www.hivsharespace.net**

Factsheet: Addressing sexual diversity (including LGBTI)

This summary presents the evidence and facts on the question: How to encourage an open discussion about equality of LGBTI youths in trainings and education about sexual and reproductive health of young people?
See for the complete fact sheet: **www.stopaidsnow.org**
or go to SHARE **www.hivsharespace.net**

Since decades international standards, including WHO's Classification of Diseases (since 1990) and the DSM for psychiatrists worldwide (since 1973), have defined **homosexuality as neither a mental disorder nor a disease.** Still, homophobia dominates many cultures and religions and sees homosexuality as unacceptable.

But, being homosexual or transgender is not a choice! There is some evidence that homosexuality might have a biological basis, but a generally agreed upon position today is that several factors contribute to a person's sexual orientation, including biological factors. We do know, however, that -- like heterosexuals -- homosexual and bisexual men and women often feel that their same-sex desires are something they can neither escape nor deny. But why is it so important to know what causes homosexuality? Nobody ever seems to wonder about the causes of heterosexuality, even though they are probably the same as for homosexuality. Regardless of cause, the rights of young people with a homosexual orientation should be respected.
However, due to homophobia LGBTIs (Lesbian, Gay, Bisexual, Transgender and Intersex) who experience the same health issues as most young people worldwide including Sub-Saharan Africa, suffer from self-stigma which aggravates their health problems. They have more mental health problems like depression, anxiety and suicide and more sexual health problems like STIs and HIV.

Although homosexuality is of all cultures and times, many countries and particularly African cultures deny sexual orientation being part of their culture. Based on prejudices and ignorance homosexuality is often portrayed as an imported Western abnormality. Consequently, rejection and exclusion of LGBTIs are common in many countries, be it at home, in schools, churches, communities, society at large, including health services.

How to encourage an open discussion about equality of LGBTI youths in trainings and education about sexual and reproductive health of young people?

Celebrating diversity

Our lives consist of diversity: people vary in culture, ethnicity, faith, gender, education, HIV-status and age, but also in sexual orientation. In addition, our different relationships – with family, friends and partners – our emotions, intimacy (emotional and physical), rights and responsibilities and power dynamics vary. Diversity is positive and makes people interesting, attractive and complementary to each other. In healthy societies we learn from and support each other. Within the concept of sexual orientation people vary as well. People can be straight, gay, lesbian and bi-sexual and their gender identity can vary in women, men, transgender, transsexuals and intersex people. Talking about sexual orientation thus means talking about intimacy, love, relationships, emotions, rights and responsibilities and power dynamics and not only about sex (SIDA 2005).

For organizing an open discussion about sexual diversity, take the next steps into consideration

STEP 1: **Always make commonly with trainees ground rules about respect, confidentiality and participation.**
Help trainees come up with own ground rules, but ensure including respect, confidentiality and participation.

STEP 2: **Integrate sexual diversity in the whole training.**
Mention sexual diversity earlier in your training makes it easier to come up with a session later on, when trainees are more familiar with openly discussing sexuality. As trigger the Carousal Game is a good example (see the session on SRHR).

STEP 3: **Speak in a common and non-judgmental language.**
- **Avoid terms like "us" and "them".** Instead: use terms like "we", "us people/human beings".
- **Avoid theological discussions on homosexuality.** Instead: discuss shared values and beliefs like respect, dignity, mercy, tolerance and acceptance. Accept that you can't change someone's beliefs overnight.
- **Encourage inclusion and avoid confusion.** Avoid abbreviations and complex descriptions as it may result into loss of attention and overwhelmed trainees. Keep descriptions simple; e.g. start talking about gays and lesbians and gradually expand to also bisexual, transgender, intersex people, WSW and MSM.
- **Respect trainees' feelings, but don't indirectly agree with anti-LGBTI attitudes.** Acknowledge feelings of discomfort or anger by saying: "I understand that it is hard to talk about sexual diversity, but let's agree upon all young people having access to information and health care". Never accept or repeat negative attitudes.
- **Don't confuse sexual orientation with sexual abuse or paedophilia.** Sexuality is only healthy when it is safe, consensual and enjoyable. Homosexuality is neither about sexual abuse nor about seducing children into sex.
- **Avoid the term "sexual preference".** This term suggests that being gay or lesbian is voluntary and therefore "curable." Being gay, lesbian or bisexual is something from birth on; it is not a choice or decision (GLAAD 2010).

Sexual orientation: the scientifically accurate term for an individual's enduring physical, romantic and/or emotional attraction to members of the same and/or opposite sex

Straight people If persons within a significant period consistently desire (emotionally, physically and/or romantically) people from the opposite sex (men who prefer women and women who prefer men) and identify as such.

Gay or lesbian people If persons within a significant period consistently desire (emotionally, physically and/or romantically) people from the same-sex (men who prefer men and women who prefer women) and identify as such. Avoid the term homosexual; it reduces people to only their sexual desires and it has been the basis for stigmatizing gays and lesbians.

Bi(-sexual) people If persons within a significant period feel attracted (emotionally, physically and/or romantically) to both sexes (women and men) and identify as such.

MSM or WSW If persons within a significant period physically desire or practice same-sex relations, but do not identify themselves as gay or lesbian, they are called MSM (men who have sex with men) and WSW (women who have sex with women).

Gender identities refer to one's internal, personal sense of being a masculine or a feminine human being.

Transgender People who identify their gender identity different from the sex that was given at birth are called transgender.

Intersex Persons are called intersex when their biological sex is ambiguous, including many genetic, hormonal or anatomical variations such as the Klinefelter Syndrome.

Intersex people often do not agree when parents and medical professionals assign intersex infants a sex and perform surgical operations to conform the infant's body to that assignment.

STEP 4: Chose your approaches: Note that this is a summary; read the complete approaches at: **www.rutgerswpf.org** Depending on the local context and/or the existing knowledge and/or dominant attitudes among trainees, choose one or preferably a combination of the next three approaches:

1. Approach 1: The Public Health Approach (summary)
The public health approach takes among others into account the bridge between the HIV epidemic in the sexual network of LGBTI, MSM (men who have sex with men) and WSW (women who have sex with women) and the epidemic in heterosexual partners. It therefore is crucial to address SRHR issues of LGBTIs as important for whole the society. LGBTIs are a vulnerable group who needs protection and support. Their well-being and health serve whole the society and helps fighting HIV.

Key aspects:
1. Use facts to show that LGBTI people have been there in all times and all cultures; it is NOT a Western concept (see complete version).
2. Discuss the **sexual and mental health issues of young LGBTI people:** such as more at risk to commit suicide, self-harm, depression, drug/alcohol abuse, anxiety issues, exclusion, rejection, violence, homophobia. Also, most young LGBTI people cannot access information or services which are non-judgmental and youth-friendly and therefore they are put more at risk of HIV/AIDS and STIs.
3. Due to discrimination, criminalisation and (self-) stigmatisation LGBTI people are forced to lead a 'normal' life. Their safety, health, wellbeing and future, including those of their family might urge a ''double life'', hindering them to be open about their sexual orientation and to love the ones of the same-sex they love. They can only enjoy relationships in secrecy, putting themselves in positions and places of higher risk. As U.N. Secretary General Ban Ki Moon stated in his speech: lives are at stake. See and use **www.youtube.com/watch?v=lUizJUQIbq4**
4. Criminalisation and discrimination push LGBTI young people in **going underground** and hinder visibility and reaching out to young LGBTIs with information and health care, causing them being more likely to engage in risky behaviour and unsafe sex practices. Not addressing health issues of LGBTIs, MSM and WSW increases the risk of spreading –the usually higher prevailing – STIs, including HIV from their sexual network to that of heterosexual partners. Fortunately, most countries acknowledge the most at risk populations (MARP) in fighting AIDS, to which LGBTIs belong, by a **MARP strategy** See: **www.aidstar-one.com**

2. The Learn to Unlearn Approach (summary); to be combined with approach 1 and/or 3
This approach aims for the acceptance (or tolerance) of sexual diversity and LGBTI young people from an individual's, professional and organisational point of view. Key is to learn to differentiate between individual and professional values in an organizational context. Professionals learn step by step to unlearn their biased, prejudiced and judgmental positions towards sexual diversity through evidence-based action learning and putting a non-judgmental, evidence-based way of working in practice. This approach is based on the idea that how more you learn about something (evidence and facts) through actions (learning by doing), you will unlearn former mind-sets (judgments, morals, beliefs and values). Key aspects:
1. **Get evidence and correct information** (evidence-based). Most of the times, evidence and facts are in conflict with existing social, cultural and religious norms (mind-sets). Use facts on prevalence, health issues and sexual orientation and clearly state that homosexuality is not a disease or mental disorder, but an issue hard to accept for traditional cultures and religions.

2. **Collect and present testimonies of LGBTI's people.** Invite a gay and/or a lesbian for a testimony (or show a video of them) as they themselves can give best insight in the – often difficult – life of LGBTIs. They can help take the perspective of LGBTIs and increase empathy among trainees. Invite LGBTIs who are acceptable for trainees and who can create empathy, using language based on common beliefs, hopes and values. Show that LGBTIs are ordinary people with same basic needs like intimacy and love instead of being limited to sex.
3. **Use role models of/for LGBTI people** (There are several LGBTI organisations in your country. A list of organisations is provided in the complete factsheet).
4. **Make a distinction between evidence and beliefs on health** (see Guide for Trainers)
5. **The Olsson's adapted "Stairs of Tolerance"** (These steps of tolerance lead people to a feeling in equality for both LGBTI and straight young people, based on respect and mutual understanding).

3. The Rights-based Approach (summary)

The rights-based approach emphasizes that all people should be treated equally; both males and females, whatever their sexual orientation is, whatever sexual health problem they have or had, whatever their HIV status is and so on. This approach is based on the "The Universal Declaration of Human Rights" (UDHR) of 1948, proclaiming that all human beings are born free and equal in dignity and rights. All human rights are universal, interdependent, indivisible and interrelated. Sexual orientation and gender identity are integral to every person's dignity and humanity and must not be the basis for discrimination or abuse.

In 1989 most countries of the world subscribed the International Convention of the Rights of the Child, which considers young people as human beings with their own rights, including the rights to express views and have them taken seriously. At the conference in Cairo, in 1994, these rights were basis for young people's sexual rights. They need to get the information and services, which help them to make a well- informed decision about their sexual life whenever that starts. Furthermore, young people need to be given the opportunity to participate at all levels of the policies and programs targeting them.

Although the rights of homosexual youth have not been made explicit in UN treaties, they do have relevance for homosexual youth, like the rights to make their own choices, to equality and to be protected from discrimination. The UN Committee on the Rights of the Child has explicitly mentioned homosexuality in one of sixteen recommendations on combating the negative effects of HIV/AIDS on the lives of children: "Children and adolescents in any type of disadvantaged situation face greater risks of HIV infection, or lack of care, and their needs must be met. Sexual exploitation, discrimination against homosexual boys, and young people living in institutions or on the streets are four of many examples of urgent needs."

Finally, also WHO's definition of sexual health includes rights. It states that sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (draft definition, WHO, October 2002).

Key aspects of the rights-based approach:
1. **Nobody can claim one's human rights by denying others' human rights,** including those of LGBTI (young) people. If people violate someone's human rights, it means they treat that person like less than being human. It encourages action if rights have been violated (e.g. sexual abuse, discrimination).
2. At the core of the rights-based approach is the **recognition of the existence of LGBTIs**. Without a positive recognition it is impossible to claim and fight for the protection and practice of their rights.
3. To be able to promote and protect the rights of LGBTI people, **a clearer understanding is needed of how people create and manifest their sexual practices,** and if and how this is part or not of sexual orientations and gender identities (read information on LGBTI, WSW and MSM).
4. Understand the difference between societal norms and rights (use Guide for Trainers).
5. **Main rights for young people are the same for LGBTIs,** for example the right: 1) to self-determination, be themselves and enjoy the one they love; 2) to enjoy safe and consensual sexuality and not to be judged, persecuted or discriminated against, based on sexual orientation; 3) to access information and health services without being judged no matter their sexual orientation; 4) to express their sexuality just like other people; 5) to equality, security, privacy and being free from and protected to discrimination; 6.to participate in policies and program affecting them. Human rights are indivisible, meaning that all rights are equally important, reinforcing and complement each other (SIDA 2005).
6. The rights for LGBTI youths are the same as the rights that we all want and have. Make sure you **end the discussion in common grounds.**

Find more information

More information on preparation, the different approaches, statistics, facts, terminology, legislative issues, LGBTI organisations, other materials, and other FAQs can be found on our website, in the complete factsheet of this summarized version.

Factsheet: Faith-based organisations

This factsheet presents the evidence and facts on the question: How do you encourage open discussions about condom-use with faith-based organisations that uses the approach abstinence only?

Churches and mosques have long been safe spaces for young people. These institutions are places where young people form and reinforce their moral values, where self-esteem is build and life lessons are taught. Public health research has shown that religion can be a positive factor to support young people's healthy behaviours in the future. Faith is an important aspect in most countries and many young people search for guidance from faith-based organisations. This provides us with opportunities to inform young people on SRHR and HIV/AIDS prevention. Yet, training and supporting faith-based organisations on SRHR/HIV prevention interventions for young people can also have its challenges. Discussing sexuality and condom-use with young people can be taboo in many communities because of different norms and beliefs.

How do you encourage open discussions about condom-use with faith-based organisations that uses the approach abstinence only?

STEP 1: Always make commonly with your participants ground rules about respect, confidentiality and participation. Let participants come up with their own ground rules, but ensure respect, confidentiality and participation are included (also see chapter 4 on facilitation skills for more information).

STEP 2: Integrate condom-use and sexuality in the whole training. If you mention it earlier on in the training and participants are more familiar in openly discussing sexuality, it becomes easier to give a session on it later on, for example use The Carousal Game (see the session on SRHR).

STEP 3: Speak in a common and non-judgmental language:
1. Respect your participants' feelings, but do not indirectly agree with anti-condom norms or attitudes. For many people discussions on condom-use can feel uncomfortable or even cause anger. These issues are real. Do not deny them, instead say: "I understand that it is hard to talk about condom-use, but we can agree about the importance of giving all young people access to information and healthcare services". Acknowledge the discomfort to talk about condom-use, but do not accept or repeat the negative attitudes.
2. Do not try to convince organisations in such a way that it results in a unidirectional and judgemental discussion between you and the participants. Facilitate dialogue between them. Propose ideas and reflect. Ask a lot of why and how questions (ACET trainer Naomi).

3. Instead of promoting abstinence, encourage faith-based organisations to use the method: "Delay of sexual activity". Discuss the possibilities of strengthening the organisation's activities on sexual delay/abstinence in combination with providing information on condom-use. Young people who are sexually active also need and have a right to information, healthcare services and participation in decision-making.
4. Do not make participants answer questions that they feel uncomfortable with. Ask the participants to share their own experiences, examples, and testimonies as much as possible. Also share your own to make it more personal. Have an inviting attitude and be open yourself. Tell something about your own teenage time and sexuality education when you were young.
5. Use Bible passages in your training sessions as a way to frame discussions in language that is comfortable to Christians. These passages may help young people and professionals to reflect on challenging issues (see the FHI manual "Teaching youth about RH and HIV/AIDS from a Christian Perspective").[8] Do not use them as evidence of a particular point of view or as public health information. The passages have different meanings to different readers and should only be used as reflecting methods.

STEP 4: Choose your approaches: The appropriate combination of approaches depends on the local context and/or the existing knowledge and/or dominant attitudes among trainees, you can use one or preferably a combination of the next two approaches:

1. The evidence-based learning approach
This approach aims for the acceptance (or tolerance) of perceiving young people as sexual beings in need of information and healthcare services (including condoms) from an individual's, professional and organisational point of view. Key is to learn to differentiate between individual and professional values in an organisational context. Professionals learn step by step to unlearn their biased, prejudiced and judgmental positions towards sexual diversity through evidence-based action learning and putting a non-judgmental, evidence-based way of working in practice. This approach is based on the idea that the more you learn about something (evidence and facts) through actions (learning by doing), you will unlearn former mind-sets (judgments, morals, beliefs and values). Key aspects:

---

8   The FHI360 manual on "Teaching youth about RH and HIV/aids from a Christian Perspective" (including biblical quotations linked to lessons, originally developed in Namibia) is available online: http://bit.ly/1kG5A4f

6. **Get evidence and correct information** (evidence-based). Most of the times, evidence and facts are in conflict with existing social, cultural and religious norms (mind-sets). There are many studies on condom-use with results like:
    - Numerous studies have shown that providing young people with information about condoms does not lead to increased sexual activity. This is a fact.
    - Although abstinence is the only way to guarantee staying 100% safe, condoms are by far the best protection for anyone who is sexually active. Many studies show that young people are sexual active. Health care professionals should also ensure the safety of these young people.
    - Young people (15-24 years) account for 41% of new infections among adults over the age of 15 years old in 2009. This means that an estimated of 5 million young people (15-24 years) are living with HIV/AIDS (2009).
    - Young women have a disproportionly high risk of infection in comparison to young men. They account for 72% of all infections in Sub-Saharan Africa. South Africa, Nigeria, Uganda, Kenya, Zambia, Malawi and Zimbabwe belong to the twenty sub-Saharan African countries with the most new HIV infections among young people (15-24 years). An estimation of 53% of girls in Sub-Saharan Africa does not know where they can get a condom.[9]
7. **Invite young people to participate**. Invite young people to participate (or show a video) as they themselves can give best insight of their needs and lives to increase empathy and understanding among participants. Invite young people who are sexually active and practice safe and consensual sex, for example a peer-educator. Train and support these youths before they present their needs and issues.
8. **Make a distinction between evidence and beliefs on health**. For example, a fact is that providing young people with information about condoms does not lead to increased sexual activity. A value is that someone thinks it is wrong for a young person to use a condom.
9. **Correct myths and misconceptions.** Use the myths or fact test in the Guide for Trainers to.

2. The human rights-based approach

The rights-based approach is based on the "The Universal Declaration of Human Rights" (UDHR) of 1948, which proclaims that a person has inalienable rights simply because he or she is a human being.[10] This means that nobody can lose these rights as nobody can cease to be human. If people violate someone's human rights, it means they treat that person like less than being human. The human rights are indivisible, meaning that all rights are equally important, reinforcing and complement each other (SIDA 2005). **The rights-based approach emphasizes that young people to take control of their own sexual and reproductive life and to become self-reliant. Young people have the right to self-determination, comprehensive sexuality education, information, youth-friendly services, protection and participation (including condom-use).** It also encourages action if rights have been violated (think of sexual abuse or discrimination). Read more about human rights in the Guide for Trainers or in the complete factsheet. Key aspects:

1. At the core of the rights-based approach is the **recognition that young people are sexual beings** that have the right to and decide for themselves when to enjoy sex by practicing safe and consensual sex. Without a positive recognition it is impossible to claim and fight for the protection and practice of their human rights.
2. To be able to promote and protect the rights of young people, **a clearer understanding is needed of how people create and manifest their sexual practices** (use facts and evidence on young people and sexual practices).
3. **Understand the difference between societal norms and rights** (use Guide for Trainers). The rights of young people are for example: 1) Self-determination, be themselves and enjoy the one they love, 2) Enjoy sex by practicing safe and consensual sex; 3) Access information and services no matter their sexual orientation; 4) Express their sexuality just like other people; 5) Have consensual sex.

Find more information

More information on preparation, the different approaches, statistics, facts, terminology, legislative issues, other materials, and other FAQs can be found on our website (in the complete factsheet).

---

9   This data is derived from the New Report on HIV Infections in Young People released, June 2011. This report, published by UNICEF with UNAIDS, UNESCO, UNFPA, ILO, WHO and the World Bank, describes the state of the epidemic in young people, the evidence for effective responses that address behavioural, social and structural challenges and prevent new HIV infections in young people (Unicef 2011). Download the report through this link: Unicef (2011) www.unicef.org/aids/index_58689.html

10   The Universal Declaration of Human Rights (1948) included the internationally agreed human rights, such as the right to education, health care, protection, support and freedom of expression.

Appendices

Other relevant materials

Healthy Woman, Healthy Men, Healthy Families (STOP AIDS NOW!) – This toolkit contains guidelines and exercises for working on HIV, while promoting gender equality and women's rights. Its conceptual approach is to support users through a learning journey leading to an empowered life in relation to HIV. The target audience is community educators working on health and life-skills with groups of various levels of education and understanding.
www.stopaidsnow.org/healthy-woman

Involving young people researchers (Rutgers WPF) – 'Explore' is a Toolkit (developed and published by Rutgers WPF and IPPF) for involving young people as researchers in SRHR programmes, amongst others on basis of their experiences with the 'Do They Match' research project. The toolkit includes guidelines to create conditions for successful youth participation in research and enhancing the effectiveness of youth SRHR programmes, as well as 3 types of manuals to train and support young people to conduct qualitative data collection for research and Monitoring and Evaluation.
www.rutgerswpf.org/explore-toolkit

Planning Sexuality Education Programme -Intervention Mapping Toolkit (Rutgers WPF) – The Intervention Mapping Toolkit provides elaborate step by step guidance to develop sexuality education programmes for young people in a systematic way, using theories and existing evidence. The Intervention Mapping (IM) toolkit translates useful academic models, evidence, theories and other information into a practical 'manual', providing many tips, experiences and tools that have been used in projects in Africa and Asia. These projects aimed at the design, implementation and evaluation of sexuality education programmes for young people.
www.rutgerswpf.org/im-toolkit

Teaching youth about RH and HIV/AIDS from a Christian perspective (FHI)
(Including biblical quotations linked to the lessons, developed originally in Namibia).
www.fhi360.org

Called to Care series – all for church audiences and very comprehensive.
www.stratshope.org/b-books.htm

Partner reduction (FHI) – Having multiple sexual partners, particularly when relationships overlap in time, is a major driver of the HIV epidemic. Overlapping, or concurrent, relationships increase the number of people who are connected in a "sexual network," and HIV spreads more quickly the larger the sexual network. Although young people report having multiple sexual partners, few HIV prevention programs for youth tackle this topic.
degrees.fhi360.org/2013/03/partner-reduction-to-avoid-hiv-risk-is-the-focus-for-a-new-publication/

Hear our voices – youth participation (STOP AIDS NOW!) – There is overwhelming evidence that the participation of young people leads to better outcomes for projects, programmes and organisations. This manual will show you how easy it can be to give the young people a voice in an organisation. In the manual you will be introduced to the STOP AIDS NOW! Youth Participation Model (SYP Model). This model can assist organisations in a self-assessment of the inclusion of young people and in highlighting areas for further improvement of youth participation. The model can be used by ALL organisations that work for/with young people (worldwide) and is thus not country-specific, nor AIDS-related.
www.stopaidsnow.org/hear-our-voices-english

International Guidelines on sexuality Education (UNESCO)
The International Technical Guidance on Sexuality Education is based on a rigorous review of evidence on sexuality education programmes and is aimed at education and health sector decision-makers and professionals.
Volume I focuses on the rationale for sexuality education and provides sound technical advice on characteristics of effective programmes. Volume II focuses on the topics and learning objectives to be covered in a 'basic minimum package' on sexuality education for children and young people from 5 to 18+ years of age and includes a bibliography of useful resources.
unesdoc.unesco.org/images/0018/001832/183281e.pdf

Healthy, Happy, Hot – (IPPF) A guide for young people living with HIV to help them understand their sexual rights, and live healthy, fun, happy and sexually fulfilling lives.
ippf.org/resource/Healthy-Happy-and-Hot-young-peoples-guide-rights

Addressing needs of young people living with HIV (STOP AIDS NOW!) The guides explains how, with small adjustments, existing educational activities can provide HIV positive youth, without disclosing their status – with skills to cope with their status and lead a fulfilling life.
www.stopaidsnow.org/addressing-needs

The World Starts With Me (WSWM) – (Rutgers WPF)
(WSWM) is an innovative, computer-based, comprehensive sexuality education programme for in- and out-of-school youth, which uses a rights- and evidence-based approach and which is available on CD-ROM, the internet and in print. WSWM combines education on Sexual and Reproductive Health and Rights (SRHR) with building IT skills and creative expression.
WSWM is originally developed for Uganda, but today WSWM is adapted to the socio-cultural contexts of Kenya, Indonesia, Indonesian Papua, Thailand, Vietnam, Pakistan and Ethiopia, while currently adaptations run in Ghana, Malawi, Bangladesh and Zambia and are planned for Burundian youth and Maasai youth in Kenya.

WSWM is mainly implemented in secondary schools, but contextualized versions have also been developed for other settings. As an example see the Ethiopian version at **www.wswmethiopia.org**

Evaluation Form

Introduction

1. The getting acquainted, expectations, meeting expectations, ground rules was..

	not at all						*very much*
a good way to start	1	2	3	4	5	6	7
clear and understandable	1	2	3	4	5	6	7
motivating for the training	1	2	3	4	5	6	7

2.   Introduction of background training and objective was..

	not at all						*very much*
a good way to start	1	2	3	4	5	6	7
clear and understandable	1	2	3	4	5	6	7
motivating for the training	1	2	3	4	5	6	7

Comments:

_____

_____

_____

Health promotion & behaviour

3. The introduction on health promotion and behaviour was..

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

4. Working with the 7 worksheets was….

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

5. Analysing our programme with the Planning and Support tool was:

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

SRHR

1. The session on defining SRH and SRHR was:

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

2. The session who are young people was:

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

3. The session on sexuality and communication was…

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

4. The session on effective approaches in CSE was….

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

Stigma

The session on naming stigma was:

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

The sessions on reflection on stigma and discrimination was:

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

Appendices

Gender

The sessions on understanding gender and sex was...

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

The sessions on gender roles and sex roles was...

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

The sessions on power, gender and roles was..

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

M&E

1. The introduction on measure effects on outcome level was...

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

2. The link with session on health promotion & behaviour was...

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

Working with the 6 steps was...

	not at all						very much
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

Finalising the M&E outcome plan was:

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

Working with the Plan of Action for improvement of our programme is:

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
useful	1	2	3	4	5	6	7

Comments:

_____

_____

_____

The training staff was

NAME: _____

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
professional	1	2	3	4	5	6	7
facilitating	1	2	3	4	5	6	7
nice to work with	1	2	3	4	5	6	7
meeting needs	1	2	3	4	5	6	7

Comments:

_____

_____

_____

NAME: _____

	not at all						*very much*
clear and understandable	1	2	3	4	5	6	7
professional	1	2	3	4	5	6	7
facilitating	1	2	3	4	5	6	7
nice to work with	1	2	3	4	5	6	7
meeting needs	1	2	3	4	5	6	7

Comments:

_____

_____

_____

Other comments:

_____

_____

_____

STOP
AIDS
NOW!

RutgersWPF