Economic and Social Commission for Asia and the Pacific

Life Skills Training Guide for Young People: HIV/AIDS and Substance Use Prevention

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This publication has been prepared by the Health and Development Section, Emerging Social Issues Division, ESCAP secretariat. It has been issued without formal editing.

PREFACE

ESCAP developed this training guide to support the efforts of government and civil society institutions and youth work personnel that are engaged in training young people on development issues. Its purpose is to provide them with training material for guiding young people to be peer educators on two interrelated and critical health issues that young people face in the ESCAP region, namely, HIV/AIDS and substance use.

In this edition, the training guide is composed of 11 modules, with an annex on training needs assessment.

Module 0 provides basic inputs on what training is, what it means to be a good trainer, learning theory and how to begin a training programme. It includes games designed to integrate participants into a group.

Module 1 deals with the basics of peer education, including the application of peer education and its relevance for young people in the context of HIV/AIDS. There are indicators on the skills that are central to the development of a peer educator and skills for undertaking peer education.

Module 2, on communication, is particularly useful for peer educators who deal with sensitive subjects, such as substance use, HIV/AIDS and sexual behaviour. Module 2, therefore, provides a critical training component on modes of communication, types of communication, effective communication, listening, seeing, observing and key messages for the prevention of HIV/AIDS.

Module 3 is designed to help the facilitator communicate an understanding of the basics of adolescence, including cognitive and emotional change, physical change and nutritional needs. The focus is on developing an understanding of adolescence from a holistic perspective.

Modules 4 and *5* are intended to provide the facilitator with techniques and methods related to the core issues of teenage pregnancy, sexually transmitted infections and HIV/AIDS. It includes a section on frequently asked questions.

Module 6 relates to drugs and substance use in the context of youth and HIV/AIDS. There is a section on critical reflection. Included here are several technical terms that are explained in the context of the training guide.

Overall life skills are dealt with in *Module 7*. Learning and practising core life skills are the focus of *Module 8*. Both modules, taken together, would enable the facilitator to help young people avoid risk behaviour and protect

themselves better from HIV/AIDS. *Module 8* introduces a range of important life skills topics, such as gender, decision making, goal setting and differentiating between "wants" and "needs."

Module 9 is designed to help facilitators train peer educators on how to care for and support people living with HIV/AIDS (PLWHAs).

Finally, in *Module 10* on action planning, participants learn to develop basic planning skills.

Each module is designed to stand alone.

Preparation of the training guide considered the need to equip facilitators with methods and techniques, as well as information on relevant conceptual issues. The guiding pedagogy is participatory. Participatory tools have been drawn from literature on participatory learning and action. Pictures, games, exercises, lectures, case studies, general reading and diagrams have been included. Inherent in the design is flexibility for innovation and adaptation to suit local contexts.

If facilitators feel that a target group needs inputs covered in all the modules, they may choose to include all of the modules in a training programme. In certain cases, especially in refresher courses, for which specific topics need to be more thoroughly covered, facilitators may use only specific modules. Facilitators of a variety of training programmes directed at young people are also encouraged to consider the possibility of integrating into their respective training, with suitable adaptation as may be required, material from this training guide.

Direct users of the guide are encouraged to approach local health and development experts, should they need further support on technical issues, especially regarding locally relevant data and information to facilitate adaptation of material in the guide for training in a local context.

It is hoped that the more this training guide is used, the more feedback can be shared with ESCAP. This will enable ESCAP to further enhance the relevance of the guide for larger numbers of users in the ESCAP region so that more effective approaches become widely available on strengthening young people's competencies in dealing with the problems and high-risk situations that they face in everyday life, especially related to the spread of HIV/AIDS and substance use.

As with this edition, the revised one will also be uploaded on to the ESCAP website for health and development issues http://www.unescap-healthdev.org. This is to facilitate its e-access by youth workers and trainers, and programme personnel concerned with training young people. It is also available in the

public domain for easy access by intermediary agencies and organizations that are in a position to support the translation of the training guide into national and local languages and its adaptation and use in the countries and areas of the Asian and Pacific region.

The next revision will be undertaken in March-April 2004. For this purpose, feedback and comments are welcome and may be forwarded to the following:

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ESCAP will issue a limited number of hard copies of the next (revised) edition of the training guide for dissemination to institutions in the Asian and Pacific region concerned with training young people on youth work, leadership and on related development issues.

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In the preparation of the training guide, ESCAP drew from insights and experiences gained in the implementation of the project. The secretariat is appreciative of insights gained from interactions with its project partners, the national counterpart organizations, in the above-mentioned countries.

The secretariat would like to express its appreciation of the participants and co-facilitators of two courses that field tested modules in Beijing (August 2003) and in Phnom Penh (October 2003), respectively. In this regard, the secretariat would like to acknowledge the cooperation and support of the All-China Youth Federation and the China Youth University, Beijing, and the General Department of Youth and Sports, Ministry for Education, Youth and Sports, Phnom Penh. The secretariat is also appreciative of Mr. Kazi Rafiqul Alam, Dhaka Ahsania Mission, Dhaka, and Mr Siddhi Aryal, Oxygen Research and Development Forum, Kathmandu, and their teams, who generously shared their insights on youth and life skills training.

Mr Amitava Mukherjee, currently Chief Technical Advisor, Private-Public Sector Partnership, ESCAP, initiated the preparation of the guide, including its design, when he was with the Health and Development Section (HDS), Emerging Social Issues Division (ESID), ESCAP. Mr Mukherjee co-authored the original manuscript with Ms Sheeba Chowdhry, HDS consultant, who benefited from his overall technical guidance for the assignment. Dr Arun Mallick reviewed the content pertaining to reproductive and sexual health for factual accuracy and comprehensiveness when he was with HDS and prior to his current assignment with UNESCO on school health.

Mr John Howard, Director, Ted Knoffs Foundation, Sydney, Australia, and Ms Cai Cai, HDS, undertook peer reviews of, and contributed useful comments on, the manuscript. Ms Janet Wong and Ms Patricia Persad, HDS, edited the manuscript under the overall guidance of Ms San Yuenwah, HDS.

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The secretariat acknowledges with appreciation the illustrations contributed by Mr Vikram Nayak, Triveni Kala Sangam, New Delhi. The illustrations will be included in full in the print edition to be issued in 2004.

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Introduction to
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FLOW CHART

Content Flow at A Glance
Module 0: Introduction To Training and Learning

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Introduction to Training and Learning

"Where the mind is led forward by thee
Into ever-widening thought and action".

Rabindra Nath Tagore

I Introduction

TRAINING

Can be a joy! Can be a dead bore!

FOR BOTH THE FACILITATORS AND THE LEARNERS

Therefore, the choice is in the hands of the facilitators and the learners. This training guide is designed to present ideas, information and strategies to address the needs of both.

Imagine that you are hosting a dinner for your colleagues and friends. You want it to be a perfect mix of ease and business. You want people to have fun, do business, find friends and leave with a treasured memory. Now, substitute the words "business dinner" with the word training. As a host, it is your job to create the perfect ambience for the dinner. As a facilitator, it is your job to create the ideal learning environment.

Use this guide to find the perfect mix of joy and learning for yourself and the participants. All of the ingredients are here, but it is up to the facilitator to find the match for each group of learners.

You can use this guide to design training for a formal or informal setting. The training could be in a village compound, a small space in a factory, under a tree or in a community hall.

As you go through the guide, it may be useful to recall Albert Einstein's words:

> "I never teach my pupils. I only attempt to provide the conditions in which they can learn".

II What is training?

The Oxford thesaurus gives many synonyms for training: teaching, coaching, tutoring, schooling, education, drilling, preparation, grounding, guidance, indoctrination, inculcation, lessons, working out, practice and exercises.

Take your pick! But remember

Training is a means to impart knowledge, and develop skills, and change attitudes and behaviour. Training is not a circus. Its purpose is not to entertain people and to help them forget about their daily preoccupations. On the contrary, it exists to help people understand and do something about their preoccupations.

Ideally, a training programme should aim to provide an environment that meets personal needs, reduces defensiveness and unveils potential for creativity and innovation.

III Who is a 'good' trainer?

A good trainer is essentially a facilitator. S/he is primarily responsible for creating the "learning environment". The learning environment has many elements and requires the facilitator to play the multiple roles of planner, facilitator, organizer and manager.

a) As a planner, focus on the following:

1 Why Training?

Setting objectives for a training session is essential. There are usually two kinds of objectives. The first kind describes general objectives using words like "to understand", "to appreciate"," to know" and "to recognize". The second kind of objective is more specific, often dealing with the concrete skills that the participants will have. If possible, use words such as "to make", " to write", "to plan", "to construct", "to solve" or "to measure". For example, participants will learn to make a plan, or the participants will learn to write a case study of a person living with HIV/AIDS.

2 Who to Train?

Understand the trainee profile. Try to find out: how many people will be present, why they want to attend the training, what their hopes and fears are and what their experience, age, gender and is. Do they have any previous exposure to the subject?

3 Where to Train?

Decide on the venue and location. The venue and location should fit the training design and be accessible to trainees. If possible, visit the training site before the participants are due to arrive. Check whether the place will suit the type of

training you have designed. Is there enough open space for exercises and games? Is the arrangement of training equipment appropriate? Is there provision for electricity, water, toilets as well as food and refreshments?

Check on the seating arrangements. Seating arrangements have a great influence on training sessions. There are six main types of seating arrangements: rows of tables and/or chairs, hollow U-shape, banquet or fish bone, conference table, circle of chairs and table trios.

4 When to Train?

The duration and timing of the training sessions must be set according to the learning principles. Be certain to allow time for relaxation and reflection. Design the sessions to include multiple methods – visual, physical, discussion, games and case studies.

The time of the day has a significant impact on how well people respond to diverse learning approaches. In the morning, most people would be more likely to concentrate better. After lunch, participants tend to be lethargic and less able to concentrate. Towards the evening, the participants may be restless. Consider these factors when planning a session.

5 What to Train?

It is important to structure each session carefully. Each session must have objectives and outcomes. Consider how much the participants already know, what they need to learn and how much time is available to cover the material. To help with the selection of materials, think about what the participants must know, should know, and could know. The session should be structured around key points the trainer believes they *must* know by the end of the session.

6 How to Train?

Inputs may be presented using various methods during training. A training that stresses active participation and open dialogue should employ a style that is consistent with the values of participation. It is best to use a combination of learning methods and to alter the tempo of the training. For example, you could start with a game, then proceed to a short lecture and end with group work.

b) As a facilitator

- Remember that the basic values of participation require you to adhere to the following:

√ are avoid dominating behaviours.
√ allow the participants to share and learn.
√ deal with bias, start from where the participants are.
√ respect diversity.
√ start at a convenient time for the participants.
√ undertake sessions in a place that is convenient for the participants
√ follow a process.

- Focus on cumulative learning by all the participants.

- Seek out diversity – everyone is different and important.
- Emphasize the group learning processes.
- Use approaches that are flexible and adaptable to suit each new set of conditions and participants.
- Use participatory processes because they lead to discussion. Often, debate concerning change leads to a change in perceptions, and people helps contemplate action that can lead to changes in attitudes and behaviour.

Key characteristics of an effective facilitator are:

- A warm personality, with an ability to show the trainees approval and acceptance.
- Good social skills, including an ability to bring a group together and maintain control without causing adverse affects.
- A manner that encourages the participants to share their ideas and skills.
- Strong organization skills that maximize the use of resources.
- The skill to identify and subsequently resolve participants' problems.
- Enthusiasm for the subject and the capacity to present it in an interesting way.
- Flexibility in response to the changing needs of the participants.
- Knowledge of the subject matter.

IV About learning and learners

a) Lewin's Three-Stage Formulation

Kurt Lewin's three-stage formulation of the learning process provides relevant insight into the design of an effective training programme. The theory proposes the following three stages in the learning process:

Unfreezing: Before unfreezing, participants do not attach sufficient importance to the problem to desire new behaviour. The training methods that should be used early in the programme, therefore, are those that offer maximum stimulation and involvement. Unfreezing is for training what ploughing is for agriculture.

Moving: Exploration, trial and error, new knowledge and experiments are all events required to move and learn. Case studies, individual exercises and practising new skills are some methods that enhance moving or learning.

Refreezing: It is the final stage. The participant fits the new knowledge and understanding, and the skills from the training that have proved useful and acceptable into their personal patterns of routine, day to day work and living. Appropriate methods for this part of the process are case studies, role-plays, individual assignments and reflection.

Source: Kurt Lewin, "Group Decision and Social Change" in T.N. Newcomb and E. Hartley (eds), Readings in Social Psychology (New York: Holt, 1947)

b) Learning

- takes place when the perceived needs of the learner are satisfied.
- should be meaningful.
- is effective when the learners participate actively.
- is effective when there is repetition of activity.
- is facilitated when the situations are real and lifelike.
- is facilitated when the learners are ready to learn – let them know what they are about to learn.
- is more effective when the facilitator praises, encourages and at times, gives rewards.
- is affected by the social and physical environment.
- is gradual, so start from the simple and move to the complex.

Source: O.P. Dahama, O.P. Bhatnagar; Education and Communication for Development (2nd Edition), Oxford and IBH Publishing Co. Pvt. Ltd, 1991.

c) How adults learn

Adults are different from children, and their learning process is different from that of a child. Some of the features that distinguish this difference are:

- Adults are voluntary learners. They have a right to know why a topic or session is important to them.
- Adults usually come with the intention to learn. If this is not understood or supported, they will switch off or stop coming.
- Adults have experience and learn by rechecking their learning against past or present experience.
- Adults learn best in an atmosphere of active involvement and participation.
- Adults are best taught through a real world approach.

Source: Robert Smith 1983; Alan Rogers 1986; Jenny Rogers 1989b

For learning to take place:

- Time for reflection is essential. Provide space for this.
- Participants must be involved as no involvement means no learning
- Practice is important. For every new skill that is taught, an exercise must be designed for practice. No skill is acquired without practice. Practice yields understanding of theory and raises new questions.
- Give time for practice, reflection, discussion and sharing.
- Be flexible. Flexibility is the key to effective facilitation. Be flexible in the use of methods, content, place, time and what ever else the participants may require.
- Provide opportunities for the learner to react to what s/he sees, hears and feels. This will also enable you to understand the needs of the learner.
-

Learners possess the ability to retain: 10 per cent of what they read, 20 per cent of what they hear, 30 per cent of what they see, 50 per cent of what they see and hear, 70 per cent of what they hear and say, and 90 per cent of the things they do.

If a message is given once, the brain remembers only 10 per cent of it one day later, and when the same message is given six times in a day, the brain remembers 90 per cent of it. Hence, trainers must repeat, recap and review the training messages several times over.

V How to Begin A Training Programme?

a) Preparing for a session

- The space for training must be prepared in advance. Arrange the materials along the wall. Have all of the things you will need on a table (for example, charts, markers, cello tape, coloured paper, pencils, pens, crayons, scissors, thread, gum, pins/tags, reading materials, hand outs, trays and transparencies) As a peer educator, you may not use any or all these things at one time but nev er the less, plan for what you will use.
- Use space on the walls (if there are no walls, make use of spaces that can be used, such as trees or rope tied to two poles or pillars) to display the topic of the training. Photographs and outputs from previous training programmes help to create a comfortable learning environment. Avoid using overt material on condoms, syringes and sexual behaviours.
- If you are using equipment such as an over-head projector, sound system, projector, tape recorder, or video/TV, make sure that it is in working condition and available for use.

b) Tips for an effective training environment

- Start the session with a circular sitting arrangement. Whether you use chairs and tables or the floor depends on availability.
- Involve the participants in the management of the training. Ask for volunteers for various tasks.
- Change the lay out of the training space each day to match the content of the sessions. For example, if you are planning to deal with sexuality on the first day, display posters and photographs related to the subject on the walls, and if on the second day you plan to deal with HIV/AIDS, change the posters, photographs and seating arrangement. This change breaks the monotony and creates a learning environment suited to the needs of the learners and trainers.
- Use energizers/games whenever you feel the group is becoming lethargic or bored. These are especially effective at the start of post lunch or post dinner sessions and during long lecture sessions.
- Go over the learnings of each day with the participants at the close of a day or first thing the next morning.
- Prepare the relevant reading material in advance and give it to the participants at appropriate intervals during the training.

c) Knowing each other

There are various ways of starting a training session. One method is to introduce the participants. This is a non-threatening activity and useful in creating an atmosphere of ease. Below are some activities that can help you start a training session. The peer educator has to decide how many, or which of them should / could be used.

d) Exercises

1 Memory Of Home

Objective To get acquainted.

Materials None.

Time 30 to 45 minutes.

Process Ask the participants to be seated in a circle (pre-arranged by the trainer).

Explain that this exercise will enable the participants to become acquainted with each other.

Ask the participants to reflect on their home for a moment. You can say,

> "Close your eyes. Think about your home and choose one item. It can be anything (a chair, a person, plants) that reminds you of your home. Think about what you have chosen and get ready to describe it to the group".

Tell the group that each member has approximately 1 minute to describe his / her choice and introduce himself / herself.

Notes for the Facilitator

Facilitate the process of sharing. You may intervene to help participants express themselves clearly and deal with questions from others. Consider yourself part of the group and introduce yourself in the same manner as the others.

This is a non-threatening exercise that creates a pleasant atmosphere. Nevertheless, be prepared to deal with emotions. This activity is especially suitable for participants who have come away from home and are still uncomfortable with the new environment.

Depending on the composition of the participants, you may replace the word "home" with something more appropriate to a particular group context.

2 Getting Acquainted

Objectives To create a relaxed atmosphere and encourage each participant to introduce aspects of himself/herself.
To involve the participants in a creative activity that allows them to express themselves.

Materials One sheet of paper per participant, markers/sketch pens/colour pencils/ crayons/pens/pencils.

Time 10 minutes of portrait drawing and 10 minutes to look at the display of the drawings.

Process Ask the participants to draw a self-portrait on a piece of paper. They can choose whatever style they like – artistic, cartoon or abstract. Ask them to write their names on the portrait.

Tell the participants that they can use whatever material they want from the material table in the room.

Ask them to write two important events that led them to this training/peer education session at the bottom of the paper.

Ask the participants to display the portraits on a wall (board) in the room.

Give the participants time to move around and have a look at the portraits. They can seek clarification from each other.

Notes for the Facilitator

This exercise is usually quite amusing. It is a good way to learn each other's names, hobbies, likes, dislikes and the reasons that motivated the participants to come to the session/training. The facilitator can also join the exercise and create his/her portrait.

The facilitator should pay attention to the reasons that have brought the participants to the training/session. These reasons give insight that can be used during the course of the training session. For example, a participant may say that the reason that s/he came to the workshop was his/her desire to get more knowledge on substance use.

3 Seed Mixer

Objective To introduce the participants to one another.
To encourage participants to talk with each other one-on-one.
To create a relaxed but animated atmosphere, and to establish an informal tone for the training.

Materials Enough seeds (beans or beads) to allow each participant to have the same number of beans / pebbles, as there are participants. For example, if there are 25 people, including the peer educator, each person will require 25 beans / beads. Paper cups / containers for participants who do not have pockets for the seeds.

Time 30 minutes (depends on the number of participants and how much they talk with each other).

Process Give each person the number of beans equivalent to the number of participants in the room (for example, if there are 25 people, including the peer educator, who should also participate in this exercise, give each person 25 beans / beads).

Ask the participants to place the beans / beads in one pocket / container and leave the second po cket / container empty.

The participants are given a fixed amount of time (about 20 minutes) in which to introduce themselves to each of the other participants (this can include saying the name, place of work, likes / dislikes or possibly exchanging salutations).
During each introduction, the participants should give the other person a bean / bead and accept in turn. They should place the other person's bead / bean / should be placed in the pocket / cup.

At the end of this exercise, each person should be left with one bean in his or her pocket / container (representing herself / himself) and the second pocket / cup should be filled with beans / beads equal to the total number of persons in the room minus one.

Notes for the Facilitator

This exercise is suitable for both large and small groups. Facilitators should take part in it. If the activity is taking too long, just clap your hands and remind the participants that they need to hurry. There is no need for a debriefing after the exercise. This activity allows people an opportunity for one-to-one interaction, and helps to create an atmosphere of informality and conviviality.

4 Getting To Knowing Each Other

Objectives To introduce the participants to each other.
To create a sense of belonging / familiarity.
To show the participants that you also want to know them.

Materials Objects / things lying in the vicinity that can be used as symbols.

Time 30 to 45 minutes.

Process Ask the participants to take 5 minutes to find an object, within close proximity of the place where they are, which they think symbolizes them in some way.

You could play some soft instrumental background music (for 5 minutes).

Reassemble the participants in the room.

Ask the participants to introduce themselves one by one, and explain why they chose what they chose as their symbol.

Notes for the Facilitator

This exercise is useful for encouraging participants to open up and share feelings early in the training session. The participants may choose objects such as sand, a stone, a pen or a flower as their symbol. The facilitator should also join the exercise.

5 We Are Here Because...?

It is always a good idea to move from introductions to reasons why everyone has come to the training programme. This can be achieved with a simple exercise.

Objectives To know what brought the participants to this training.
To understand what they know and consider important.

Materials Flash cards or A-4 paper sheets, markers.

Time 45 minutes.

Process Ask the participants to take two flash cards / papers and markers from the tray.

Ask the participants to use one flash card / paper to write or draw the reason they are attending the training.

Ask the participants to place the flash card / paper on the floor once they have finished.

Ask the participants to use the second flash card to write or draw the ability / knowledge they bring to the training. The cards should form a row.

Ask them to place these cards on the floor in another row adjacent to the previous one.

When all of the cards are placed on the floor, ask the participants to stand in a circle around the cards.

Ask volunteers to read out the cards.

Finish the activity with a round of applause.

Notes for the Facilitator

This exercise is very useful for getting to know the different reasons participants have for attending the training programme. It also gives the facilitator information about the special abilities and knowledge present in the group. Information gathered during this exercise is often useful for planning future sessions and when seeking volunteers from the group.

At times, a needs assessment cannot be done before the start of the training programme. This activity is a useful way of getting an indication of why the participants are at the training. Sum up the broad trends from both categories of cards, and put them up on the wall.

It is also a good way, both for the facilitator and for the participants, to keep track of whether the needs are being met. Sometimes there will be reasons for coming to the programme that the facilitator knows will not be addressed during the training course. Please discuss this point with the participants and arrive at a solution that is mutually beneficial.

6 Why Am I Here?

Objective To allow participants to express, share, and reduce misconceptions they may have brought to the training programme.

Materials Flipcharts, markers / pens.

Time 30 minutes.

Process Sometimes participants may know very little about the content of the training sessions, may not know what is expected of them, may feel / worried about their participation or may have misconceptions about the programme. Under such circumstances, it is appropriate to create a forum for sharing and discussion.

Divide the participants into small groups of 4 to 6 people. Ask them to take a flip chart and markers for group work.

Ask them to select one person within each group to record the discussion.

Ask the groups to respond to the following questions:
What fears did you have about coming to this training?
What concerns do you have about this training?
What preconceived notions did you have before coming here today?

Allow 20 minutes to finish the exercise. Then, invite the groups to present their work.

Notes for the Facilitator

This exercise provides excellent opportunities for the facilitator to empathize with trainees' needs, and give reassurance by sharing how the training does / does not relate to their concerns or how the training might help them overcome their fears and concerns. The trainer should be prepared to deal with issues such as:

Will others laugh at me if I ask silly questions?
Will I really learn about the things I want to know?
What will the trainers be like?
Will the food be to my liking?

The trainer can ask the participants for solutions / response. Ask the participants what you could do to reduce their concerns or fears.

7 I Am Here Because....

Objective To elaborate in detail on what participants want / do not want from the training.

Materials 3 large flip charts previously prepared by the facilitator, small pieces of paper / flash card s for the participants, markers, pens.

Time 45 minutes.

Process Put up the previously prepared flip charts. These should be marked "content", "format" and "practical details". Each flip chart should be divided into two columns marked "want" and "do not want".

Ask the participants to take small pieces of paper / flash cards and markers.

Ask them to use one piece of paper / flash card for writing the main thing they want from the training programme and one piece of paper / flash card for the main thing they do not want from the training programme. This can relate to any of the topics already displayed on the wall – content, format, and practical details.

Ask the participants to put their slips of paper up on the appropriate chart and in the appropriate column. Similar responses can be grouped together.

Once the exercise is completed, ask a volunteer to read out what has been written by the participants to the larger group.

Notes for the Facilitator

The facilitator can also read out the charts if s/he thinks it is appropriate. This exercise tells you the participants' expectations and allows you to frame the ground rules for the training. You can now respond to those expectations in the course of the training. The facilitator must be sensitive to the mood of the group and tactful in addressing concerns expressed. A blunt statement to the group that some needs will not be met may result in low morale among some members.

This activity provides a visible record of what people do/do not want from the training programme. It allows the facilitator to build consensus and motivation among group members. It is also helpful to refer back to these charts during the evaluation at the end of the training.

You can adapt this exercise to a simpler format by putting up charts with the headings "I want to know/learn", "I want to share" and "I don't want". Leave the room for 20 minutes, and allow the participants to express themselves on the charts under the three headings. Upon your return, ask for volunteers to explain the charts briefly.

e) Setting the ground rules

After introductions and the expectations session, ground rules should be set at the start of the training. Explain to the group that this is their time together and that it is useful for everyone to agree to so me ground rules. You may make some suggestions such as punctuality, being non-judgmental or giving everyone a chance to participate and to speak.

Ask the participants to use flip charts and markers to write/draw the ground rules for their training programme. Encourage the participants to discuss the issues and arrive at a consensus. Once the exercise is completed, ask the participants to go over it once, and put it up on the wall. Encourage the participants to stick to these ground rules during the course of the workshop and follow them yourself.

Recommended Ground Rules

Respect	Everyone should pay attention to the person who speaks and respect her/his ideas.
One at a time	Only one person should speak at a time.
Confidentiality	What is shared in the group shall remain in the group.

Openness	Everyone will try and be as open and honest as possible without discussing personal and private issues or lives. Everyone will avoid using names and places while sharing their experiences.
Non-judgmental approach	No one will put down, make fun of or tease another person about her/his beliefs and ideas.
Acceptance	It is okay to feel uncomfortable while discussing sensitive issues like sexuality and HIV/AIDS.
Have a good time	Enjoy being together and doing things together.
Keep time	Stick to the time schedule set for the course.

f) Trust and confidentiality

Trust and confidentiality are of prime importance in a training programme dealing with sensitive and personal issues such as sexuality, HIV/AIDS and sexually transmitted infections (STIs). There are many games and processes that can be used in the course of the training, to build a comfortable learning environment. Try the following exercise:

Keeping The Faith!

Objective To define participants' understanding of "trust and confidentiality" within the training programme.

Materials None.

Time 1 hour.

Process Explain that in this exercise the participants are going to explore the issues of mutual trust and confidentiality within the group. Caution them that they are going to be talking about some personal and difficult things.

Ask the participants to divide into small groups of four persons each. Tell them to imagine a situation where they are suffering from a disease and find it impossible to come to terms with it. They want to talk about it with someone (to seek help and advice). What qualities would they seek in that person? They should concentrate on the qualities of the person and not mention the name of any person. Give the groups 15 minutes to have this discussion.

Call all the groups back to the circle, and ask them to describe the qualities that they discussed in the small groups. If possible, invite the participants to write down the qualities, and fix them on the wall for future reference.

Notes for the Facilitator

The facilitator plays an important role in tying up this exercise. S/he should be prepared to debrief the activity. Focus on the qualities, and point out to the group that all of us must try to display these qualities during the course of the training, as this will maximize learning for all. Discourage the participants from making any written rules about these issues, as a breach may cause unnecessary disruption and feelings of betrayal. The intent of the exercise is to unveil the qualities that participants need to establish trust and confidentiality.

g) Cooperation

In any adult learning environment dealing with HIV/AIDS, STIs, sexuality and reproductive health, cooperation between the facilitator and the participants, and more importantly, among the participants, is of great value. Try to build cooperation and team support. The following game is useful in achieving these ends.

Blind Walk

Objective — To help participants experience the value of team support and cooperation.

Materials — A piece of cloth/scarf/large handkerchief.

Time — 45 minutes to 1 hour.

Process — Ask the participants to form a line from one end of the training room to the other. Ask for a volunteer to be blindfolded. Explain to the group that this exercise is not intended as a competition but as an exploration of feelings and to highlight he importance of support.

Use the scarf/cloth to blindfold the volunteer. Turn him/her around several times. Ask the volunteer to walk in a straight line from one end of the room to the other. S/he should stop when s/he thinks that s/he has reached the end of the room.

Tell the rest of the group to remain completely silent and give no encouragement or guidance at all. They must not touch the volunteer.

When the volunteer reaches the other end (or says that s/he has reached the other end) of the room, ask her/him to take off the blindfold. Ask her/him to share feelings they experienced during the walk. You may ask questions such as, “Did you think you had gone where you wanted go?” or “Did you feel the need for some guidance from the others?”

Ask the volunteer to replace the blindfold. Ask him/her to walk from one end of the room to another again. This time, the others in

the room should give verbal guidance and encouragement. However, nobody should touch the volunteer.

Ask the volunteer to share his / her experience with others.

Repeat the exercise again with another volunteer, and this time, ask the observers to help the volunteer in any way they can.

Ask the volunteer to share the experience.

Notes for the Facilitator

Generally, the volunteer would have felt the most comfortable reaching her / his destination with the help from other group members. The ease of reaching the destination increases as the level of support and help from the group members increases. This exercise demonstrates the importance of receiving support when trying to reach one's destination.

You can repeat the exercise with more volunteers (depending on the time). Encourage the volunteer and the observers to exchange their experience. Close the exercise by emphasizing the need for mutual support and trust during the course of our lives. You may need to explain to the group that this exercise is not intended as a competition but as an exploration of feelings and the importance of support.

Module 1
Peer Education

FLOW CHART

Content Flow at A Glance
Module 1: Peer Education

Subject/topic/activity	Objective	Page No.
Reading material for the peer educator.	To know about the concept of peer education.	1-2 to 1-8
Some games to introduce the concept of peer education to the participants.	To introduce some basic principles and qualities required for becoming a peer educator.	1-9 to 1-14
Material for reading, preparation of handouts and facilitation of sessions.	To help the peer educator in the facilitation of sessions.	1-15 to 1-16
Games for learning to communicate and identify the qualities of a peer educator.	To introduce the participants to the importance of communication in peer education. To facilitate the identification of the qualities of a good peer educator.	1-17 to 1-20

Module I
Peer Education

"Never doubt that a small group of thoughtful, committed citizens can change the world. In fact, it is the only thing that ever has".

Margaret Mead

I Definition of Peer Education

Peer education is a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy.

In the olden days of kings and queens (in England), peers were nobleman, aristocrats, lords, titled men and patricians. The English term "peer" refers to "one that is of equal standing with another; one belonging to the same societal group especially based on age, grade or status". In modern times, the term has come to mean fellow, equal, like, co-equal or match according to the dictionary of synonyms (Oxford Thesaurus). Recently the term is used in reference to education and training. Peer education is now viewed as an effective behavioural change strategy, and it draws on several well-known behavioural theories – Social Learning Theory, Theory of Reasoned Action and Diffusion of Innovation Theory.

II Theories of Peer Education in Brief

Social Learning Theory asserts that people serve as models of human behaviour, and some people (significant others) are capable of eliciting behavioural change in certain individuals, based on the individual's value and interpretation system (Bandura, 1986).

Theory of Reasoned Action states that one of the influential elements for behavioural change is an individual's perception of social norms or beliefs about what people, who are important to the individual, do or think about a particular behaviour (Fishbein and Ajzen, 1975).

Diffusion of Innovation Theory posits that certain individuals (opinion leaders) from a given population act as agents of behavioural change by disseminating information and influencing group norms in their community (Rogers, 1983).

The Theory of Participatory Education has also been important in the development of peer education (Freire, 1970). Participatory, or empowerment, models of education posit that powerlessness at the community or group level, and the economic and

social conditions inherent to the lack of power are major risk factors for poor health (Amaro, 1995). Empowerment, in the Freirian sense, results through the full participation of the people affected by a given problem or health condition. Through such dialogue the affected community collectively plans and implements a response to the problem or health condition in question. Many advocates of peer education claim that this horizontal process of peers (equals) talking among themselves and determining a course of action is key to the impact of peer education on behavioural change.

III Application of Peer Education

Peer education has been used in many areas of public health, including nutrition education, family planning, substance use and violence prevention. Use of peer education in the realm of HIV/AIDS stands out because of the number of examples of its use in the recent international public health literature. Because of this popularity, global efforts to further understand and improve the process and impact of peer education in the area of HIV/AIDS prevention, care and support have also increased.

Questions concerning the nature of a peer and what constitutes education have a range of answers. Peer education typically involves using the members of a given group to effect change among other members of the same group. Peer education is often used to effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. However, peer education may also effect change at the group or societal level, by modifying norms and stimulating collective action that leads to changes in programmes and policies.

Learnings from Experience

A study of 21 peer education and HIV/AIDS prevention and care projects in 10 countries in Africa, Asia, Latin America, and the Caribbean (AIDSCAP) revealed that peer education has been an effective strategy in the prevention of HIV/AIDS. Study findings documented the need for initial and reinforcement trainings, ongoing follow up, support, supervision, clear understanding of the role of peer educators and continued incentives and motivation techniques. The study also documented that peer educators must broaden their understanding of HIV/AIDS to include care of people living with HIV/AIDS and family planning. The final output of the review was a handbook of guidelines from which future peer education programmes could be designed, entitled *"How to Create an Effective Peer Education Project"* (Flanagan and Mahler 1996).

A comprehensive and participatory assessment of HIV/AIDS peer education programmes was recently conducted in several clusters (regional HIV/AIDS NGO networks) in Tanzania (Hooks et al. 1998). The results of this assessment stated that:

- Community involvement and ownership is critical for the continuity and sustainability of a peer education programme.
- Ongoing capacity building and supervision are important for the maintenance of quality in the programme.
- One should capitalize and build on the knowledge, creativity and energy of

peer educators, through their involvement in programme planning.

- The reach of peer education should be increased through more training of trainer programmes in new geographical areas.
- Both financial (such as access to credit and compensation for expenses) and non-monetary (such as bicycles, T-shirts and materials) incentives are important to motivate peer educators.
- Reproductive health and other topical areas, as identified by communities, should be included in the scope of peer educators (Hooks et al. 1998).

IV Peer Education and Youth

In most societies, young people often find it difficult to obtain clear and correct information on issues that concern them such as sex, sexuality, substance use, reproductive health, HIV / AIDS and STIs. This happens for many reasons: socio-cultural norms and taboos, economic deprivation or lack of access to information. Many times, information is available but it may be given in a manner that is authoritarian, judgmental, or non-adapted to the young people's values, viewpoints and lifestyle.

One effective way of dealing with these issues is peer education, because it is a dialogue between equals. It involves members of a particular group educating others of the same group. For example, young people share information with each other, some acting as facilitators of discussions. It usually takes the form of an informal gathering of people who, with the help of the peer educator, (someone of a similar age or social group), discuss and learn about a particular topic together. Peer education works well because it is participatory and involves the young people in discussion and activities. People learn more by doing than just getting information. Peer education is, therefore, a very appropriate way to communicate in the context of HIV / AIDS. It empowers young people to take action. Examples of participatory activities used in peer education are games, art competitions and role-plays. All of these can help people to see things from a new perspective without “being told” what to think or do.

V Relevance of Peer Education for Young People in the Context of HIV/AIDS

Peer education works very well for students and young people. Sharing a conversation on HIV / AIDS with people of the same age or social group makes for a relaxed learning environment. Young people feel free to ask questions on taboo subjects, such as sex and men who have sex with men (MSM) and are able to discuss without the fear of being judged and labelled. They can discuss issues that are difficult to discuss with an adult and gain insights through mutual sharing of experiences, knowledge and information.

VI Role of the Peer Educator

The main role of the peer educator is to help the group members define their concerns and seek solutions through the mutual sharing of information and experiences. S/he is the best person to disseminate new information and knowledge to the group members and can become a role model to others by "practicing what s/he preaches". Since s/he is from the same group, s/he can empathize and understand the emotions, thoughts, feelings, language of the participants, and, therefore, relate better.

A peer educator not only tells the peers about a desired risk reduction practice but also models it. S/he demonstrates behaviour that can influence the community norms in order to promote HIV/AIDS risk reduction within their networks. They are better able to inspire and encourage their peers to adopt health-seeking behaviours because they are able to share common weaknesses, strengths and experiences.

VII Knowledge and Skills Needed to be A Peer Educator

The basic requisite for becoming a peer educator is to be a ***peer***. For example, a sex worker peer educator will be more comfortable working with sex workers, a migrant worker peer educator will be more at ease with migrants and so on. If you are a peer, you speak the same language and are familiar with the cultural norms and values of the group/community.

It is important for them to have had some training in group facilitation or peer education. In order to answer questions clearly and correctly, the peer educator also needs to have an overall knowledge of the subject. It is not necessary to be an expert. It is generally better to refer people to organizations or leaflets where more information can be found. A peer educator should be aware of where more information and support can be accessed. As a person grows into the role of a peer educator, one should increase one's knowledge of the subject and include related subjects, such as reproductive health care and support for people living with HIV/AIDS. Updating knowledge and skills in group facilitation continuously, increase a peer educator's value for the group.

A peer educator should be sensitive, open minded, a good listener and a good communicator. S/he should be acceptable to the community and be trust worthy. In brief, s/he should possess good interpersonal skills.

A peer educator should also develop leadership and motivation skills.

People often tend to judge others. Peer educators need to be non-judgmental and open minded. Being non-judgmental means not making judgement statements out loud or in one's mind

VIII Organizing A Peer Education Programme

Use the six helpers in organizing your programme:

- Who are the participants?
- Why is the programme/session being organized; define specific objectives.
- What are the needs of the participants and the content of the programme/session?
- Where will the programme/session be held (venue)?
- When will the programme/session be held (time)?
- How will the programme/session be conducted (methodology)?

IX Starting A Session

A session can be started in several ways. There is no fixed rule. Sometimes, it can be done with a game, which is great to get people laughing and relaxed. At other times, it can be through relevant exercises. For example, to start a discussion on sexual behaviour, one can begin by asking the group to draw a picture of the male and female reproductive organs. The next step is to name the body parts in non-scientific language. This gets everyone involved and discussing. Whatever topic the session is on, it should include everyone and be simple enough to understand. Just remember that people learn best by doing. Every session should be a combination of listening, speaking, seeing and doing.

X Facilitating Participation

Facilitating and enabling maximum participation by the group members is the prime responsibility of the peer educator. This is possible with the use of various tools, such as small group discussions, games, role-plays, case studies and a host of others. It is always useful to divide people into small groups, as this increases interaction between people and encourages shy people to contribute.

XI Tips for A Peer Educator

Peer educators need the skills to bring out the views and concerns of the participants. It is important to realize that the peer educator's role is to give information, and let young people make their own decisions based on facts. A peer educator should always avoid being directive and authoritarian. S/he is a peer and not a parent. Make sure participants know that there will be no report of the session made. Ask them to try not to discuss the opinions of particular individuals outside of the group, but warn them that confidentiality cannot be guaranteed. The discussion should be conducted in a manner that is not personalized and specific. If possible, give out information about where individuals, who want to discuss a personal situation, can get confidential advice. At the end of the training, do not forget to ask them to fill out the evaluation forms you have prepared. It makes the work much easier the next time around.

XII Developing A Peer Educator

The development of a peer educator involves the application of various methods such as counselling, training, personal orientation, exposure visits, improving social contacts, participatory planning and assessment.

Probation	It is advisable to have the peer educators work on probation for 2-3 months on a project or programme so that they can receive training in the basic skills required for their work.
Counselling	Continuous sessions of counselling will help to improve communication patterns, family and interpersonal relations, self-confidence and self-respect.
Training	Is very effective for skill development and education. It increases motivation and self-respect.
One-to-one Education	Personal and individual education are of prime importance in equipping the peer educators with information on sexual health and related matters.
Exposure visits	These are highly useful for refreshing and developing relationships, motivation, cohesion, "we feelings" and pride in one's work.
Social Contacts	Peer educators make many social contacts when they are involved in the advocacy process. This increases their motivation and commitment.
Participation	Participation in the planning and evaluation of their work leads to better understanding and improves skills for implementation.

Tips for a basic training course for peer educators

Knowledge	Skills	Personal development
HIV / AIDS Routes of transmission, prevention Fears about HIV / AIDS, prejudice, stigma and discrimination Risk behaviours / practices Safe / safer behaviours Drugs Drug use Condoms Rights and responsibilities STIs – symptoms and treatment Contraception Physical anatomy of a man and woman	Group Work Facilitation Communication Basic counselling Methods of delivering Information Presentation	Communication Empathy and non-judgmental attitude Assertiveness Self confidence and self worth Group dynamics Sensitivity Gender issues Socio-cultural and economic dynamics

Session 1.1
Peers influence Your Life

Expected Outcomes

Participants will become aware of the influence their peers have on them. Participants will become conscious of this influence and take measures to protect themselves from negative influences.

Understanding Peers

Objective To understand that peers can influence you.

Materials Flip charts, markers, crayons, pencils

Time 1 hour

Process Invite the participants to sit in a circle. Explain that they will be doing an exercise to understand the influence their peers can have on them.

Ask the participants to divide into groups of 4-5.

Ask each group to do the following:
Reflect for sometime on your peer group.
Discuss and list (on the flip chart) the things you have learnt from your peers, both negative and positive (for example, new phrases, dressing style, mannerisms, habits etc.).
Against each learnt thing recorded, on the flip chart, mention how you learnt it from your peers.

Give the groups 30 minutes to do this exercise.

Ask them to reassemble in the large group and present their work.

Encourage the participants to discuss each other's presentation. You can facilitate the discussion by asking the following questions:

- *Were you surprised at the things you have learnt from your peers? Why/ Why not?*
- *Have you ever reflected on the influence your peers can have on you? Why/ Why not?*
- *How do you feel about the ways in which you have learnt things from your peers?*
- *What are the positive things that you have learnt from your peers?*
- *Are there some things you should avoid learning from your peers? What/Why?*

Notes for the Facilitator

Young people are often deeply influenced by their peer group. However, most of the time, this influence is very subtle, and they do not notice the changes in their behaviour, attitudes and skills. Peer influence also exerts pressures. At times, many young people end up doing things they would not have done on their own. This exercise provides many opportunities for discussion on the pros and cons of peer influence.

Session 1.2
Influencing the Peers

Expected Outcomes

Participants will become aware of the influence they can exert on their peers. Participants will have the potential to influence their peers in positive ways.

Objective To understand that you can influence your peers.

Materials Flash cards, markers

Time 45 minutes

Process Invite the participants to sit in a circle. Explain that they will be learning about the influence they can have on their peers.

Ask the participants to pick up 2 flash cards and a marker each.

Ask them to close their eyes for a few minutes and think about their peers. Ask them to think of situations when they have been able to influence them to do or not do something.

Explain that they should use one flash card for writing a positive influence and one flash card for writing a negative influence.

Assure the participants that we all influence people with positive and negative effects, and there is no harm in learning from both.

Ask the participants to place the two sets of cards in two vertical lines. Invite them to read the cards. Ask a volunteer to do this.

Then, ask the group to cluster similar cards from both the lines.

Ask the participants to put the cards up on a wall, so that everyone can see them.

Invite the group to sit facing the cards, and facilitate a discussion using the following questions:

- *How did you feel writing about the positive and negative influences that you may have had on your peers? Why?*
- *Have you ever reflected on your ability to influence others? Why/Why not?*
- *Can you think of ways you can use the ability to prevent your peers from indulging in risk behaviours? How?*

Notes for the Facilitator

This exercise is useful when it is done with the previous exercise. The outputs of both exercises allow the participants to compare and analyze their results. Help them understand that peer influence is a mutual process in which everyone can be influenced, and, in turn, influence others. This is one reason why peer education programmes are effective in the behavioural change processes.

Session I.3
Appreciating Others

Expected Outcomes
Participants will become aware of each other's positive traits.
Participants will become more appreciative of people around them, especially their friends and family.

I like You

Objective To learn to appreciate each other's good qualities.

Materials None

Time 45 minutes

Process Invite the participants to sit in a circle.

Explain that we all have good and bad in us, and it is important to recognize the good.

This exercise will enable us to appreciate each other's positive qualities.

Start at one end of the circle, and ask each participant to tell the person on his / her left one thing that s / he likes about him / her.

When the circle is complete, repeat the exercise in reverse order (i.e., each participant tells the person on his / her right one thing that S / he likes about him / her).

You may the use the following questions to facilitate a discussion after the exercise:

- *How did you feel giving a compliment? Why?*
- *How did you feel receiving a compliment? Why?*
- *How often do you appreciate your friends and family members for the things they do for you?*
- *How do you feel when your friends criticize you or say negative things about you? Why?*
- *Can you think of ways in which you can use your good qualities to help your friends? How?*

Notes for the Facilitator
This is an enjoyable exercise that produces good feelings in the group. You can use this opportunity to discuss the ways in which young people can help friends in difficult situations. You can alternatively follow this exercise with an exercise on helping friends in need.

Session 1.4
Helping Friends

Expected Outcomes

Participants will learn ways to help friends in times of need.
Participants will support and help fiends who need their support in managing difficult situations.

I Can Help You

Objective To practice ways of helping friends.

Materials As needed by the participants

Time 1 hour 30 minutes

Process Use an energizer to form groups of 4 or 6.

Explain that the groups will prepare role-plays to show ways they can help their friends based on the scenarios provided.

Give one scenario to each group.

Explain that they have 20 minutes to prepare the role-plays and can use whatever props and materials they need for an effective display.

After all the groups have completed their presentations, invite them to sit in a circle and facilitate a discussion using the following questions:

- *How did you decide on the things to show in your role-play?*
- *How did you feel during the other role-plays? Why?*
- *Can you use similar ways to help your friends if required? Why/why not?*
- *Have you ever helped a friend in similar circumstances? Would you like to share it with the group?*
- *How easy or difficult is it to help a friend solve his/her problem? Why?*
- *What qualities help you to help others? Why?*
- *What qualities prevent you from helping others? Why?*

Notes for the Facilitator

This is an effective exercise for promoting qualities of cooperation and care. The discussion can be used to enable reflection and analysis in relation to the participant's real life experiences. It is possible that good intentions and attempts to help can produce an undesirable effect. Help the participants find ways of dealing with this kind of situation. Focus on qualities that help to resolve difficult situations and how these can be nurtured.

Scenario 1
Your friend has suddenly become very withdrawn and sad. S/he has stopped participating in group activities and spends most of his/her time alone.

Scenario 2
Your friend is unable to concentrate in the classroom and plays truant. You have observed that s/he is becoming very erratic and showing signs of weight loss.

Scenario3
Your friend is constantly worried about his/her weight. S/he avoids eating and stays away from group activities like picnics and parties.

Scenario 4
Your friend has been indulging in sexual activity and is now worried that s/he may be HIV infected.

Scenario 5
Your friend is pregnant. She is unmarried and scared about her future.

Scenario 6
Your friend is married and contemplating divorce.

HELPLINE for the peer educator

Material for reading, preparation of handouts and facilitation of the session

Ways friends help each other

- Sharing information or knowledge.
- Motivating each other to do certain things.
- Giving encouragement and emotional support.
- Being attentive and making one feel important.
- Giving material things.
- Being a companion.
- Sharing happiness together.
- Being a role model (someone you want to behave like).
- Teaching social skills.
- Helping to do things at home or at work.
- Introducing new people and friends.
- Helping convince parents when one wants to tell or do something.
- Introducing one to a new behaviour.
- Warning one against doing something wrong.
- Praising ones good qualities.
- Looking after one in times of illness.

Helping Your Peers:

- You can share and discuss opinions, feelings, ideas, experiences, information and knowledge.
- You can demonstrate new behaviours.
- You can do things together and promote safe behaviour and practices.
- You can teach your friends to say "no" to things that may have negative consequences, after discussing reasons or motivations.
- You can create pressure that will stop one from doing harm to self and others.
- You can be a role model and encourage your peers to adopt desirable qualities, skills and knowledge.

Help from peers is more effective and desirable because

- You see each other often.
- You enjoy doing things together.
- You understand each other's feelings and motivation.
- You know each other's language and needs.
- You are less likely to form judgements and more likely to be patient and concerned.
- You can keep secrets and share feelings of trust and confidentiality.
- You like to keep the "we feeling" and therefore, do your best to help each other.
- You would rather seek help from peers than your parents and family.

Peer education can help in HIV/AIDS prevention and care:

- By providing information about STIs, HIV/AIDS and behaviour related to the risk of infection.
- By helping each other through discussions, sharing information and experiences related to risk behaviour for HIV infection and STI infection.
- By encouraging compassion and non-discriminatory attitudes and practices towards persons with HIV/AIDS and their families, including how to provide basic care for persons living with HIV/AIDS.
- By developing group norms among peers to support each other to resist behaviour that puts them at risk of infection of STIs and HIV.
- By holding awareness-raising campaigns and drives in the community.
- By developing a network for home-based care of people living with HIV/AIDS.

Session I.5
Learning to Communicate

Expected Outcomes
Participants will acquire some of the basic communication skills required to be a peer educator.

Lets Talk!

Objective To practice some basic communication skills for peer education.

Materials Slips with scenarios

Time 1 hour 30 minutes

Process Invite the participants to sit on the floor in a circle.

Explain that peer education is possible among friends, and that in this session, participants will be practicing some basic communication skills needed for this purpose.

Pass the container, full of the slips of paper, around the circle. Ask each participant to pick one slip.

Ask them to read the slip and prepare themselves for the exercise.

Allow 5-10 minutes to prepare (individually).

Then, start at one end of the circle, and ask the participant to give a response to the situation written on the slip.

Explain that they can choose a partner to do the exercise.

Complete the circle.

After each presentation, ask for feedback and suggestions.

After the exercise is over, facilitate a discussion in the large group using the following questions:

- *How did you feel doing this exercise? Why?*
- *In a real-life situation, would you be able to use these skills? Why/Why not?*
- *Have you ever discussed these kinds of issues in your circle of friends/peer group? Would you like to share some of the experiences?*
- *What are the basic requirements of good communication?*

Notes for the Facilitator

This exercise creates confidence among the participants concerning their ability to communicate on issues related to HIV / AIDS. It can also be useful for re-capping basic HIV / AIDS issues. You can create similar exercises to practice other skills, such as designing messages for a public campaign or making presentations. Encourage the participants to experiment and ask questions. The scenarios for this exercise should be based on the aptitude and readiness of the participants. If you feel that the exercise cannot be conducted in a mixed group, due to socio-cultural reasons, divide the group and conduct the exercise separately. Alternatively, you may wish to do this exercise in pairs.

Scenarios for the slips of paper required for this exercise

Your friend starts a discussion on HIV / AIDS and asks you about the ways in which it is spread.	Your friend asks you about the ways in which HIV cannot be spread.	Your friend is very depressed and seeks your advice on STIs.
Your friend is curious about homosexuality and asks you about it.	Your friend has just seen a film on AIDS and wants to know how he can avoid it?	Your friend wants to try smoking and asks your advice.
Your friend is going to a new city and wants your advice on how s / he should conduct his / her life.	Your friend is worried that S / he is becoming obese and wants to know what S / he should do.	Your friend wants to go to a party and you know there is going to be alcohol and drugs.
Your friend is smoking marijuana and asks you if it is okay?	Your friend has been asked to go for an HIV test and s / he asks you to tell him / her about the possibilities.	Your friend is HIV positive and wants to know if you will continue being his / her friend.
Your partner has been diagnosed with STI and asks you to have a check up as well.	Your friend asks you about condom use.	Your friend asks you if birth control pills are useful in protection against HIV / AIDS.
Your friend wants to donate blood and asks you what precautions s / he should take.	Your friend is pregnant and asks you if she can smoke and drink alcohol.	Your friend is very sad and lonely because s / he is HIV positive.
Your friend wants to become a musician, but his parents want him to become an engineer. He asks your advice.	Your friend is planning to get married and asks your advice, as S / he is HIV positive.	Your friend is injecting drugs and shows you the needle marks on his / her arms.
Your friend is very ill and asks you if s / he is going to die.	You are very busy but your friend wants you to go to a movie with him / her.	You are feeling tired but your friend wants you to talk with him / her.

Session I.6
Identifying the Qualities of a Peer Educator

Expected Outcomes
Participants will realize the importance of the certain qualities for a peer educator.
Participants will become aware of whether they possess those qualities, or not.

Qualities Of A Peer Educator

Objectives To arrive at a consensus on the qualities of a peer educator.
To assess oneself against the identified qualities.

Materials Flash cards, markers, stones / pebbles / seeds

Time 1 Hour

Process Invite the participants to sit in a circle.

Explain that a peer educator must have or develop qualities that allow him / her to work with people. This exercise will enable the group to discuss and list the essential qualities for a good peer educator.

Ask each participant to take a flash card and a marker.

Ask them to close their eyes. You might want to play some soft music on a tape recorder.

Explain that everyone should think of a person they love and can talk with.

After 5 minutes, ask them to open their eyes, and write the one quality they like the most in the person they just thought of.

Ask them to place their respective cards on the floor after they finish writing.

Invite the participants to read the cards and group the cards that are similar.

Ask them to arrange the cards in a vertical line on the floor.

Ask each participant to take as many stones / seeds / leaves (marker) as there are cards. For example, there may be 6 cards on the floor so every participant must have 6 markers.

Start at the top of the vertical line. Ask the participant to think for a moment and place one marker in front of the card if they feel that they possess that quality. If someone feels that s / he does not possess that quality, they should not place their marker against it.

Finish marking all the qualities in this manner.

Invite the participants to sit in a circle around the display, and facilitate a discussion based on what you observe. For example, card number one may have as many stones as there are participants. This means that every one thinks they have the quality written on that card. Ask how this quality can help them in their own lives and when helping their friends.

Cover all the cards in this manner.

Sum up the discussion and the results of the exercise, by emphasizing the importance of those qualities for a peer educator.

Notes for the Facilitator

This exercise is fairly simple and allows the participants to determine the qualities that a peer educator should have. You can use this exercise to focus on the qualities that need to be developed by a peer educator. You can take this exercise a step further, and ask the participants to list the manner in which these qualities can be developed. Ask them to list the method for each quality. Once this is done, it will be easy for you to design a session for them. You could also undertake a similar exercise to determine the skills and knowledge required by a peer educator.

Listed below are some qualities that need to be developed by a peer educator in order to be effective in his/her work:

- Ability to keep abreast of new information and knowledge in the area of HIV/AIDS and related subjects, such as reproductive health and family planning.
- Ability to listen and communicate effectively.
- Ability to deal with emotions and difficult situations.
- Non-judgmental attitude and ability to express emotions.
- Adaptive and flexible nature.
- Ability to encourage and provide support.
- Ability to lead by example.
- Ability to keep confidences and foster trust.
- Ability to look at things from various perspectives.
- Ability to make decisions and encourage others to do so.

Module 2
Communication

FLOW CHART

Content Flow at A Glance
Module 2: Communication

Module 2
Communication

"The eyes of men converse as much as their tongues, with the advantage that the ocular dialect needs no dictionary, but is understood the world over."

Ralph Waldo Emerson

I Introduction

The word communication originates from the word "communis", which means common. Communication, therefore, is an act by which a person shares knowledge, feelings, ideas and information, in ways such that each gains a common understanding of the meaning, intent and use of the message.

Sociologists, educationists and psychologists have defined communication according to the disciplines to which they belong. Some definitions are given below:

> "It is a process by which two or more people exchange ideas, facts, feelings or impressions in ways that each gains a common understanding of the message. In essence, it is the act of getting a sender and a receiver tuned together for a particular message or series of message".
>
> *Leagans*

> "It is a process by which information, decisions and directions pass through a social system, and the ways in which knowledge, opinions and attitudes are formed or modified".
>
> *Loomis and Beegle*

> "Communication is the force by which an individual communicator transmits stimuli to modify the behaviour of other individuals".
>
> *Howland*

II How Communication Takes Place

Communication can occur without words. Our four senses, audio, visual, touch and smell, communicate. The ring of the alarm tells us its time to wake up, the eyes gaze at the window and check for the time of day or weather, the touch of the wind on our skin tells us if it is hot or cold and the smell from the kitchen tells us what is cooking. When a message is sent from a source to a receiver, a specific mental or physical response (communication) occurs.

Communication is a two-way process. It has a transmitter and a receiver. Therefore, it is essential for facts to be transmitted in such a manner that the meaning intended

is conveyed and the receiver understands the use of the message. It becomes a two-way process.

There are many different types and methods of communication. For example, in India, people fold their hands in greeting. In Japan, people bow from the waist. In Pakistan, people touch their forehead with the right hand. Simple gestures are an effective means of communication. An effective and culturally sensitive communicator is able to read feelings and reactions through these gestures.

Communication is a process. It is the process of transmitting meaning between individuals. Early human beings communicated through symbols and gestures. Later, the spoken word, in the form of language, was used for communication. As technology developed, written words and media were used, in addition to symbols, gestures and the spoken word.

Research shows that, on average, a person spends about 70 per cent of his/her active time communicating – speaking, reading, gesturing, writing, listening and watching.

Communication can be defined as a process of meaningful interaction whereby a person not only sends but also receives and understands a message. Communication always has a purpose.

III Types of Communication

Communication can be categorized into four different types, depending on the nature of the interaction.

Intrapersonal communication	is a type of communication whereby a person interacts with himself/herself. This type of communication is intrinsic or reflective.
Interpersonal communication	is a type of communication where there is one-to-one interaction or interaction among a small group. This is the most commonly used/practiced from of communication.
Intergroup communication	is a type of communication where interaction between different groups takes place.
Mass communication	is a type of communication where a large body (millions of people) of people is addressed.

IV Verbal and Non-Verbal Communication

Communication can be verbal and non-verbal. In verbal communication, we use words/language in the written or spoken form. Non-verbal communication is often given secondary importance, but it is much more important than verbal communication. It includes a series of gestures, such as facial expressions, signs, body movements, eye contact, tone of voice, and sounds. In

normal interpersonal communication 5-10 per cent of total communication is verbal while 90-95 per cent is non-verbal. People can receive valuable information through non-verbal cues such as:

- Body language
- Eye contact
- Facial expression
- Head nodding or shaking
- Playing with objects
- Making sounds
- Signs
- Touch
- Taste
- Silence

V Barriers to Communication

There are many barriers to communication. These barriers can stall or distort communication, therefore, attention must be paid to overcome these barriers. Communication barriers can be classified into three main groups:

Judgmental attitude may be reflected through excessive analysis, bossiness, name-calling, ridiculing, making value-based comments and judgments, moralizing or ignoring. This is often the single most powerful barrier in communicating with young people on the subject of HIV/AIDS and related subjects, such as sexual health, reproductive health, STIs and drug use

"Know it all" attitude may be reflected through advising, moralizing, ordering, patronizing, threatening or lecturing. This form of behaviour often inhibits people from sharing their concerns and experiences. When communicating with youth, this kind of behaviour/communication should be avoided.

Unconcerned attitude may be reflected through voicing platitudes, diverting the issue, using excessive logic, offhanded assurances, half-listening, not making eye contact or being flippant. In communicating with people on sensitive topics, such as HIV/AIDS, care must be taken to avoid such behaviour and actions. Concern, empathy and confidentiality are valued components of communication on sensitive subjects.

VI Listening

Listening is the highest form of communication. When they consider communication, people tend to think more of speaking and less of listening. We rarely receive any training on how to listen but reading, writing and speaking are taught in abundance.

Always remember that the responsibility for ensuring that the listener gets the message lies with the sender. To introduce new material to an audience we must tap into known material. The new material should be linked to what they already know or have experienced.

There are 5 main forms of listening

"Ignoring" listening occurs when the listener is not attentive to the message, as s/he is otherwise preoccupied and unwilling to receive a message.

"Pretending" listening occurs when the speaker is in a higher position and the listener cannot ignore him/her. S/he pretends to listen, even when the message is boring or irrelevant.

Selective listening occurs when the listener picks up only those parts of the message that interest him/her and ignores the rest of the message.

Attentive listening occurs when the listener not only listens and is able to answer questions, but also understands the significance of the message.

Empathic listening occurs when the listener does not necessarily agree with the speaker, but deeply understands that person emotionally and intellectually. This is the highest form of listening and is often referred to as being in "someone's shoes".

VII Barriers to Receiving Messages

Human beings can receive messages subject to certain limitations. These limitations are called filters. Anything below or above the range of these filters is usually left out:

Physical filters The inherent structure of our senses limits our capacity to perceive. For example, we can only see certain colours from a spectrum of colours. We can only hear between certain frequencies – 20Hz to 20,000 Hz. All frequencies higher or lower are filtered out.

Psychological filters enable people to look/view the same things differently. Our attributes, expectations, past experiences, and knowledge influence what we perceive and how we perceive it. These perceptions change during the course of life and greatly influence the way we communicate.

VIII Seven Steps to Effective Messages

- ***Know your target audience*** – who are they, what do they need, how can you reach them?
- ***Set clear objectives*** – what do you expect from the message, how will you measure it, when will it happen?
- ***Work for approval*** – your audience should chose your message over the others that are also coming its way
- ***Be strategic*** – use words, images and sounds that are acceptable to your audience, because your main purpose is to make them listen.
- ***Work for acceptance*** – is your message credible, do people believe your message and the communicator, who and what will people believe?
- ***Work for recall*** – the message should remain with the audience, make it catchy, make it funny, repeat if necessary, use different types of media

- ***Review and re-plan*** – are you reaching the intended audience, are you achieving the objectives, do you need to change, do you need a new message?

IX Distortions in Effective Communication

Communication can be blocked or result in undesired impacts. This may happen because of many reasons that are known as distortions. Distortions can occur because of the following:

- A very long transmission chain (message is passed from one person to another and goes through a long chain of receivers and senders).
- A very long message.
- A complicated and poorly organized message.
- Non-availability of feedback at appropriate time.
- The sender and the receiver have different mindsets.
- Inappropriate use of media and medium (i.e., method and language).
- Lack of common perceptions between the sender and the receiver.
- Hurried and uninsured transmission (you send the message without checking if it has actually reached the intended person).

X Reducing Distortions

Distortions can ruin a communication, especially if you are communicating with people on an issue as sensitive as HIV/AIDS. Communication on HIV/AIDS usually involves dealing with young people or groups that are marginalized. It also involves serious issues of trust and confidentiality, as it relates to peoples personal and intimate behaviours. You could reduce these distortions and increase the effectiveness of your communication by:

- Communicating with small groups and being direct.
- Using language easily understood and spoken by the target group.
- Increasing the similarities between the sender and the receiver.
- Keeping the message short and dear.
- Putting yourself in the receiver's shoes.
- Using multiple ways of communicating – verbal, written, audio or visual.
- Keeping confidences and listening.

Session 2.1
Hearing and Listening

Expected Outcomes

Participants will know the difference between hearing and listening.
Participants will become more aware of themselves, while listening to others.

Listening

Objective To know the difference between hearing and listening.

Materials 10-15 lines of written script on any topic.

Time 30 minutes.

Process Invite the participants to sit in a circle.

Ask for volunteers. Take the volunteers out of the room, and instruct them to make noise while the script is being read out. These noises, for example, tapping a pen on the floor a few times or knocking on the wall, (should be loud enough for everyone to hear but not overwhelming enough to attract the complete attention of the participants) should be made once or twice.

Explain to the participants that you will read out a small text. and they should try to remember as much as they can of the text.

After the reading, ask the participants to tell you all that they heard.

Allow 7-8 minutes for this activity. Then, invite the participants to listen to the same text being read out for a second time.

This time they should have an objective when listening to the text. Complete the reading, and ask the participants to report on the stated objective.

During the first round of reading, most participants will probably be able to tell you bits and pieces of the text you read.

Listening to the second round of reading with an objective will result in accurate responses from a large number of participants.

Ask the participants:

- *Why do they think this happened?*

Some participants will tell you that this was because, the second time, they had an objective. Commend the answers. Emphasize that the difference between hearing and listening is that listening has an objective while hearing is general.

Close the exercise by pointing out that in effective communication listening is an important element.

Notes for the Facilitator

This exercise points out the difference between hearing and listening. It allows the participants to learn from their on experience, and therefore, they tend to remember it. As a peer educator, you may want to use section VI on listening (beginning of this module).

Session 2.2
Seeing and Looking

Expected Outcomes
Participants will become aware of the difference between seeing and looking.
Participants will be more observant and aware and this will improve their ability to communicate.

Objective To know the difference between seeing and looking.

Materials None.

Time 20 minutes.

Process Invite the participants to take a break. Ask them to take a walk outside and come back in 5 minutes.

When they return, ask them what they saw during their walk outside.

After about 5 minutes, ask them to, once again, go out for a walk. This time, they should bring back information on something specific (flowers trees a structure) that they find in the surrounding environment.

Ask the participants to share their information on the specific item, then, ask what they think was the difference between their first and second walk.

Somebody might point out that they had an objective on the second walk. It is also possible that this point will not be raised. In either case, the message is that the difference between seeing and looking is that looking has an objective, while seeing is general. Eyes have an important role in communication. When we wish to communicate effectively, we must remember that visuals should require an objective for them to make sense to the receiver.

Notes to the facilitator
Research shows that visual communication is very effective in transmitting a message and is often retained by the receiver. Therefore, if you want to be an effective communicator, remember that in order to have maximum effect, every visual message should have an objective. This exercise effectively transmits this message to the participants.

Session 2.3
Pitfalls of Communication

Expected Outcomes

Participants will learn the importance of feedback in communication.
Participants will know that both verbal and non-verbal means of communication are important.
Participants will become better communicators.

How should I Communicate?

Objective To demonstrate the pitfalls of communicating without verbal or visual feedback.

Materials A shirt with the front undone.

Time 15 to 20 minutes.

Process Invite the participants to sit in a circle.

Place the shirt in the centre of the circle.

Ask for two volunteers.

Request that they stand in the centre of the circle. They should stand with their backs to each other.

The observers should maintain silence during the co urse of the exercise.

One of the volunteers should take the shirt and the other should give him / her the instructions how to put it on.

The two volunteers must not look at each other or ask questions. The instructor should give instructions and the receiver should follow the instructions.

Allow 5 to 6 minutes for this activity

Ask the volunteers for their reactions by asking the following questions:

- *Did you manage to put the shirt on properly by following the instructions? Why?*
- *Why were you not able to give instructions effectively?*

Now ask the volunteers to stand facing each other.

Ask one volunteer to give instructions while the other volunteer follows the instructions. The volunteers are allowed to ask questions and make suggestions.

Allow 5 minutes to finish, but it is likely that they will finish sooner. Ask about their second experience.

- *Did you manage to follow the instructions and complete the task? Why?*
- *Why were you able to follow the instructions this time?*
- *Were you able to give your instructions in a more effective manner? Why?*

You can involve the observers in the discussion by asking for their opinions and observations. They can also give their responses to the questions asked.

Notes to the Facilitator

This is exercise demonstrates the importance of verbal and visual feedback in any communication.

Session 2.4
What Influences Our Perception?

Expected Outcomes
Participants will understand the reasons people perceive things different.
Participants will design their future methods of communication more effectively.

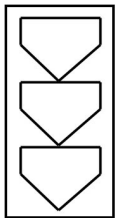
Whose Perception Counts?

Objective To demonstrate that recent events influence the way we see things.

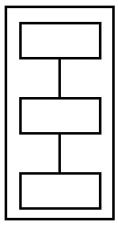
Materials Flip charts, markers, white board or black board, chalk.

Time 15 minutes.

Process Invite the participants to sit so that everyone is able to see the board. Exhibit the following diagram:



Ask them, "What do you see"? They will probably say three arrows, houses on the side, sign showing go left or you may get the correct response, which is two Ks. Commend the answers, and quickly move to the following exhibit:



Ask them "What do you see now"? It is likely that you will get the correct response immediately (2 Hs). Now, ask the group if they would have seen this as quickly, had they not had the benefit of the first round?

Notes to the Facilitator
It is best to prepare the two diagrams in advance, as the process of drawing them can reveal the answer. Use this exercise to point out the importance of conditioning. Ask them why they saw the H's faster than the Ks, could they give any examples of a similar experience in their life when they have analyzed something or perceived something in light of what had happened immediately before. Point out that while communicating, it is important to keep a link with what has preceded, as it enables faster learning and analysis.

Session 2.5
Blocks in Receiving Messages

Expected Outcomes

Participants will understand that even simple messages can be misunderstood. Participants will be more careful in designing messages and communicating with others.

State It Clearly!

Objective To demonstrate that it is easy for messages (even simple ones) to be misinterpreted, if the words used are not familiar and clear, and that, things become worse, if the recipient is not able to ask for clarification.

Materials 4 square sheets of paper.

Time 15 minutes.

Process Ask for 4 volunteers.

Ask the volunteers to stand facing the rest of the participants.

Explain that you will give them some instructions, and they should follow the instructions without talking and with their eyes closed.

The observers should watch and be silent.

Explain that the exercise is intended to demonstrate some important issues in communication. If the volunteers are hesitant, ask for another.

Invite the 4 volunteers to take one piece of the square paper each. Ask them to close their eyes and follow the instructions. The instructions to be given are as follows:

Fold your paper in half and tear of the bottom right corner of the paper.
Fold the paper in half again and tear off the upper left hand corner.
Fold the paper diagonally and make a hole in the centre.

Ask the volunteers to open their eyes and unfold the papers. Invite them to share the outcome with each other and the participants.

Ask the volunteers:

- *How were the instructions?*
- *Did all of you understand my instructions in the same manner?*
- *What was difficult or easy to understand?*
- *How could I have framed my instructions to reduce the probability of multiple interpretations?*

You can involve the observers by opening up the conversation once the volunteers have answered.

Notes for the Facilitator

Usually the volunteers end with different results from the same set of instructions. It is usually because of the way they hear the instructions. Sometimes the words used are not understood properly. You can use this exercise to point out the importance of words in communication – words must be commonly understood, i.e., they should be understood by the receiver in the same way as intended by the sender. The ability to visualize something is important. Volunteers would have corrected their mistakes, if they had been allowed to keep their eyes open. They would have looked at others' work or people's expressions. Listening is also important. The person who paid attention to the instructions would have produced the best results. Since the volunteers were not allowed to ask questions or get clarification, communication was unsuccessful.

Session 2.6
Messages on Prevention of HIV/AIDS

Expected Outcomes
Participants will design messages using the principles of communication learnt in earlier sessions.

Modes of Transmission

Objective To prepare and deliver a message on ways in which HIV can be transmitted.

Materials Left to the discretion of the users.

Time 2 hours.

Process Ask the participants to divide into 4 groups.

Explain that each group will use one particular method to deliver their message on ways in which HIV / AIDS can be transmitted.

While one group presents, the other three will observe the content, method of delivery and use of language in the message delivered. The observers will provide the presenters with feedback on the three criteria.

The four groups can chose from the following methods, or the facilitator can assign one method to each group:
Posters
Presentation using transparencies or flip charts
Role Play
Jingle or song

Give the groups 30 minutes to prepare their presentation.

Each presentation should not be longer than 10 minutes.

Invite the observers to give feedback after each presentation. Explain that the feedback should be on the presentation, not on the presenters.

Allow 10 minutes for feedback after each presentation.

Conclude the session with your observations on the presentations and highlight the positive points of each presentation.

Notes for the Facilitator

This exercise builds skill for effective communication. You could make the exercise more interesting by asking the observers to rate the four presentations on a scale from 1 to 5. They could also set their own criteria for rating. You could invite an expert on communication to come and give his/her feedback on the presentations.

HELPLINE for the peer educator

Material for reading, preparation of handouts and facilitation of session

Feedback is the most important element affecting the communication process. Feedback is a mechanism by which the initiator can understand the impact of his/her communication on the receiver. It is most effective when it has the following characteristics:

- Is non-judgmental – gives descriptive feedback on the content, process and method rather than on the communicator.
- Is specific.
- Is useful and useable – the receiver should be able to use the feedback to make corrections or changes. The feedback should contain proactive suggestions.
- Is accurate.
- Uses "I" statements.

Some basic principles of communication while dealing with sensitive topics, such as HIV/AIDS, reproductive health and drug use are:

Respect

The receiver should feel respected and trusted if s/he is to communicate. If not s/he may want to end the conversation and leave as soon as possible.

Safety

Safety is important, as one is discussing personal and intimate matters. The person needs to know that s/he will not suffer negative consequences for the information being shared, for example, s/he ill not be sent to jail because s/he is using illegal drugs, or s/he ill not be stigmatized because s/he is HIV positive.

Non judgmental attitude

Do not moralize or lecture people about their life choices. Give factual information without personalizing it, and do not be shocked, disgusted or alarmed at the information shared.

Confidentiality

This is an important issue. People infected with HIV/AIDS, using drugs or discussing any other private matter need to feel assured that their information will not be shared with anyone else. The choice of sharing or not sharing the information must be left with the individual.

Sensitivity
Be aware of the comfort and discomfort of the person speaking with you or to whom you may be speaking. Learn to read body language and take cues that inform you about another's feelings and emotions.

Privacy
In cases where the issues being discussed are private and personal, make sure these are discussed in private. If you are in a group meeting and personal issues emerge, establish that these will only be discussed after the group meeting and in private. Do not refer to personal information in public forums. Do not give examples using names and places.

Cultural and Religious sensitivity
HIV / AIDS, sexual health, and reproductive health are all sensitive subjects. They are often mired in religious and socio-cultural taboos and beliefs. Therefore, it is very important that you become aware of these dimensions. Religious beliefs are an important part of the cultural identity of many people. Freedom of thought and religion is a basic human right recognized in the Universal Declaration of Human Rights.

Most religions and cultures of the world promote tolerance and love. These should be used to help overcome the discrimination and stigmatization associated with HIV / AIDS and other sexual and reproductive choices, such as, homosexuality and use of family planning methods.

General reading material for the peer educator that may also be used to make posters

Some pointers for an effective question and answer session

- Listen to the questions.
- Observe the tone and the manner in which the question is asked.
- Repeat the question as you understand it, and ask if you got it right.
- Answer if you can and cannot involve others in finding an answer.
- Speak clearly and confidently.
- Do not fidget or read from a paper, if you need to consult your notes, say so.
- Establish eye contact with as many people as possible.
- Be aware of your body language. Do not point or lean threateningly.
- Involve the participants in seeking answers. Ask for their opinion and knowledge.
- Allow time for questions and answers.

Some practical points for working in different socio-cultural and religious settings

- Do not address religious or sensitive socio-cultural issues without setting the stage first. Try to form alliances with people already working at the location, especially youth groups.
- First, find out what is possible, and what is already happening on the issue of HIV / AIDS, sexual health and reproductive health.
- Contact existing open-minded religious leaders and groups because they might lend you their support.

- Gather knowledge and information about the social, cultural and religious practices and beliefs of people; research their scriptures and holy books.
- Confrontation can be counter-productive.
- Remember that all religions are in favour of tolerance, respect for all God's children and caring for the weak and the sick.
- Present facts and avoid getting into arguments.
- Start with simple, non-threatening activities, such as group discussions on what is culturally acceptable concerning sexuality or reproductive health. Some people feel that anonymous telephone helplines are a useful initial step.

Module 3
Basics of Growing up-
Understanding Adolescence

FLOW CHART

Content Flow at A Glance
Module 3: Basics of Growing Up – Understanding Adolescence

Module 3
Basics of Growing Up – Understanding Adolescence

"I – I hardly know sir, just at present at least I know who I was when I got up this morning, but I think I must have been changed several times since…."

Alice in Wonderland

I Introduction

As one grows up, one experiences many changes. There are changes in the body; in the way one behaves and the way others expect one to be. There are also changes in interests and preoccupations. All of this is normal. It is part of growing up, but growing up is not easy. This is a time when one has many questions and hardly any answers. It is difficult to talk about the things upper-most in your mind. Why is my body changing? Why do I get an erection? Why do I feel attracted to the opposite sex? Many older people are not willing to discuss these issues openly. As a result your friends (peer group), TV, films, magazines and imagination become your sources of information.

In order to deal with the turmoil, we need to know the facts of growing up, distinguish between myths and realities and come to terms with change. This module deals with these issues.

Session 3.1
Understanding Changes during Adolescence

Expected Outcomes
Participants will understand the facts about physical changes that take place during adolescence.

Body Maps

Objectives To discover the physical changes that take place during puberty.
To enable boys and girls to learn about the changes in each other's bodies.

Materials Flip charts, markers, crayons, cello tape, scissors, stapler.

Time 1 hour and 30 minutes.

Process Ask the participants to divide into 2 groups – males and females (if desirable separate the groups and do the exercise in separate locations).

Invite them to pick up flip charts and markers for the group task.

Explain that they will be making a body map to show the physical changes that have occurred in their bodies since they were 10 years old.

The body map can be easily drawn – one person from the group should lie on a sheet of paper (you may have to join 2 to 3 sheets together) while someone else traces the outline of his / her body.

Then the group will discuss and mark the physical changes on the body map.

Explain that technical names and drawings are not necessary. They can use the language they normally use to communicate with each other.

Allow 30 minutes to do this exercise. Ask them to put up their respective charts on a wall, or spread them out on the floor. Invite each group to present their body maps.

Put up a third chart (on the wall or on the floor along side the other two maps) that shows the physical parts of the male and female body (you can prepare this chart yourself before the start of the training or you can buy one).

Ask the participants to take a close look at their charts and the one you have put up. Encourage them to discuss and point out the similarities and differences.

The following questions can be used for discussion:

- *How did you feel drawing the body map? Why?*
- *How did you feel about sharing the body maps with each other? Why?*
- *When did you first notice a physical change in your body? How did you feel?*
- *What questions did you have and were you able to get answers? Who did you talk to?*
- *Were you curious about the changes in the body of the opposite sex? What questions came to your mind and whom did you speak with?*

Notes for the Facilitator

This exercise enables participation of all the group members. It also allows you to get an understanding of the way in which the participants view their bodies and their feelings related to the changes. Body mapping is a participatory tool and has been used extensively by health workers in creating awareness about the body and health problems. It is especially effective for dealing with intimate health issues, such as sexual health and gynaecological problems among women.

Using biological facts briefly summarize the physical changes that take place during adolescence. Ask the participants if they have any questions on the subject. It is good to facilitate this exercise in a mixed group. It allows males and females to understand each other's bodies better. Sometimes, the participants feel inhibited and shy in each other's presence. This may be due to cultural and religious reasons. Ask the participants if they are comfortable in the mixed group and proceed accordingly. If the participants are not comfortable in a mixed group you may have to do the exercise in separate groups, and you may need the help of a co-facilitator.

HELPLINE for the peer educator

Adolescence

The period between 10 to 19 years of age is called adolescence. The word is derived from the Latin word *adolescere*, which means to grow. During this time, a number of physical, cognitive and social emotional changes take place in the body.

Physical changes

In a span of 7 to 9 years, boys and girls grow up to be young men and women. For a brief period of two or three years, they experience what is known as a growth spurt. Adolescents experience a quick gain in height and weight. The growth spurt begins two years earlier for girls than boys, but it lasts longer for boys. Within nine years, boys gain an average of 36 cm in height and 25 kg in weight. Similarly, girls gain an average of 24 cm in height and 21 kg in weight. However, these are only average values and wide variations in these figures should not be considered abnormal.

The rapid acceleration in height and weight is accompanied by changes in body proportions. The different parts of the body have their own sequence of rates of growth. Some grow slowly, while others grow quickly. At this age, before the arms and legs reach their full length, hands and feet become almost adult size. Girl's hips become wider in relation to their shoulders.

There is a slight change in facial features. The jaw and the nose become larger, while the mouth widens and the chin becomes prominent.

In both boys and girls, as the height increases, there is a rapid increase in the development of muscles. However, boys show a more rapid increase than girls do. As a result, they gain more muscle tissue. That is why boys are more muscular than girls. The rate of development of muscles in adolescents is faster than the development of fatty tissue. This occurs more in boys than girls. That is why girls tend to retain some of their fat, especially on their arms, legs and hips.

Along with changes in the body size, physical changes in the reproductive system also occur, leading to sexual maturity. For the first time in life, obvious differences in girls and boys emerge. Sexual maturation consists of two types of changes in the reproductive system: those that relate to primary sex organs, such as the penis and the testes in the males, and the vagina and the ovaries in the females. Associated changes visible on the body are referred to as secondary sex characteristics. These include breast development in females, facial hair or beard in males and growth of underarm and pubic hair for both sexes. Girls also begin their monthly menstruation cycle. For boys, semen secretion begins to take place (while urinating boys may find a few drops of whitish fluid known as discharge and this can be frightening for some). Erections also become frequent, especially when one is excited.

The skin becomes oilier and pimples may appear on the face and sometimes on the back. These changes happen because of changes in the natural chemicals in the body known as hormones. Voice also begins to change in both boys and girls. The voice of boys becomes hoarse and full, while in girls it becomes high-pitched and clear. Both boys and girls have hormones but they have different amounts of different hormones.

Session 3.2
Understanding Cognitive and Emotional Changes during Adolescence

Expected Outcomes

Participants will learn the facts about cognitive and emotional changes during adolescence.

Body Maps Revisited

Objective To understand the emotional and cognitive changes during adolescence.
To realize that emotional and cognitive changes among boys and girls are less similar.

Materials Body maps from the previous exercise, markers, flip charts.

Time 1 hour.

Process Invite the participants to sit in a circle. Place the body maps in the centre of the circle.

Explain that the physical changes that take place in the body during adolescence have already been discussed, and this session will focus on the emotional and cognitive changes that take place during adolescence.

Ask them to discuss "emotional changes since the onset of puberty" and "cognitive changes since the onset of puberty."

They can use the body maps to mark out the emotional and cognitive changes. Let the participants decide and proceed accordingly.

The body maps that were prepared by the participants during session 3.1 may be re-used for this exercise. If not, the participants can draw fresh body maps. For this purpose, they will need large sheets of paper and markers. One member of the group should lie on the sheets that have been taped together and another member should draw the outline of his / her body.

Allow the participants 30 minutes for the discussion.

After the exercise has been completed, facilitate a discussion using the following questions:

- *How did you feel about doing this exercise in a mixed group? Why?*
- *Are there any differences in the changes (emotional and cognitive) between the males and the females? What?*
- *Are women more emotional than men? Why/ Why not?*

- *Are men more intelligent than women? Why/Why not?*
- *How did you handle the emotional changes?*
- *Did you notice any changes in the way adults behaved toward you? What and how?*
- *Did you receive any support from your friends in dealing with the changes? What kind of support did you get?*
- *Now that you know a little more about the process of growing up, will you be able to help those who may be going through the process? How will you help?*

Conclude the discussion with a brief summary of the discussion and a presentation on the basic emotional and cognitive changes experienced by the adolescent. You may want to use the material given in the "Helpline for the peer educator" for the presentation and concluding remarks.

Note for the facilitator

This exercise provides the participants with information on the similarities and differences between males and females. This exercise can be further developed to include a discussion on the concept of "gender". You may ask the participants to decorate their body maps by adding clothes and other accessories that define the male and female look. You could then facilitate a discussion on whether these are basic biological differences or differences created through social and cultural norms and beliefs.

HELPLINE for the peer educator

Emotional changes: Increased hormonal activity during adolescence produces changes in the emotional state of the adolescent. They experience frequent changes in moods, ranging from feelings of extreme happiness to extreme sadness. At times, they find themselves bursting into a rage or tears. Later, they wonder why they did what they did.

Sex drive emerges in both boys and girls. Sex drive is an impulse related to the sexual need. It is a natural biological instinct. The immediate outcome of the sex drive for the adolescent is:

- *Attraction towards members of the opposite sex*
- *Crushes or infatuations (can be with persons of opposite sex or same sex)*
- *Need for sexual experimentation (this is critical in the context of HIV/AIDS and STIs)*
- *Need for physical contact and intense emotional relationships*

During this period, friends and peers become more important. Acceptance and popularity among peers become very important. To gain acceptance in the peer group one starts adopting the prevalent norms and behaviour of the group (using slang, smoking, hairstyle, dress etc). This is also one reasons for experimentation with sex and drugs. The stress is on looking and sounding different from children and adults. The need for independence intensifies and awareness of the self increases.

Cognitive changes: One of the main features of adolescent thought is systematic thinking. Adolescents develop the capability to organize their thoughts, reflect on

them and come to a decision that they may implement. For example, if a 16-year old is given money to go shopping, s/he will go to the market, look at the things available, choose what s/he likes and then buy it.

Adolescents are also capable of abstract thinking: the ability to imagine phenomena that are concrete, hypothetical or imaginary. This includes mathematics, physics, geography and other concepts.

Adolescents become more creative and seek to experiment with new and different things/ideas.

They develop coping strategies to deal with change and sudden occurrences.

Adolescents develop the abilities to seek relationships and keep them.

Changes also emerge in the way they communicate. Often they develop a special vocabulary that reflects their disdain for adult society. They coin phrases and words that express their exclusivity and strengthen their bonds with their peer group.

Session 3.3
Sexual Maturation during Adolescence

Expected Outcomes
Participants will know the facts related to sex and sexuality.
Participants will develop a common understanding of "sexuality".

Understanding 'Sex' and 'Sexuality'

Sexuality is about many things such as emotions, beliefs, relationships and self-image. It is definitely more than simply sex. All human beings are sexual and develop their sexuality from a number of influences, including social, cultural, biological, economic and educational factors. Sexuality is a multifaceted and sensitive issue, and there is often confusion about how best to address it. Notions of sexuality, sexuality education, sexual health and rights have different meanings in different contexts. Different people in different societies understand these notions differently. As a result, there is a need to understand sexuality in the broader context of culture, tradition, religion and morals.

Objective To help the participants explore their understanding of the term "sex." To develop a common understanding and definition of "sexuality."

Materials Flash cards, markers, blackboard / white board, chalks / white board markers or large flip charts.

Time 1 hour 30 minutes.

Process Invite the participants to sit in a circle. Explain the objectives of the session and reassure the participants that this exercise is simply an exploration of their personal understanding of the terms and that there are no right or wrong answers.

Give one flash card to each participant and ask him or her to express his or her understanding of the term "sex" either through writing or drawing on the flash card. Give them 10 to 15 minutes.

Ask the participants to read out / show their card and place it on the floor.

When all the cards are placed on the floor, ask the group to cluster the similar cards together.

Once this has been done, ask them to make a collage for display and put it up on the wall.

Facilitate a discussion using the following questions:

- *How did you feel doing this exercise? Why?*
- *What does the collage depict – "sex" or "sexuality"?*
- *Do you think there is a difference between "sex" and "sexuality"? Why/Why not?*

Note for the facilitator

Usually this exercise can be done in a mixed group, but if participants feel uncomfortable, you can do the exercise in separate groups for men and women. When asked to define sex, participants often end up describing sexuality, and that is one reason why the exercise is effective in prompting discussion on sexuality. You should be ready with the dictionary definitions of "sex" and "sexu ality" to facilitate this exercise. Help the participants to arrive at a common understanding of the two terms, and express it through a collage prepared from their writings and drawings. Listed below are the definitions that you may want to use during the discussion on sex and sexuality.

- **Sex,** *noun* – being male or female, males or females collectively. (Oxford dictionary)

- **Sex,** *noun* **1** identify the sex of the animal gender. **2** attraction based on sex sexuality, sexual attraction, sexual chemistry, sexual desire, sex drive, sexual appetite, libido. **3** lessons in sex / sex education facts of life, sexual reproduction, reproduction. **4** have sex with him / a relationship without sex intimacy, coitus, coition, coupling, copulation, carnal knowledge, making love, mating, and fornication. (The Concise Oxford Thesaurus, Oxford University Press, 1995)

- **Sexuality,** *noun* **1** differences based on sexuality, sex, gender, sexual characteristics. **2** famous for her sexuality sexual desire, sexual appetite, sexiness, carnality, physicalness, eroticism, lust, sensuality, voluptuousness, sexual orientation, sexual preferences. (The Concise Oxford Thesaurus, Oxford University Press, 1995)

Session 3.4
Sexual Maturation during Adolescence

Expected Outcomes
Participants will understand the biological facts of sexual maturity.
Participants will know the terms used for male and female sexual organs.

My Body

Objective To create awareness about sexual maturity among young men and women.

Materials Body maps made by the participants in earlier exercises, flipcharts, markers, tape, flash cards.

Time 1 hour.

Process Ask the participants to divide into 2 groups – male and female.

Explain that they will revisit their body maps, (made during session 3.1) and 3.2) and discuss the changes in their respective sexual organs since the onset of puberty. They can indicate the changes on the body maps, if this is not done already. The participants may wish to draw new body maps; encourage them to do so.

They should discuss the "terms" and body parts related to sexuality, and put them on the body map. The "terms" need not be scientific. Commonly used terms should be used.

Allow the groups 30 minutes to do this exercise and then facilitate a sharing of their outputs. If the groups do not feel comfortable sharing, ask them to share it with you separately, and you can become the medium to bring the two outputs together.

Place the 2 body maps on the floor and ask the participants to sit around them in a circle. Use the following questions to facilitate a discussion:

- *How did you feel during this exercise? Why?*
- *What are the differences between the male and female reproductive systems? Can you point these out using the body maps?*
- *How do you feel about your body and your sexuality? Why?*
- *Do you discuss your body and sexuality with your friends?*
- *Have you ever discussed these issues with any adult? Why/Why not?*
- *Do you know of any beliefs or taboos associated with these body parts? If yes, what are they?*
- *Why are there so many beliefs and taboos associated with sexual body parts and sexuality?*
- *How do you feel about the opposite sex? Why?*

Notes for the Facilitator

This exercise may have been covered under the "physical" changes exercise also done with the help of body mapping. In this case, however, the participants will be discussing their sexual organs and their relationship to sexuality. Please request the participants to focus on this topic of discussion. You may ask the participants to improvise on the earlier body maps, or create new ones for this exercise. You should be prepared with the facts and drawings of the male and female reproductive system. Encourage the participants to share these exercises, but if they are too shy, for whatever reason, try to bring them into the discussion gradually.

Helpline for the peer educator

Terms used in male sexuality

Penis	The male organ for sexual intercourse.
Scrotum	The pouch located behind the penis that contains the testicles, provides protection to the testicles and controls the temperature necessary for sperm production and survival.
Testis	Two round glands that descend into the scrotum following birth, produce and store sperm and produce the male sex hormone testosterone.
Seminal	A sac-like structure lying behind the bladder that secretes a thick milky fluid that forms part of the semen.
Prostate Vesicle	A gland located in the male pelvis that secretes a thick milky fluid that forms part of the semen.
Semen	Milky white fluid passed out of the penis at the time of ejaculation. Semen contains sperm, secretions of the prostate gland and seminal vesicles.
Erection	The process by which the penis fills with blood in response to thoughts, fantasies, temperature, touch or stimulation and grows taut.
Ejaculation	The release of semen from the penis caused by sexual excitement. This occurs in situations other than intercourse. It may occur at night and is commonly known as a "wet dream". However, this is a misnomer for nocturnal emission, because it does not occur only because of a sexual dream. It is a natural and normal phenomenon. It is also known as spermarche.

Terms used in female sexuality

Labia majora	Two sets of folds on either side of vagina; and labia minora provide protection to the clitoris and the urethral and vaginal openings.
Clitoris	A small structure located at a point where the labia meet; the point of stimulation for the female.
Vaginal opening	Located between the urethral opening and the anus; outlet for menstrual flow.
Vagina	Canal through which a baby passes during delivery; passageway for the menstrual flow. Capable of expanding during intercourse and childbirth.
Pelvis	The basin shaped bone structure that provides support and protection to the internal reproductive organs, bladder and large intestine.
Hymen	It is a fold of mucous membrane stretched across and partially closing the vagina. Tears during physical activity or sexual intercourse. Different societies have different myths about the hymen.
Cervix	The mouth or opening into the uterus; protrudes into the upper most part of the vagina.
Uterus	A pear shaped muscular organ located in the pelvic region; beginning at puberty, the lining sheds periodically (usually monthly) during menstruation; baby develops here during pregnancy.
Fallopian tubes	Passageway for the egg from the ovary to the uterus, place where fertilization occurs.
Ovaries	Oval shaped structure located in the female pelvic region. Begins release of eggs at the time of puberty, produces female sex hormones.
Ovum or egg	Roughly the size of a pinhead. If the egg meets the sperm, then conception occurs. If the egg is not fertilized i.e., does not encounter the sperm, then it dissolves and is discharged during menstruation.
Ovulation	Release of an ovum from the ovary. Usually one egg is released every month.
Fertilization	The union of the sperm with the ovum. It takes place in the fallopian tubes.

Session 3.5
Sexual Maturation during Adolescence: Beliefs and Misconceptions

Expected Outcomes

Participants will know that many things that they believe about sexuality and sex are actually misconceptions.

Agree, Disagree, Don't Know

Objective

To surface the prevalent misconceptions about sex and sexuality in the group.
To clarify the misconceptions.

Materials

List of statements, signs that indicate agree, disagree, don't know.

Time

1 hour 30 minutes.

Process

Invite the participants to put the three signs up (agree, disagree, don't know) around the room.

Explain that the signs will be used in the exercise on myths and reality about sex and sexuality.

All societies have myths regarding the subject of sexuality. Many beliefs and misunderstandings surround the subject. The exercise will explore these misconceptions and provide the facts.

Explain that you will read out some statements. The participants should listen to the statements and decide whether they agree, disagree or don't know. Depending on their response, they should stand under the corresponding sign (these signs have already been pasted on the walls around the room).

After each statement, ask the respective responders to give reasons for their agreement, disagreement or confusion.

After the participants give their response to each statement, you should provide the correct response.

Complete the list of statements and ask the participants to sit in a circle. Facilitate a discussion using the following questions:

- What are your observations on the exercise just completed?
- Have you learnt something from this exercise? What?
- How do you feel about your understanding of sex and sexuality?
- Did you gain any insights into why you believe or disbelieve certain things?
- After the exercise, will you be able to clarify misunderstandings and doubts of your friends?
- How will you inform your friends about the new things you learnt through this exercise?

Note for the facilitator

This exercise is non-threatening and can be done in a mixed group. It allows the participants the necessary space for reflection and correction. The exercise requires preparation by the facilitator. The facilitator must prepare the list of statements and correct responses before starting the session. The facilitator should also give reasons for right and wrong answers. The facilitator can always seek the help of the participants. Ask the participants if anyone got all the responses correct. You can give a chocolate to that person or to the person who got the maximum number of correct responses.

List of statements that may be used for this exercise (this list is only a guide and you may add and delete statements depending on the group and the time available):

- Once a girl has had her period, she can become pregnant.
- Masturbation makes a boy impotent.
- Masturbation is something that only boys do.
- A girl should not engage in physical activity during her period.
- A drop of semen is equal to 60 drops of blood. Therefore, the loss of semen weakens the body and should be avoided.
- The size of the penis is important and determines masculinity or virility.
- Boys can tell when a girl is having her period.
- One should not bathe during menstruation.
- Nocturnal emissions are a disease and require treatment.
- Thinking about sex is dirty.
- A girl cannot get pregnant if she has sex only once or only a few times.
- It is possible to get pregnant by kissing.
- During menstruation a girl becomes “unclean” or “impure”
- If a boy has swelling in his breast, it is nothing to worry about.
- Women are responsible for the sex of the child.
- Men who have sex with men or think of having sex with men are not normal.
- If a girl does not bleed after initial intercourse, she is not a virgin.
- Women who have sex with women are depraved or abnormal.
- It is immoral to have sexual fantasies.
- Having an orgasm is essential for sexual pleasure.
- All girls must start menstruating by the time they are 13 years old.
- Using protection, such as condoms during intercourse, reduces pleasure.
- Only immoral and perverted persons get sexually transmitted infections.

- Only men can use contraceptives.
- The "pill" is good protection against sexually transmitted infections.
- Girls should not eat spicy food as it increases their sex desire.
- Sex is the only way to express love and affection.
- Going to sex workers is safe for the society because it prevents rape and molestation.
- Men have sexual needs but women do not.
- Abstinence is the only method of birth control that is 100% effective.
- Once you have had gonorrhoea and have been cured, you cannot get it again.
- A girl can get pregnant even if a boy does not ejaculate or "come" inside her.
- Sexually transmitted diseases can be cured if the infected man has sex with a virgin.
- Most of the women who have HIV / AIDS are prostitutes.
- STI / STDs can only be transmitted via the genitals.
- Girls and boys can have sexually transmitted infections without showing any symptoms.

HELPLINE for the peer educator

Sexual maturation in girls and boys occurs in the following sequence:

Girls

- Breast development: Breasts enlargement continues throughout adolescence.
- Appearance of pubic hair.
- Growth in the vagina and the uterus.
- Growth in the other parts of the female genital i.e., labia and clitoris.
- Menarche or the first menstruation: contrary to what most people believe, menarche is not the first sign of puberty in girls but appears fairly late in the sequence of pubertal events. The event consists of a flow of sticky blood in small amounts from the vagina. There are many rituals linked with the onset of menarche in many societies. It is a subject of many taboos and misconceptions.
- Ova (eggs) begin to ripen. Release of the mature ovum from the ovary (ovulation) begins a few months after menarche.
- Broadening and rounding of hips.
- Growth of underarm hair.

Boys

- Increase in the size of the testes and wrinkling of the scrotum.
- Appearance of hair in the pubic area.
- There is an increase in the size of the penis, the external sex organ. It continues to grow for two years.
- Enlargement of the prostrate and seminal vesicles (which together produce semen; the fluid that contains the sperm.).
- Appearance of facial hair and axillary hair (also called underarm hair). The facial hair emerges most prominently on the cheeks, the chin and the upper lip.
- Spermarche is the first spontaneous discharge of the semen through the penis. It generally occurs during sleep and the person may be unaware.

- Appearance of hair on the chest and legs.
- Cracking of the voice: this happens because the larynx (voice box) enlarges and vocal chords lengthen. The change causes a lowering of the pitch so the voice becomes deep. While the change from the high pitch to the low pitch takes place, the voice cracks uncontrollably.

Session 3.6
Nutrition during Adolescence

Expected Outcomes

Participants will become aware of their anxieties related to food.
Participants will know about foods that are essential for their healthy growth.

Gosh, I Am Too Fat!

Often adolescents are very particular about their bodies and strive to meet mainstream standards of beauty. Often this desire to look "good" leads them to eat too much or too little. The adolescent needs a lot of calories and other nutrients, due to rapid growth and increased physical activity. If they eat food that is lacking in nutritional value or do not eat enough, their growth will be affected adversely.

Nutritional deficiencies during this period retards physical growth, impairs intellectual development and delays sexual maturation. The diet of adolescents should meet the demands of physical and intellectual growth, provide adequate reserves for illness / pregnancy and prevent onset of diseases related to nutrition.

Why I Eat What I Eat

Objectives To enable sharing of the group's anxieties about eating.
To give information on adequate nutrition during adolescence.

Materials Flip charts and markers.

Time 45 minutes.

Process Ask the participants to divide into groups of 5 or 6.

Explain that during adolescence the body needs extra nutrients. In many cases however, young people are too worried about their looks to pay adequate attention to their body requirements. In other cases, young people may not be able to get adequate nutrition due to poverty, cultural myths and taboos.

Food is critical for survival and healthy life.

Ask them to discuss their daily diet and anxieties or concerns they have regarding their eating habits. Invite them to use flip charts and markers to record the discussion for presentation.

Allow the groups 20 minutes to do this exercise.

Reconvene the large group, and ask each group to make their presentation.

You can use the following questions to facilitate a discussion:

- *What is the average diet of a young person in your group?*
- *Do you notice any differences between the diet of a young man and a young woman? What and why?*
- *Do you know of any beliefs or taboos regarding food in your society? What are they?*
- *What could be the reasons for not eating enough?*
- *Are there any difference between men and women regarding the consumption of food? What and why?*
- *Do you have a friend who does not get enough to eat or know someone who avoids food on purpose? Would you like to share your knowledge with the group?*
- *Are you familiar with the terms "anorexia" and "obesity"? What do these mean to you?*

Note for the facilitator

This exercise helps the participants to explore their eating habits and creates an environment for discussion on food and its importance in the lives of young people. It also allows you to facilitate an exploration of socio-cultural and gender dimensions of food. Make sure that information is given in a language understood by the participants and that it is useful for the participants. For example, young people living on the streets may not find it useful to learn about food they cannot afford or access.

HELPLINE for the peer educator

Some facts about food

Proteins and carbohydrates: are available in pulses, cereals, vegetables, meat, fish, eggs etc. Generally protein and carbohydrate requirements can be met through the consumption of a diet consisting of a combination of these items during the course of the day.

Minerals: are available in fruits, vegetables and dairy items like milk and yogurt. Since there is an increase in skeletal mass and blood volume, the body needs calcium, phosphorus and iron.

Calcium: calcium intake must be increased. Adolescents should drink at least one glass of milk a day and consume milk products like cheese and yogurt, as they are a rich source of calcium.

Iodine: the iodine requirement can be easily met through the consumption of iodized salt in food. Usually iodine deficiency is found in remote rural areas and places where iodized salt is not available.

Iron: lack of adequate iron in the diet results in anaemia. An anaemic person looks pale and feels tired easily. Sometimes, upon recommendation from a doctor, it may become necessary to take iron tablets. Iron demand increases in adolescents due to rapid increase in blood volume and muscles.

In boys, iron deficiency occurs due to rapid muscle growth if it is not adequately supplemented. In girls, it occurs due to menstruation in addition to the rapid growth, if it is not adequately supplemented. The effects of iron deficiency are more profound in girls. In most developing countries, women suffer from anaemia. Anaemia in pregnancy leads to low birth weight babies and complications during pregnancy and delivery.

Green leafy vegetables, puffed rice, red meat, whole pulses and fruits, such as dates, are a good source of iron. For better absorption of iron, one should also eat food rich in vitamin such as citrus fruits (lemons, grapes, oranges), amla and sprouted grains, such as black gram and green gram.

Obesity and Anorexia Nervosa

Obesity and anorexia nervosa are two increasingly common eating problems of youth in urban areas.

Obesity: A person is considered fat or obese if his/her body weight is 20% or more over the weight considered normal for that age, height and body frame. Adolescence is a vulnerable period for obesity. During puberty, when the rate of growth is accelerated, young people feel very hungry. These hunger pangs also are heightened during periods of depression. If the adolescent does not do enough physical exercise, eats at irregular intervals and eats food high in fats and carbohydrates, s/he may become obese. Obesity in adolescence may persist in adult life and has significant implications. It can lead to cardiovascular problems and hypertension.

Anorexia Nervosa: this refers to a persistent refusal to eat, which appears to be motivated by the pursuit of extreme thinness and a fear of gaining weight rather than genuine lack of hunger (Wicks-Nelson and Israel, 1984, p. 120). It is largely a female disease, with only about 5 to 15 percent of reported cases being male. The highest incidence is in females between the ages of 15 to 24, and it occurs most frequently in higher socio-economic strata of society (Jones, Fox, Haroutan, Babigian, and Hutton, 1980). Characteristics associated with this disorder include – loss or disruptions in the menstrual cycle, sensitivity to cold and sleep disturbances.

Session 3.7
Nutrition during Adolescence

Expected Outcomes

Participants will analyze their daily diet and know whether the food they eat is healthy, or not.
Participants will know what food is healthy and essential for a strong body.

Is My Food Healthy?

Objective To learn about good nutrition consisting of food from the essential food groups.

Materials Flash cards, markers.

Time 1 hour.

Process Invite the participants to sit in a circle on the floor. Explain that they will be doing an exercise to understand the nutritional value of the foods they eat.

Ask a volunteer to sit in the circle with a stack of flash cards and markers. Ask the participants to call out the food they eat during the course of the day.

Ask the volunteer to record the names of the food called out by the participants on flash cards, and place it on the floor so that every one can see it. Encourage the group to help the volunteer write and arrange the cards.

The cards may contain names food prepared with a combination of ingredients. Ask the participants to specify the things used in the preparation of the food.

After all the cards are ready and placed in the centre of the circle, ask the participants to classify / categorize the cards according to what they think they gain by eating those foods. For example, rice may be classified as carbohydrates.

The participants may not know the technical classifications for the food but allow them to classify according to their own understanding of what each food gives their body.

You can use the following questions for discussion:

- *Do all of you eat this food in an average day? Why/Why not?*
- *Is some food okay to eat for males but not for females? Why?*
- *Were you comfortable classifying the types of food? Why/Why not?*
- *Given the choice what types of food would you like to eat? Why?*
- *Why are you not able to eat the food you would like to eat?*

- *Do young people require more food? Why/Why not?*
- *Do you know of any illnesses or deficiencies that may be caused by inadequate food? What and why?*

Notes to the facilitator

This is a useful exercise to enable participants to analyze their eating habits and the kinds of food they eat – why they eat and what is the benefit of eating what they eat? You can facilitate this process by giving information on the nutritional value of the food they indicate as part of their diet. This could be done either by inviting someone knowledgeable about local food and nutrition (maybe a local doctor) who can give feedback on the nutritional values of the foods, or you could do it yourself by preparing notes in advance on the subject. For the latter, you would have to gather information on local food and its nutritional value.

Since food is a sensitive socio-cultural subject, it is useful to learn about the food normally eaten by the participants so that you can provide feedback. Pre-designed lectures on "good food" and "bad food" are not useful, because often people are not in a position to change the food they eat. You may suggest alternatives to the current food intake as long as they can be accessed locally and are affordable.

Clarify misconceptions and myths related to food and explore the gender dimensions of food – do women eat less, or are they prohibited from eating certain foods? Why?

Below is a chart of the 5 major categories of food essential for a healthy diet
This can be used by the peer educator for preparation and as a handout

Protein is the body builder. Builds and repairs body tissue for growth, builds resistance to infections, and supplies additional energy	**Vegetables** (Vitamins – A, B1, B2, C, D, E, K)	**Carbohydrates** are the main source of energy Supplies energy to the body	**Fruits** (Minerals – calcium, phosphorous, iron, iodine)	**Fats and Oils** give more energy than carbohydrate or protein per unit of weight Supplies essential fatty acids, helps body make use of fat soluble vitamins (A, D, E, K)
Mussels Squid Eggs Beef Fish Chicken Shrimp Crab Milk Peanuts	Mushrooms Tomatoes Cauliflower Eggplant Bitter gourd Sugar peas Shallots Kale Bell peppers Pumpkin Coriander Lettuce Onions Garlic Sweet peppers Bird peppers Cucumbers Cabbage	Potatoes Corn Rice Cassava Noodles Taro Sugar cane Yams Sugar Bread	Apples Mangoes Grapes Pomelo Custard apples Lychee Mangosteen Rose apples Oranges Pineapple Banana Langsat Zalacca Milk / milk products Salt	Butter Coconut Egg yolk Vegetable oil Palm oil Beans

*The facilitator can use this chart to give feedback on the nutritional value of the food consumed by the participants.

During the course of the day, if a person eats at least one item from each of these groups, s / he is eating the nutrients required by his / her body.

Module 4
Teenage Pregnancy, Sexually Transmitted Infections and HIV/AIDS

FLOW CHART

Content Flow at A Glance
Module 4: Teenage Pregnancy, Sexually Transmitted Infections and HIV/AIDS

Module 4
Teenage Pregnancy, Sexually Transmitted Infections and HIV/AIDS

"He who has health has hope. He who has hope has everything".

Arabic Proverb

Introduction

Teenage pregnancy, sexually transmitted infections and HIV/AIDS are all important issues during adolescence. Adolescence is the time of experimentation and curiosity. It is important to address these issues because they are intrinsically linked with unsafe behaviour and practices. Listed below are some points that will help you prepare for this session.

- Young people are especially vulnerable to STIs and HIV/AIDS. Adolescence and youth are times of discovery, emerging feelings and exploration of new behaviour and relationships. Sexual behaviour is an important part of this process and may involve risk. The same is true of experimentation with drugs, legal and illegal.
- Some young people will be infected with STIs or become pregnant. The same behaviour that causes teenage pregnancies and STIs also causes HIV/AIDS.
- Young people think of themselves as invincible. The general attitude is that "AIDS cannot happen to me".
- STIs and HIV/AIDS are no longer restricted to certain groups. It is the behaviour that puts people at risk. It is not who you are but what you do that matters.
- Around 60 per cent of the new HIV infections worldwide occur in young people.

Session 4.1
Understanding Sexual Behaviour

Expected Outcomes

Participants will have an understanding of their sexual behaviour.
Participants will be able to distinguish between healthy and unhealthy sexual behaviour.

Images Of Sex

Objectives To enable participants to share their understanding of sexual behaviour.
To learn to distinguish between healthy and unhealthy sexual behaviour.

Materials Flash cards or notebook sheets, markers / crayons, flip charts, scissors, old magazines or leaflets with pictures, gum, sticky tape.

Time 1 hour and 30 minutes.

Process Ask the participants to divide into groups of 4 to 6.

Give each group some flash cards / notebook sheets, markers / crayons, scissors, gum, old magazines / leaflets.

Explain that you would like them to draw, create (from the magazines / leaflets) or write something related to sexuality / sex. The final product does not have to look professional. The point is to express their ideas.

Their creations can be funny, sad, ugly, happy, or curious, as long as they are able to relate it to sexuality / sex. Allow the groups 30 minutes to do this exercise.

While the small groups are busy, take four sheets of chart paper and place them on the floor. Join the 4 pieces of paper with tape or staples, and make sure that there is enough space for all the participants to gather.

Ask the participants to stay in their groups, and gather around the charts on the floor. Ask them to choose one end of the four sheets as the “good end” and the other end as the “bad end”.

Once everyone has agreed on which end is good and which end is bad, ask the groups to look at their creations and place them at the appropriate end, depending on what the creations represent and how they feel about them.

Once all of the drawings/creations have been placed on the sheets on the floor, the participants should move along the four sheets together, starting at the good end. The group that created the piece of work should explain the meaning of their creation as you move from one to the other.

To learn about the issues raised, participants should be encouraged to discuss the subject of each drawing.

Explain that you would like to keep a record of their concerns on the flipchart. Ask a volunteer to help you with this process, if necessary. Once the exercise has been completed you can ask the participants to put their drawings on the four sheets.

Notes for the Facilitator

This can be a valuable opportunity for the participants and facilitator to learn what the group knows about sexuality/sex. If the participants prefer not to talk about themselves, you can encourage them to talk about issues that they might have heard or read about. In this case, people are able to talk about themselves without feeling embarrassed or threatened.

Record the terms that come up (pregnancy, sexually transmitted infections/diseases, HIV/AIDS, rape, sex worker, homosexual, lesbian) during discussion and build future sessions on the emerging issues.

HELPLINE for the peer educator

This material can also be used to make handouts and posters

Guiding Principles
For Working on Issues of Sexuality

Affirmative Approach to Sexuality: Sexuality is part of everyone's life. Sexuality is complex. It can be pleasurable, satisfying and an enriching part of life. An affirmative approach improves sexual well-being.

Diversity: Different women and men have different needs, identities, choices and life circumstances. Therefore, not all women and men have similar sexual concerns.

Autonomy and Self Determination: Women and men have the right to make their own free and informed choices about all aspects of their lives, including their sexual lives.

Gender Equity: Programs that are based on gender equity recognize and provide equitable access (by all) to information, services and education that promote sexual well-being.

Responsiveness to Changing Needs: women and men's needs for information and services on sexuality change over time and throughout the life cycle.

Prevent Violence, Exploitation and Abuse: Violence, exploitation and abuse are often the conditions under which people, especially women, experience their sexuality or are initiation into sexual activity.

Comprehensive Understanding of Sexuality: Programmes and services must address and integrate emotional, psychosocial and cultural factors in planning and service delivery.

Non-Judgmental Services and Programmes: People with different value systems make different choices about sexuality. Providers must respect these values and refrain from judging others or imposing their own values on them.

Confidentiality and Privacy: Sexuality touches upon intimate aspects of people's lives. Individuals have a right to privacy and confidentiality.

Cultural Sensitivity: Cultural perceptions about issues of sexuality differ among different groups and communities.

Accessible Programmes and Services: Accessibility entails more than availability of services. It includes quality, confidentiality, staffing and being able to cater to a range of needs.

Core Values

The basic values of choice, dignity, diversity, equality and respect underlie the concept of Human Rights. These affirm the worth of all people. In the context of sexuality, these words have the following meaning:

Choice: Making choices about one's sexuality freely, without coercion, and with access to comprehensive information and services, while respecting the rights of others.

Dignity: All individuals have worth regardless of their age, caste, class, gender, orientation, preference, religion and other determinants of status.

Diversity: Acceptance of the fact that women and men express their sexuality in diverse ways and that there is a range of sexual behaviours, identities and relationships.

Equality: All women and men are equally deserving of respect and dignity and should have access to information, services and support to attain sexual well-being.

Respect: All women and men are entitled to respect and consideration, despite their sexual choices and identities.

(www.tarshi.org or www.siecus.org)

Session 4.2
Understanding the Consequences of Sexual Behaviours

Expected Outcomes

Participants will understand the consequences of certain sexual behaviour.
Participants will be aware of the preparation required for dealing with the consequences.

My Life And My Options

Objectives To examine the consequences / impact of sexual intercourse.
To examine the preparedness required for dealing with the consequences.

Material Flip charts, markers.

Time 1 hour.

Process Ask the participants to divide into groups of 4 or 6.

Explain that our actions have consequences that affect those around us. The decision to have sex is not an exception and in this exercise, we will brainstorm the consequences of such a decision.

Ask them to brainstorm and prep are presentations on:

- *What do you think the consequences of having unprotected sex will be? How will these consequences affect your life now and in the future?*
- *Are you prepared to deal with the consequences and impact?*
- *How will you deal with the consequences?*

Allow the groups 45 minutes to do this exercise.

Invite the groups to make their presentations.

After the presentation, facilitate a discussion using the following questions:

- *What did you learn from this exercise?*
- *In your peer group, do you know anyone who is pregnant? What issues does this person face?*
- *How can you deal with the consequences of unprotected sex?*
- *How can you help a friend who is pregnant or has contracted an STI?*

Notes for the Facilitator

Sexual behaviour can be safe and unsafe. Usually, young people ignore the safety precautions required for "safe" sexual behaviour. Often, young people do not have adequate knowledge to practice safe sex. Unsafe behaviour, like sexual intercourse without a condom, can lead to pregnancy, STI and HIV / AIDS.

This exercise is straightforward and open-ended. It enables the facilitator to address issues of teenage pregnancy, STIs / STDs, HIV / AIDS and introduce the subject of life skills for dealing with these concerns and problems. This exercise can be done in a mixed group, or separately. If women and men work in separate small groups, they should come together for the presentations. The facilitator might choose to give brief presentations, or show a video, on issues that emerge. They can also be dealt with in subsequent sessions.

Session 4.3
Understanding the Implications of Teenage Pregnancy

Expected Outputs

Participants will become aware of the impact that teenage pregnancy can have on their lives.
Participants will become aware of the gender dimension of teenage pregnancy.

I Am Having A Baby

Objectives To know the physical, psychological, social and economic implications of teenage pregnancy.
To know why teenage pregnancy occurs and how it can be avoided.

Materials Blackboard and chalk / whiteboard and markers.

Time 25 minutes.

Process Ask the participants to divide into 2 groups.

Ask group one to think about the physical and psychological implications of teenage pregnancy, and prepare to act it out in a 10-minute role-play.

Ask group 2 to think about the socio-economic implications of teenage pregnancy for their role-play.

Give both groups 20 minutes to prepare for their respective role-plays.

Bring the groups back and present the role-plays.

Note the highlights or emerging concerns in both the role-plays. After both groups have presented, encourage them to clarify their doubts and questions.

You may use the following questions to facilitate a discussion:

- *What do you think about this exercise?*
- *How can one plan for pregnancy?*
- *In your peer group, how do you view pregnancy? Do you discuss its possibility and the possible consequences?*
- *In your opinion, would a pregnancy affect a man the same way as a woman? What would be different? What would be similar?*
- *Do women get the blame for becoming pregnant? Why?*
- *How would you help a friend who became pregnant because of negligence?*

Notes for the Facilitator

For younger mothers, there can be serious physical consequences since their sex organs are not mature, and this can cause difficulty during labour and delivery. There may be complications during pregnancy and childbirth that can result in death.

Babies born to a teenage mother have lower birth weights than normal deliveries.

Sometimes young girls are frightened of the consequences and attempt unsafe abortions (using coat hangers or sticks of wood). This can damage their uterus, resulting in problems with future pregnancies. In many countries, abortion is still illegal. Research the legality of this issue.

If a teenager is unmarried, they may experience mental anguish and trauma. Society and her family may look down upon her or pressure her to have an abortion. Her friends may ostracize and ridicule her. She may have to discontinue her education. Parents may try to force her to marry the father of the expected child, or someone else, to avoid shame and ridicule. The marriage may lead to problems, as both the girl and the boy are ill prepared for the responsibilities of parenthood. They may not be able to get a job or earn a living and may not be able to care for the child.

The consequences of teenage pregnancy are extreme for a girl. The best way of avoiding teenage pregnancy is to abstain from sexual intercourse. If two people do decide to have sex, they should discuss the means of birth control and protection. They might use a condom, the pill, or a female condom.

For facilitation of this exercise, gather information about the societal norms and practices on pregnancy. Also, get practical information on clinics and health centres where a young woman and man can seek guidance and help.

You can introduce the subject of contraceptives at this stage, but be aware of the cultural and religious dimensions of the subject. Subsequent exercises in this module will enable you to give information on contraceptive methods. Some of the exercises in Module III will show the participants the proper to use a condom using a dildo or a banana.

Session 4.4
Understanding Contraceptives

Expected Outcomes

Participants will become aware of the range of contraceptives, their respective benefits and method of use.
Participants will develop some material that will be useful in generating awareness among youth on the use of contraceptives.

Use Me

Objectives To learn about contraceptives – methods, utility and availability.
To design material for the promotion of contraceptive use among youth.

Materials Brochures, pamphlets and other materials used for the promotion of contraceptives by the public health department, flip charts, old colourful magazines, newspapers, glue, scissors, crayons, markers, stapler.

Time 1 hour 30 minutes.

Process Invite the participants to face the facilitator during his/her presentation on contraceptive methods. The peer educator can prepare this presentation by making transparencies for an over-head projector or by making charts using the material given at the end of this exercise.

After the presentation, clarify participants' doubts or questions.

Ask the participants to divide into groups of six.

Explain that they may choose any one of the methods just shown (in the presentation) for their group work. They can make use of the brochures, pamphlets and other materials to prepare a IEC (Information, Education and Communication) brochure for youth.

Allow 30 minutes to do this exercise.

Ask the groups to present their materials. Encourage discussion and observations after each presentation.

After the presentations, use the following questions for discussion:

- *What are your thoughts on the exercise just completed?*
- *What do you think about the IEC materials used by the public health department? Why?*
- *Do you think any of the contraceptives methods we have discussed are useful protection against STIs and HIV? Why/Why not?*
- *How will your materials be used to raise awareness on contraception, STIs and HIV/AIDS among your peers?*

Notes for the Facilitator

This exercise generates awareness about contraceptive methods. It also shows participants how to create materials they can use to dissemination information to their peers. The participants become informed about IEC materials and discuss why they may, or may not, be effective in communicating with the youth. In your presentation of contraceptive methods, introduce the gender dimension and issues of accessibility and control.

HELPLINE for the peer educator

Contraceptive Methods – A chart

During the session on contraceptives, this chart can be used by the peer educator as a hand out

Type of contraceptive method	How it works	Effectiveness	Benefits	Instructions for use	Benefits other than contraception
Birth Control Pill: contains synthetic oestrogen	Alters natural ovulation cycle	Theoretically 99-100 per cent, but women have conceived on the "pill"	Low cost, easily available and control by the woman	Taken daily after the menstrual cycle begins	None
Birth Control Injection: given in the first days of menstruation and then every 2-3 months		Not known		Given by the doctor	None
Withdrawal: removal of penis from the vagina before ejaculation	Prevents the semen from going into the vagina	Theoretically, 85 per cent but in reality about 70 per cent	No cost and under the control of the man and woman involved	Dependent on the man	None
Intrauterine Device (IUD): small plastic device that fits inside the uterus. Can be used for 3-5 years	Inserted inside the uterus by a doctor	Theoretically 95-98 per cent	Long-lasting and relatively inexpensive	Inserted by the doctor in the first few days of menstruation. Should be examined every few months	None

Male Condom: rubber sheath that fits over the penis	Rolled over the penis	80 – 85 per cent	Low cost, easily accessible and reduces risk of STDs / STIs	Do not use with oil - based lubricants, such as, creams and lotions	Can be effective in prevention of STIs and HIV / AIDS
Implantable Hormone Device: continuous release of hormone	Continuous release of hormones	Not known	Continuous birth control for 5 years	Implant of the capsule in the upper arm. Done by the doctor	None
Calendar method: woman predicts the day of ovulation by keeping a calendar of the length of each menstrual cycle	Allows the woman to keep track of "safe" days for sex	Theoretically 85 per cent but in reality about 60 per cent	No cost and under the control of the woman	Woman must keep track with the help of a calendar	None
Sterilization: vasectomy for males and tubal ligation for females	Passageway for the sperm or the egg is surgically tied	Theoretically 100 per cent but, exceptions have been known to take place	Highly effective, permanent and one time expense	Doctor performs an operation	None

* Some of the methods are intrusive in nature and have side effects that may be harmful. The users must examine its pros and cons before making a choice.

Information on Birth Control

Youth must receive information about birth control in their teenage years because during this period they undergo tremendous physical and psychological changes. Youth should be made aware of the fact that there are two types of birth control - permanent and temporary.

1 ***Permanent Birth Control Methods***

- Male sterilization
- Female sterilization

2 ***Temporary Birth Control Methods***

- Birth control pill
- Injections
- Implants (under the skin)
- Intrauterine Device (IUD)
- Condoms
- Calendar / Rhythm Method
- Early Withdrawal

1 *Permanent Birth Control*

Permanent birth control means male or female sterilization. It is a permanent way of preventing pregnancy. Male and female sterilization does not take a lot of time. You do not have to stay overnight in the hospital. Once the operation is completed, you may go home. After sterilization, your body will be strong, and you will be able to work as usual. Your sexual competence remains intact and you will still experience sexual pleasure. Sterilization will not make you bloated or give you a headache. You can find sterilization services at hospitals or at health promotion centres.

1.1 Vasectomy

Before leaving the body, sperm produced in the testes move through a series of small tubules, including the vas deferens. A vasectomy is a surgical procedure during which the vas deferens are resected.

How it works: Vasectomy is a procedure that blocks the passage of sperm through the vas deferens. Small incisions, on either side of the scrotum, allow a surgeon to isolate each vas and to resect it.

Instructions for effective use: A male should have a physical examination and complete a health history before the surgery. Because he may not be sterile immediately after the surgery, other methods of birth control should be used for the next 20 ejaculations. Strenuous exercise should be avoided for a week after the procedure.

Effectiveness: Vasectomy is an extremely effective method of birth control.

Benefits: Vasectomy is a simple procedure that is effective, safe, and inexpensive.

Side effects: At the site of the incision, some pain may be experienced. It should only last for a short time after the surgery

1.2 Tubal Ligation

Tubal ligation is a method of female surgical sterilization.

How it works: The purpose of tubal ligation is to prevent a sperm and ovum from uniting. Because fertilization takes place in a fallopian tube, tubal ligation is designed to block the tubes, so that a mature ovum cannot move through a tube to the uterus.

Instructions for effective use: A woman should be fully informed before deciding on a surgical procedure. A general physical examination, including a Pap smear and pelvic examination, are essential. After the procedure, the patient will be advised to rest for 24 to 48 hours and will be fit to resume her normal activities in a few days. Heavy lifting, strenuous exercise, and penile-vaginal -intercourse should be avoided for a week.

Effectiveness: Tubal ligation is theoretically 100 per cent effective. The procedure is immediately effective, although for absolute effectiveness, a backup contraceptive method should be used until the first menstrual cycle begins. Female sterilization has a failure rate of 0.2 per cent. If the tubes rejoin or there is a surgical error, failure may occur.

Benefits: Sterilization is highly effective, permanent, and involves a one-time expense.

Side effects: Some pain may be experienced for a short time after the surgery. About 2 per cent of females may experience minor complications including bleeding, fever, abdominal pain or infection.

2 *Temporary Birth Control*

2.1 The Pill

The combination pill contains chemicals called synthetic oestrogen and progestin, and together, they suppress the natural menstrual cycle in order to prevent ovulation.

How it works: In the normal unaltered menstrual cycle, oestrogen levels are low during and after the menstrual flow. Low oestrogen levels trigger the pituitary gland to secrete FSH (Follicle Stimulating Hormone). Under the influence of FSH, a single follicle matures in an ovary and ruptures, releasing the ovum into the terminal end of a fallopian tube. The pill alters this natural cycle. A female begins taking the pills on the first Sunday after menstruation begins. The pills raise the level of oestrogen so that little, if any, FSH is secreted, a follicle does not mature, and no ovum is released from an ovary. Ovulation does not occur. The progestin in the pill makes the cervical mucus very thick and the sperm have difficulty passing through the cervix into the uterus. The lining of the uterus is also altered, making it unsuitable for the implantation of a fertilized ovum

Instructions for effective use: It is important for a female to follow her physician's recommendations concerning the pill. Most physicians recommend starting the pill on the first Sunday after the menstrual period begins. The pill should be taken at the same time each day, usually in the evening at bedtime.

Effectiveness: When the combination pills are taken according to instructions, they are 99 to 100 per cent effective against pregnancy, and no backup form of contraception is required. The actual effectiveness, after factoring in misuse, is 97 to 98 per cent. When taking antibiotics, it is recommended that the female use a back-up barrier method to maintain effectiveness.

Benefits: In addition to being highly effective, the pill may have additional medical benefits, including the following: predictable 28-day menstrual cycle; reduced menstrual flow, therefore less blood loss and less risk of anaemia; fewer menstrual cramps; reduced incidence of ovarian cysts; prevention of tubal or extopic pregnancies; decrease in fibrocystic changes in breasts and reduced incidence of iron-deficiency anaemia.

Side effects: Side effects may include the following: nausea, mild weight gain, fluid retention, mild headache, spotting or bleeding between periods, decreased menstrual flow, vaginitis, recurring yeast infections, depression, mood changes, fatigue and decreased sex drive.

2.2 Injectable Progestin

Injectable progestin is a shot of synthetic progesterone that is given intramuscularly every three months to inhibit ovulation, thicken the cervical mucus to reduce sperm penetration, and thin the endometrial lining to interfere with implantation. The contraceptive used is medroxyprogesterone acetate or Depo-Provera.

How it works: When given intramuscularly in a dose of 150 mg every 3 months, Depo-Provera I, eliminates the mid-cycle rise of luteinizing hormone that inhibits ovulation. The injection reduces sperm penetration by thickening the cervical mucus and interferes with implantation by thinning of the endometrial lining

Instructions for effective use: This method of birth control is simple to use. It simply requires a female to have a thorough medical examination and an injection of Depo-Provera.

Effectiveness: Depo-Provera is better than 99 per cent effective in preventing pregnancy.

Benefits: Depo-Provera can be used in situations in which oestrogen is contraindicated. It has a minimal effect on blood pressure and lactation.

Side effects: The most common side effects are irregular menstrual bleeding and amenontlea one year after beginning injections. Other side effects may include nervousness, headaches, nausea, and weight gain.

2.3 Implantable Hormone System

The implantable hormone system is a hormone (progestin only) system that is implanted under the skin in the upper arm.

How it works: The implantable hormone system consists of six capsules, each containing progestin. The capsules are implanted under the skin of the upper arm during the first seven days of the menstrual cycle. Small amounts of progestin are released into the body and a constant level of progestin is maintained in the blood. This level interferes with the ovulation process and causes the cervical mucus to thicken, thus stopping sperm penetration. The level of hormone also changes the lining of the uterus to prevent implantation of a fertilized ovum.

Instructions for effective use: A physician should implant the capsules. They may be left in place for up to five years or removed at any time.

Effectiveness: The effectiveness of the implantable hormone system is 97 to 99 per cent against pregnancy. Body weight seems to affect the level of progestin in the blood.

Benefits: The implantable hormone system offers a continuous method of birth control lasting up to five years. The lack of oestrogen and the small dosage of progestin can minimize the side effects that sometimes occur with the combination pill.

Side effects: Many of the side effects are the same as listed for the combination pills. Irregular vaginal bleeding remains one of the most prominent side effects. Infection may occur at the site of the implants, but it is rare.

2.4 Diaphragm

The diaphragm is a dome-shaped circular cup that fits snugly over the cervix and provides a mechanical barrier to keep sperm from entering the uterus.

How it works: When inserted properly into the vagina, the diaphragm fits snugly over the cervix and provides a mechanical barrier to keep sperm from entering the uterus, thus preventing the fertilization of an ovum. The diaphragm should always be used with a spermicidal cream or jelly, which provides a mechanical chemical barrier. The spermicidal is placed inside the dome of the diaphragm prior to insertion. The diaphragm keeps the spermicide in place where it is in direct contact with the cervix

Instructions for effective use: The diaphragm should always be fitted by a physician or another trained health care provider. The most effective diaphragm is one with the largest rim that is still comfortable.

Effectiveness: The diaphragm can be 97 to 98 per cent effective against pregnancy, when used as instructed. The effectiveness of the diaphragm is dependent on the users being committed to its pro per use. In actual use, the diaphragm may be only 75-80 per cent effective because of user failure.

Benefits: In addition to contraceptive benefits, the diaphragm with spermicidal cream, or jelly containing nonoxynol-9, is believed to afford some protection against STDs and HIV. However, it cannot be relied upon for this purpose.

Side effects: Most side effects involve the individual user's sensitivity to the diaphragm and/or the spermicide. If the diaphragm is too large, there may be cramping and pain. A large diaphragm may put pressure on the bladder and result in recurring urinary tract infections. If it is too small, the diaphragm may be difficult to remove.

2.5 Cervical cap

The cervical cap is a cup-shaped rubber or plastic device that fit snugly over the cervix. It should be used with a spermicide containing nonoxynol-9.

How it works: The cervical cap uses suction to fit firmly around the cervix to provide a mechanical barrier that prevents sperm from penetrating the uterus. Additional protection is afforded with the use of spermicide.

Instructions for effective use: The cap is manufactured in multiple sizes and must be carefully fitted by a health care provider who is trained in the use of the product. The cervical cap should be inserted before intercourse and should be left in place for at least six to eight hours after intercourse. The cervical cap can remain in place for up to 48 hours before removal.

Effectiveness: For effective use, a female should be familiar with her anatomy and willing to learn the proper technique for application and removal. When used

properly, the cervical cap is 97 to 98 per cent effective. However, in actuality, the effectiveness of the cervical cap is approximately 75 to 80 per cent effective.

Benefits: The cervical cap is usually effective for 48 hours, but, in certain cases, it may be a few hours more or less.

Side effects: Although rare, the cervical cap may cause irritation or ulceration of the cervix. If this happens, use of the cervical cap should be discontinued.

2.6 Intrauterine device

The intrauterine device (IUD) is a small plastic-silastic design that fits inside the uterus and prevents pregnancy.

How it works: The IUD immobilizes sperm, speeds the movement of the ovum through the Fallopian tube, and impairs implantation. Some IUDs use small amounts of copper that are toxic to sperm.

Instructions for effective use: An IUD should be inserted by a physician during the first few days of menstruation. At this time, the cervix dilates more easily and there is no chance of a pregnancy occurring. When the IUD is in place, neither partner can feel the device. A small string is left protruding for a short distance from the cervix. The female can use the position of this string to check for correct positioning of the IUD. This check should be made after each menstrual period.

Effectiveness: Theoretically, the IUD is 95 to 98 per cent effective against pregnancy. Actual effectiveness depends on IUD characteristics, such as size, shape and presence of copper or progesterone, and user characteristics, such as, age and number of children. The first-year failure rate is approximately 3 per cent. The lowest expected pregnancy rate after the first year is approximately 2 per cent.

Benefits: The progestin-releasing IUD decreases menstrual blood loss and reduce menstrual cramps.

Side effects: Some females who use an IUD, experience increased menstrual cramps or increased spotting and menstrual bleeding. These effects are most noticeable for the first three months after insertion and may be controlled with medications, such as, Ibuprofen. However, it is advised that medication should only be taken on the medical advice of a qualified physician. Severe pain, or bleeding, may be a warning that the IUD has been partially or completely expelled. In this case, a physician should be contracted.

2.7 Spermicidal foam

A spermicide is a chemical that kills sperm. The most widely used spermicides contain nonoxynol-9.

How it works: The foam (cream or gel) is inserted into the vagina near the cervix. During intercourse, the spermicide is spread around, blocking the cervix and forming both a mechanical and chemical barrier to sperm.

Instructions for effective use: The contraceptive benefits depend on the user following directions carefully. There must be sufficient foam, and it must be used

correctly to function as a spermicide. To be effective, it must be inserted at least three to four Inches into the vagina. During sexual intercourse, the foam must be in contact with the cervix. Foam can be used alone. However, it is most effectively used in combination with the condom or diaphragm.

Benefits: Spermicidal preparations that contain nonoxynol-9 can also destroy STDs and HIV, however the prevention of infection is not guaranteed. Spermicides are simple to use.

Side effects: Side effects are few. One or both partners may be allergic to the spermicide and experience irritation in the vagina or penis. Some females experience a burning reaction.

2.8 Male Condom

The male condom is a thin sheath of latex that is placed over the erect penis to collect semen during ejaculation.

How it works: The condom collects semen during ejaculation, thus preventing semen from entering the vagina during sexual intercourse. The condom also helps prevent the exchange of body fluids.

Instructions for effective use: For the condom to be effective, the user must carefully follow the instructions of use. Even pre-ejaculatory fluid contains some sperm and may also contain HIV and STIs. Before placing the condom on the erect penis, the tip of the condom should be pinched closed in order to leave an empty space. This space provides room to collect the ejaculated semen. No air should be in the tip of the condom because this can cause the condom to break or rupture. While continuing to pinch the tip of the condom, the condom should be unrolled toward the base of the erect penis. The penis should be withdrawn from the vagina while it is still erect. For added effectiveness, the penis can be removed prior to ejaculation. The condom should not be removed from the penis until the penis is withdrawn. When withdrawing the man should hold the rim of the condom at the base of the penis and carefully remove the penis and the condom.

Effectiveness: When used properly, the condom is theoretically 97 per cent effective against pregnancy. Actual user-effectiveness may drop to 80-85 per cent.

Benefits: The condom has more than contraceptive benefits. Because it provides a mechanical barrier that keeps male and female secretions separate, the condom helps prevent the spread of STIs and HIV. However, users must be warned that the condom is not 100 per cent effective in preventing the spread of HIV and STIs. Consistent use of condoms helps decrease the rate of infection of HIV but does not entirely eliminate the risk.

Side effects: Some males complain that the use of the condom reduces the sensitivity of the glands of the penis, and, consequently, interferes with sexual satisfaction.

2.9 Female condom

The female condom is a lubricated, polyurethane sheath that fits the contours of the vagina, collects semen, and helps prevent the transmission of body fluids between partners during sexual intercourse.

How it works: The female condom fits the contours of the vagina and collects semen. This prevents the sperm from passing through to the cervix into the uterus. The female condom also protects the entire vagina and labia from contact with the male's body fluids.

Instructions for effective use: The inner ring of the female condom fits behind the pubic bone and the outer ring remains outside the body. Both partners must take care that the female condom does not slip inside the vagina and that the penis is inserted in the pouch, not outside it.

Effectiveness: The female condom is more difficult to use than the male condom. Pregnancy may occur due to incorrect use.

Benefits: For females, the female condom is believed to have several advantages over the male condom. It is the female who chooses and uses it. She can insert if before intercourse (an advantage over the male condom, which must be put on the erect penis causing disruption). When correctly used, the part of the condom outside the vagina covers the area around the vagina and the base of the penis during intercourse. This offers better potential protection against genital warts and genital herpes. The pouch is made of polyurethane, which has been shown in laboratory tests to offer better protection against the passage of viruses than latex.

Side effects: Some women find the female condom to be uncomfortable because of the inner ring. Some partners have also indicated that they do not like the sound produced by the female condom during sex.

2.10 Calendar Method (Rhythm Method)

This method may be a choice for women whose period arrives regularly each month (i.e., if your period comes on the 27th or 28th day of the month, it will come on the same days each month). Usually, the “safety period” is counted as 7 days before your period and 7 days after your menstruation period. If your period comes on the seventh of the month, the “safety period”, when you can have sex is the first to the 13th. However, there is the chance that this method will fail if the days of your period are not counted accurately.

2.11 Early Withdrawal

This is another type of birth control because it may prevent pregnancy. This method is never 100 per cent effective because it depends on controlled male ejaculation during intercourse.

Session 4.5
Gender Dimension of Contraceptives

Expected Outcomes

Participants will become aware that men and women have different needs and expectations from a contraceptive method.
Participants will learn to choose a contraceptive method that is mutually beneficial to the partners.

Sweet Dreams Are Made Of These!

Objectives To explore the gender dimension of contraceptives.
To explore the qualities of an "ideal contraceptive."

Materials Flip charts, crayons, markers.

Time 1 hour.

Process Invite the participants to sit in a circle.

Ask them if they have heard about contraceptives. If yes, what are the methods known to them?

Explain that this session is aimed at imagining the "ideal contraceptive" and exploring its existence.

Ask the participants to divide into 2 groups – men and women separately.

Give 10 minutes to the groups to come up with a list of "ideal contraceptive" qualities i.e. the kind of contraceptive they would like to use.

Ask the groups to make their presentations.

Facilitate a discussion based on the following questions:

- *What are your observations about the presentations?*
- *What differences do you notice in the presentations?*
- *Do you know of any contraceptive that matches or comes close to the qualities discussed and presented?*
- *How do you feel about using contraceptives?*
- *What could be the possible consequences/benefits of contraceptive use?*

Notes for the Facilitator

Usually men and women desire different kinds of contraceptives for different reasons. Explore the gender dimension of contraceptives through this exercise. You can use the out puts from the previous exercise to enhance the quality of the discussion. Perhaps the participants will wan to make changes to the materials they designed for awareness generation based on the insights they gain from this exercise.

Session 4.6
Knowing about STIs

Expected outcomes
Participants will learn about STIs – the definition, symptoms, types, myths and prevention.
Peer Educator will become aware of the knowledge level of the participants.

Winning A Point

Objectives To understand the prevalent knowledge/beliefs/misconceptions in the group about STIs.
To give information on the types of STIs.

Materials Flip charts, markers, box with questions, answer sheet.

Time 45 minutes.

Process Ask the participants to divide into 2 groups. Explain that they will play a game to gain understanding about STIs.

Ask the groups to decide on a leader who will choose the question for the team. Also, ask them to choose a name for their group.

Ask the two groups to sit facing each other. Place the box of questions in the centre of the two groups.

Keep the question and answer sheet with your. Inform the groups that the decision of the facilitator regarding the scores will be final.

Put a flip chart up to keep scores on– divide it into 2 columns using the names of the groups.

Rules of the game:

- Each group will alternatively be asked a question.
- If a group fails to answer correctly, the question will be passed to the other group.
- Each team will have 2 minutes to produce the correct answer.
- Each correct answer will be worth 10 points. If the question is passed to the other group and correctly answered, it will receive 10 bonus points (10+10).
- The scores will be added after the final question has been answered.
- The winners will receive a reward.
- The facilitator will provide the correct answer if both groups fail to give the correct answer.

Use the following questions to facilitate a group discussion after the game:

- *Did you know as much about sexually transmitted diseases as you thought you did? Why/Why not?*
- *How would you start a conversation with your friends/peer group on STIs? What would you say?*
- *Did the exercise clarify your misconceptions or beliefs about STIs? Do you still have some beliefs that require clarification?*
- *What are the best ways of avoiding STIs? Why?*
- *Can you be sure who the source of the infection is? Why /Why not?*

Notes for the Facilitator

This exercise is fun. It allows the participants to share information with each other and receive correct information. This exercise can be done in a mixed group or separately, in gender based groups. If you are doing this exercise with people who are not literate, please ask the questions yourself. The table given below can also be given as reading material after the exercise is over.

Questions and answers that can be used for the exercise

Questions (to be copied on slips of paper put in a box for the groups)	**Answers (to be kept by the facilitator with the questions for scoring and giving information)**
What is a STI/STD? Give a correct description.	STIs are sexually transmitted infections. Previously they were known as sexually transmitted diseases. These are passed on through sexual intercourse and intimate body contact, especially if exchange of body fluids takes place.
What is another name for sexually transmitted infections?	Venereal diseases and or STDs.
Name 4 sexually transmitted infections.	Gonorrhoea, Syphilis, Herpes, HIV/AIDS, Genital Warts, Chancroid.
Are all STIs curable?	No, most are curable, but the exceptions are the viral STIs such as herpes, HIV/AIDS and Hepatitis B.
Do you know immediately that you have a STI?	Not always. You may have a STI but may have no symptoms for a long time (e.g., Chlamydia for both sexes, Gonorrhoea for women).
Give 3 possible symptoms of an STI.	Burning sensation while urinating. A clear or creamy discharge from the penis. Blisters, ulcers or swelling on or around the genitals. Warts around the penis, vagina or anus.
Why are some STIs dangerous?	If not detected and treated, the infection can spread and can, for example, cause sterility in women. Syphilis can lead to death. The presence of an STI also facilitates HIV transmission.
Is HIV/AID an STI?	Yes, when the virus is transmitted by sexual intercourse.

Name the 3 most effective ways to protect yourself from STI infection.	Abstinence (no sex), being faithful (mutual monogamy), correct condom use (ABC of prevention).
What is the first thing you should do when you think you have a STI?	See a doctor to get proper diagnosis and treatment. Inform your sexual partners that you may be infected.
Your doctor prescribed medication for 10 days but the symptoms disappear after 5 days of medicine intake. Can you stop taking the medication?	No, STI germs are hard to kill. Therefore, the medication must be taken for the duration prescribed by the doctor.
Why are people who have a STI more vulnerable to HIV infection?	Many STIs cause sores (openings on the skin, in or around the genitals). These sores make it easier for HIV to enter the body.
Can a pregnant woman who has an STI pass the infection to the baby?	Yes, children born to infected mothers can become infected with a STI during delivery. The HIV virus can also be passed on to the baby through breast-feeding.
You can have sex while you are being treated for an STI.	No, you can infect your partner even while you are being treated. Therefore, you should not have sex until you are completely cured.
STIs can be cured by having sex with a virgin.	No, this is a total fallacy. In fact, it is likely that you will infect the virgin with STI.
You can contract STIs only if you go to sex workers for sex.	No, STIs can be contracted from anyone who has the infection, including your regular partner.
You will not contract STIs if you are careful and wash your genitals with soap and water after having sex.	No, STI viruses / germs cannot be removed through washing or bathing.
Only women can spread STIs.	No, STIs can be spread by any person who is infected.
Birth control pills are a good method for STI prevention for women.	No, birth control pills do not prevent STI. Only the use of condoms can reduce the risk of STIs.
You can buy medicines from the drug store to treat the STI infection without going to the doctor.	No, STIs must be diagnosed and treated by a qualified doctor.

Session 4.7
Understanding STIs

Expected Outcomes
Participants will know the symptoms of most STIs.

Which STI Is This!

Objective To identify the symptoms of the most commonly contracted STIs.

Materials 2 sets of cards – one set will have the names of the STIs and the other will have the symptoms of the STIs, transparencies or charts showing the names of the STIs and corresponding symptoms.

Time 1 hour.

Process Based on the number of participants, prepare as many cards as required. It is all right if the cards are repeated.

Ask the participants to sit in a circle. Place the cards with the symptoms of STIs in a box in the centre of the circle.

Inform the participants that they will learn about STIs and their corresponding symptoms through this exercise.

Ask each participant to come to the centre, pick a card and return to his/her place.

Ask them to read the card and ask questions for clarification if they do not understand what is written.

Now, place the second box in the centre of the circle. Inform the group that this box has the cards with the names of various STIs corresponding to the symptoms on the cards they hold.

Empty the contents of this box on the floor, and ask the participants to find the name of the STI they think represents the symptoms on the cards they have.

Allow 30 minutes for this activity.

Ask the participants to return to their seats.

Now, show them the correctly matched cards on a transparency or a flip chart (prepare in advance).

Ask each participant to check their cards to see if they were correct.

Ask all those who made the right connection to gather at one end of the room and all those who did not make the correct connection to gather on the other end of the room.

Ask the correct group to share the reasons for being able to identify the connection.

Then, ask the incorrect group to share the reasons for not being able to make the correct connection.

If nobody succeeds in making a correct match, or if only one or two people succeed in doing so, your task becomes simpler. It proves that it is not easy to diagnose STIs. In fact, it can only be done by a doctor / health practitioner.

Close the session with a summary of the exercise based on the responses of the participants. Emphasize the importance of information in making decisions and the fact that not everyone knows everything. Focus on the issue of sharing and seeking guidance. Point out that the symptoms of various STIs can be confusing and overlap, therefore, it is important to seek the services of a doctor. In fact, STIs can only be diagnosed by a qualified doctor. Also, emphasize that if a person is actually showing physical symptoms, it is a fairly advanced case.

Notes for the Facilitator

This is a simple exercise that provides basic information on STIs and their symptoms. It can be done in a mixed group. It emphasizes the importance of information and the ability to use the information.

Table of commonly contracted STIs and their symptoms

This table should be used to make the cards for the game, and it can also be given as a handout.

Name of the STI	Symptoms
Syphilis	Hard, painless, single, clean, ulcer / lesion on the penis / vaginal area, inside rectum or mouth Persistent fever Sore throat Patches of hair loss Rashes on palms, soles, chest and back (bacterial infection)
Chancroid	Ulcers – painful, multiple, soft Painful swelling of nymph nodes (one side) (bacterial infection)
Herpes Genitalis	Multiple ulcers, shallow erosions, incurable, severe pain, fever, difficulty urinating, tenderness on the inside of the legs (viral infection)

Gonorrhoea	Thick yellow discharge from penis / vagina, pain urinating and, or, during sex (bacterial infection)
Chlamydia	Abnormal discharge from the penis / vagina, infertility, bleeding / pain during intercourse, pain while urinating (bacterial infection)
Hepatitis B	Severe infection shows: Loss of appetite, nausea / vomiting, fever, joint pains, jaundice symptoms, dark urine, pain in abdomen (viral infection)
Urethritis	Mild / sever pain while urinating, pus / mucous discharge from penis / vagina (bacterial infection)
Proctisis	Itching / burning around anus, pus / mucous discharge in stool, mild / severe pain during bowel movement, occasional diarrhoea or fever (3 out of 10 men show no symptoms) (bacterial infection)
Genital warts	External warts around anus or penis / vagina (viral infection)
Crabs	Lice in the hairy parts of the body, itching (mostly) at night (parasite)
Scabies	Itchy red spots or rash on wrists, ankles, hands, penis / vagina, chest and back (parasite)
HIV	Damages immune system, incurable, leads to AIDS

HELPLINE for the peer educator

This material can also be used to make handouts and posters.

Definition of STI

S Sexually
T Transmitted / Transmissible
I Infection

Initially called STDs (Sexually Transmitted Diseases), but the term did not include sexually transmitted illnesses that do not exhibit symptoms.

Differ from UTI (Urinary Tract Infection) and RTI (Reproductive Tract Infection), as these infections are not sexually transmitted.

Modes of Transmission of STIs

- STIs spread, if a person has unprotected sexual intercourse with an infected partner. The sexual act can be vaginal, anal or oral.

- STIs require direct contact of mucus membranes or open cuts/sores with infected blood or other body fluids (semen, vaginal secretion)

Some STIs can also be transmitted by

- Sharing of contaminated needles (Syphilis, Hepatitis B/C and HIV)
- Transfusion of infected blood (Syphilis, Hepatitis B/C and HIV)
- Infected mother to child (Syphilis, Gonorrhoea, Hepatitis B/C and HIV)

Reasons for Underestimating STIs

- Men and women with STIs may not have symptoms, so they do not seek treatment.
- Clinics that report STI cases may not be easy to reach.
- People with STIs usually initially go to alternative health care providers.

Signs and Symptoms of STIs

General (male and female)

- Burning/pain during urination, increased frequency of urination
- Blisters/sores (ulcers) on the genitals - painful/painless
- Swollen/painful glands in thegroin
- Itching in the groin
- Non-itchy rash on the body
- Warts in the genital area
- Sores in the mouth
- Flu like syndrome -fever, body ache, headache

Females

- Unusual vaginal discharge (yellow, frothy, curd-like, pus like, foul smelling, blood tinged)
- Lower abdominal pain
- Irregular bleeding from the genital tract
- Burning/itching around the vagina
- Painful intercourse

Males

- Discharge from the penis

Note: Some STIs do not produce any symptoms, particularly in females. Therefore, they are carriers of the disease.

STIs Can Not Spread By

Using a public latrine, insect bites, sins of past life, masturbation, eating "hot" food, bad blood or working in a hot atmosphere.

STIs Can Not Be Cured By

Eating certain types of food, application of certain oils, having sex with a virgin girl /boy.

Complications of Untreated STIs

- Pelvic inflammatory disease (PID) -swelling of uterus, tubes, ovaries causing abdominal pain, vaginal discharge and fever.

- Infertility (male and female).
- Ectopic pregnancy (pregnancy developing outside uterus).
- Abortion, stillbirth, early childhood deaths.
- Eye infection of newborn -blindness (gonorrhoea).
- Birth defects.
- Cancer of cervix.
- Chronic abdominal pain.
- Death due to sepsis, ectopic pregnancy or cervical cancer.

Relationship between STIs and HIV

- Transmitted by the same route.
- STI increases the chances of transmission of HIV (l0x genital ulcers, 5x discharge).
- Same modes of prevention and same target group.
- STI may be more severe and more resistant to treatment in HIV patients.
- STI prevention is one of the main strategies to prevent HIV / AIDS.

Increased risk of HIV infection associated with common STIs and their curability.

Name of STI	Increased risk of HIV	Curability
Gonorrhoea (Genital discharge disease)	++ >	95 per cent
Chlamydia (Genital discharge disease)	++ >	95 per cent
Syphilis (Genital ulcer disease)	++ >	95 per cent
Chancroid (Genital ulcer disease)	+++ >	95 per cent
Trichomoniasis (Urethral / Vaginal discharge disease)	+ >	95 per cent

Common STIs

(a) Genital Ulcer Diseases

1. Syphilis
2. Chancroid
3. Lymphogranuloma Venereum (LGV)
4. Granuloma Inguinale (Donovanosis)
5. Herpes Genitalis

(b) Genital Discharge Diseases

1. Gonorrhoea
2. Non-Gonococcal Uretheritis
3. Candidiasis
4. Trichomoniasis
5. Bacterial Vaginosis

(c) Other Diseases

Genital Warts
Molluscum Contagiosum
Scabies
Hepatitis B and C
HIV / AIDS

Syndromic Management of STIs

- Identification of consistent group of symptoms and easily recognizable signs (syndromes)
- Treatment of main organisms responsible for causing the syndrome

The common syndromes include

(a) Urethral discharge
(b) Genital ulcer disease
(c) Vaginal discharge
(d) Lower abdominal pain
(e) Ophthalmia neonatorum
(f) Inguinal bubo
(g) Swollen scrotum

Main features of STI management include

(a) Grouping the main infectious agents according to the clinical syndromes they cause.
(b) Using flow charts as tools.
(c) Treating patients for all important causes of a syndrome.
(d) Educating patients, promoting condom use and emphasizing the importance of partner referral.

Module 5
Basics of HIV/AIDS

FLOW CHART

Content Flow at A Glance
Module 5: Basics of HIV/AIDS

Module 5
Basics of HIV/AIDS

"In the future we will say one of the two things, "I wish I had" or "I am glad I did," but we make that choice today".

Anonymous

Introduction

The HIV/AIDS epidemic in Asia and the Pacific has not yet reached the dimensions witnessed in some African countries. However, based on current trends, in terms of the absolute number of people affected, the region could replace sub-Saharan Africa as the centre of the global HIV/AIDS epidemic over the next decade.

In Cambodia and Thailand, national adult HIV prevalence rates are at least 1 per cent. However, the low national prevalence rates in the rest of the region disguise the severity of the threat. In just two countries alone (China and India), an estimated 5 million people were already living with HIV/AIDS at the end of 2002. Official estimates predict a 10-fold increase in PLWHAs in China by 2010. In China, the number of new HIV infections reported rose by about 17 per cent in the first six months of 2000. Prevalence in only 6 states of India translates into absolute numbers of between 2 and 3 million. In the country as a whole, there are nearly 5 million (NACO 2003). The pandemic is also growing at an alarming pace in the Central Asian republics and in the Russian Federation.

In Indonesia, drug injection was practically unknown 10 years ago. Currently, this problem is growing significantly in urban areas. National estimates indicate that some 43,000 injecting drug users (IDUs) are already infected with HIV/AIDS. With needle sharing becoming the norm, HIV/AIDS is likely to spread more widely throughout this population. If current high-risk, injecting behaviour continues, it is estimated that the number of IDUs living with HIV/AIDS could almost double in 2003, accounting for more than 80 per cent of new HIV infections nation wide.

High prevalence rates have also been reported among sex workers in some areas of the region. Heterosexual intercourse is the main mode of transmission in the region. Injecting drug use among young people remains the predominant mode of HIV transmission in the Central Asian republics, the Russian Federation and some other countries in the region.

The following material is essential reading for a peer educator who plans to conduct sessions on HIV/AIDS. The material is also useful for preparing handouts, presentations and posters.

Helpline for the Peer Educator

The International Guidelines on HIV / AIDS and Human Rights

UNAIDS and the Office of the United Nations High Commissioner for Human Rights have developed a set of guidelines for Member States to assist them in designing programmes and policies and developing legislation that promote and protect human rights in the context of HIV / AIDS.

The International Guidelines on HIV/AIDS and Human Rights

- ✓ Represent the collective recommendations of experts from the health, human rights, government and civil society, including people living with HIV / AIDS on how human rights should be protected and promoted, respected and fulfilled in the context of HIV / AIDS.
- ✓ Are based on existing human rights principles translated into concrete measures that should be taken as part of an effective HIV / AIDS strategy.
- ✓ Are not a formal treaty, but are based on international human rights treaties that must be observed by all states that have ratified them.
- ✓ Have been welcomed by the United Nations Commission on Human Rights and by human rights, development and health organizations around the world.

The Guidelines

1. States should establish an effective national framework for their response to HIV / AIDS which ensures a co-ordinated participatory, transparent and accountable approach, integrating HIV / AIDS policy and programme responsibilities across all branches of government.

2. States should ensure, through political and financial support, that community consultation occurs in all phases of HIV / AIDS policy design, programme implementation and evaluation and that community organizations are enabled to carry out their activities in the field of ethics, law and human rights, effectively.

3. States should review and reform public health laws to ensure that they adequately address public health issues raised by HIV / AIDS, that their provisions applicable to casually transmitted diseases are not inappropriately applied to HIV / AIDS and that they are consistent with international human rights obligations.

4. States should review and reform criminal laws and correctional systems to ensure that they are consistent with international human rights obligations and are not misused in the context of HIV / AIDS or targeted against vulnerable groups.

5. States should enact or strengthen anti-discrimination and other protective laws that protect vulnerable groups, people living with HIV / AIDS and people with disabilities from discrimination in both the public and private sectors, ensure privacy and confidentiality and ethics in research involving human subjects, emphasize education and conciliation, and provide for

speedy and effective administrative and civil remedies.

6. States should enact legislation to provide for the regulation of HIV -related goods, services and information, so as to ensure widespread availability of qualitative prevention measures and services, adequate HIV / AIDS prevention and care information and safe and effective medication at an affordable price.

7. States should implement and support legal support services that will educate people affected by HIV / AIDS about their rights, provide free legal services to enforce those rights, develop expertise on HIV / AIDS related legal issues and utilize means of protection in addition to the courts, such as offices of ministries of justice, ombudspersons, health complaint units and human rights commissions.

8. States, in collaboration with and through the community should promote a supportive and enabling environment for women, children and other vulnerable groups by addressing underlying prejudices and inequalities through community dialogue, specially designed social and health services and support to community groups.

9. States should promote the wide and ongoing distribution of creative education, training and media programmes explicitly designed to change attitudes of discrimination and stigmatization associated with HIV / AIDS to understanding and acceptance.

10. States should ensure that government and the private sector develop codes of conduct regarding HIV / AIDS issues that translate human rights principles into codes of professional responsibility and practice, with accompanying mechanisms to implement and enforce these codes.

11. States should ensure monitoring and enforcement mechanisms to guarantee the protection of HIV / AIDS -related human rights, including those of people living with HIV / AIDS, their families and communities.

12. States should co -operate through all relevant programmes and agencies of the United Nations system, including UNAIDS, to share knowledge and experience concerning HIV / AIDS -related human rights issues and should ensure effective mechanisms to protect human rights in the context of HIV / AIDS at international level.

Frequently asked questions about HIV / AIDS

I What is HIV and how is it transmitted?

HIV stands for human immunodeficiency virus and it is the virus that causes AIDS. People with HIV have what is called HIV infection.
The most common ways that HIV is transmitted are by having unprotected sexual intercourse with an HIV infected person, by sharing needles or injection equipment with an injecting drug user who is infected with HIV, from HIV infected women to their babies during pregnancy, delivery or breastfeeding and finally through

transfusions of infected blood. HIV is not transmitted through normal, day-to-day contact.

II What do we know about HIV?

- HIV, like other viruses is very small, too small to be seen with an ordinary microscope. Viruses cause all sorts of diseases from flu (influenza) to herpes to some kinds of cancer.
- To reproduce, HIV must enter a body cell, which in this case is an immune cell. By interfering with the cells that protect us against infection, HIV leaves the body poorly protected against the particular types of diseases, which these cells normally deal with.
- Infections that develop because HIV has weakened the immune system are called "opportunistic infections". These include: respiratory infections for example, tuberculosis, neumocystis carinii pneumonia; gastro-intestinal infections for example, candidiasis in the mouth or diarrhoea; and brain infections for example, toxoplasmosis or cryptococcal meningitis.
- Some people may also develop cancers, for example Kaposi sarcoma, a cancer which often causes red skin lesions.

III What is AIDS? What causes AIDS?

AIDS - the Acquired Immuno-Deficiency Syndrome -is the late stage of infection caused by the Human Immunodeficiency Virus (HIV).

A person who is infected with HIV can look and feel healthy for along time before signs of AIDS appear. But, HIV weakens the body's defence (immune) system until it can no longer fight off infections such as pneumonia, diarrhoea, tumours, cancers and other illnesses.

Today there are medical treatments that can slow down the rate at which HIV weakens the immune system (anti-retroviral treatment). There are other treatments that can prevent or cure some of the illnesses associated-with AIDS, though the treatments do not cure AIDS itself. As with other diseases, early detection offers more options for treatment and preventative health care.

IV What are antibodies?

The body's defence system (immune system) develops germ fighters, called antibodies to fight off and destroy various viruses and germs that invade the body.

The presence of particular antibodies in a person's blood indicates that the person has been exposed to that infection. For example, when a blood test reveals that the antibodies to HIV are present in the blood, it means that the person is infected with HIV.

V What is the "window" period?

This is the time that the body takes to produce measurable amounts of antibodies after infection. For HIV this period is usually 2-12 weeks, and in rare instances it may be longer.

This means that if an HIV antibody test is taken during the "window" period it will be negative since the blood test is looking for antibodies that have not yet developed. But, that person is already HIV-infected and can transmit HIV to others.

People taking the test are advised, if the result is negative, to return for a re-test in 3 months by which time if the person had been infected, the antibodies are almost certain to have developed (they should avoid risk behaviours during the 3 months).

The most common test for HIV antibodies is called the ELISA test.

VI What does the asymptomatic period mean?

- The asymptomatic period is the period of time between infection and the beginning of signs and symptoms related to AIDS.
- This varies from person to person for HIV/AIDS. It may be as short as 6 months or as long as 10 years.
- People usually have an asymptomatic period of several years in which they may have swollen lymph nodes but no other complaints. Then, they may start to develop symptoms like oral thrush or night sweats. It may then still take years before they develop full-blown AIDS. The period between the development of full-blown AIDS and death may be as short as 6 months or as long as 2 years. During the asymptomatic period there may be no evidence that the person is sick, however, HIV-related illnesses can occur regularly over many months or years before full-blown AIDS develops. During the asymptomatic period (as well as during the symptomatic period), the person is infectious - that is, can pass HIV on to others.

VII Can I get AIDS from "casual contact" with an infected person?

No. This means that it is **OK** to play sports and work together, shake hands, hug friends or kiss them on the cheek or hands, sleep in the same room, breathe the same air, share drinking and eating utensils and towels, use the same showers or toilets, use the same washing water and swim in the same swimming pool. You cannot get infected through spitting, sneezing, coughing, tears, sweat or bites from mosquitoes or other insects.

VIII Can someone infected with HIV look healthy?

There is no way of knowing whether someone is infected, just by looking at them. A man or woman you meet at work, at school, in a sports stadium in a bar or on the street might be carrying HIV -and look completely healthy. But during this time of apparent health, he or she can infect someone else.

IX What are the symptoms of AIDS?

This question must be approached with caution, since it is often difficult to determine if the symptoms actually mean onset of AIDS or if they are simply symptoms of other conditions. People develop signs and symptoms of their HIV infection before they develop what has been defined as AIDS. AIDS is the final and most severe phase of HIV infection and leads to death.

The obvious signs and symptoms are indications of an opportunistic disease, such as tuberculosis or pneumonia. However, associated findings might include recent, unexplained weight loss, fever for more than one month, diarrhoea for more than one month, genital or anal ulcers for more than one month, cough for more than one month, nerve complaints, enlarged lymph nodes and skin infections that are severe or recur.

X Is there a cure for HIV/AIDS?

There is no cure for HIV/AIDS. Although some very strong drugs are now being used to slow down the disease, they do not get rid of HIV or cure AIDS. The drug treatments are called Highly Active Anti-Retroviral Therapies (HAART). They are a mix of drugs that help to reduce the level of HIV in the blood. HAART can help to slow down HIV and keep some people healthy longer. Even though HAART work better than anything else so far, there are some problems. They do not work for all people, and it is not know how well they will work over time, considering their high price and significant adverse effects.

XI Is there a "morning after" pill that prevents HIV infection?

You may have heard about a morning after pill for HIV, in fact, this is Post-Exposure Prophylaxis (PEP). It is not a single pill, and it does not prevent HIV/AIDS. PEP is a 4-week treatment that may reduce the risk of acquiring HIV for people who have been exposed to the virus. It does not eliminate the risk. So far, PEP has mostly been used to treat health care workers who have been exposed to HIV at work. Right now, there is no proof that PEP works, or that it is safe. PEP is not at all a solution to prevent HIV transmission.

XII What should I do to protect myself from HIV?

Since there is no vaccine to protect people against getting infected with HIV, and there is no cure for AIDS, the only certain way to avoid AIDS is to prevent getting infected with HIV in the first place. The best prevention method is the adoption of safe-sex behaviour. Safe sex includes using a condom, but, using a condom correctly and using one every time you have sex. You should learn how to use condoms and how to negotiate the use of condoms with your partner. For information about effective and healthy use of condoms, you should consult health services for young people and pharmacies.
(Please also see: http://www.unaids.org/hivaidsinfo/faq/condom.html)

XIII Do sexually transmitted infections (STI) increase your chance of getting HIV?

There is strong evidence that other sexually transmitted infections put a person at a greater risk of getting and transmitting HIV. This may occur because of sores and breaks in the skin or mucous membranes that often occur with STIs.

If you suspect you may have acquired or been exposed to an STI, you should seek medical advice.

A person who has an STI should be aware that if they are having unprotected sexual intercourse, they are at an even higher risk of getting HIV.

XIV What are the risks of getting HIV through injecting drug use?

The only way to be sure you are protected against HIV is not to inject drugs at all. If you do inject drugs, you can avoid the very high-risk of being exposed to HIV by always using sterile, un-used needles and syringes and using them only once.

XV How is HIV transmitted with injection needles and syringes?

Small amounts of blood remain in the needle and syringe after use. If someone else then uses that needle and syringe, any blood left in the syringe or needle will be injected into their bloodstream. If the first user was infected with HIV, the second person may now also be infected.

Only a very small amount of blood is needed for transmission to occur. Sharing needles and syringes used for anything - medicines or heroin, cocaine, amphetamines (speed) and even water can spread HIV. It is not what is put into the syringe that transmits HIV but the blood that remains in the needle and syringe.

Some countries have needle and syringe exchange programmes (used needles and syringes are exchanged for new ones) for injecting drug users. Those who cannot stop injecting drugs can join these programmes to avoid HIV transmission.

If people are not in a position to use a new needle and syringe, the equipment can be boiled or, if boiling is not possible, cleaned in the following way:

Rinse the syringe out with clean, cold water at least twice (not hot water). Squirt the used water down the drain.

Rinse the syringe out at least twice with fresh, household bleach, squirting the used bleach down the drain.

Rinse it out again, at least twice with clean, cold water to get rid of the bleach.

Be extremely careful if you come across a needle or syringe in a park or street. Dispose of it safely without touching it with unprotected fingers.

XVI Do some people have an increased likelihood of getting HIV?

Yes. It depends on a person's behaviour: Some behaviour / activities carry a higher risk of getting HIV than others. These include:

- Having many different sexual partners.
- Practicing unsafe sexual activities for example, have sexual intercourse without a condom.
- Having sex when you have other sexually transmitted diseases.
- Sharing needles and syringes for injecting drug use.

Some situations, which are beyond an individual's control, can put them at risk. These include:

- Receiving injections with needles that are not cleaned or sterilized properly.
- Receiving blood transfusions with blood that has not been tested.

XVII Are men and women equally vulnerable physiologically to HIV infection?

Women are slightly more vulnerable physiologically to HIV infection than men. The area of mucous membrane exposed during intercourse is much larger in the woman than in the man, and the mucous membrane surface of the vagina (compared to the penis) can more easily be penetrated by the virus. Very young women are more vulnerable than women in the 18-45 year age group; their immature cervix and relatively low vaginal mucus production present less of a barrier to HIV. Women are becoming infected at younger ages than men. This is partly because many young women marry or have sex with men older than themselves, who have already had a number of partners and partly because of their biological vulnerability.

XVIII If a woman is menstruating is there a greater risk of getting infected with HIV (for her partner and for herself)?

Menstrual blood from HIV-infected women does contain the virus. Infection would be dependent on whether the menstrual blood had contact with the sexual partner's bloodstream. A woman who is menstruating is likely to be at a higher risk for HIV through sexual intercourse.

XIX Can you become infected by blood transfusion or by blood products?

Recommended standard practice for all transfusion services is to test, and exclude from use, all blood and blood products that are “Sero Positive” i.e., contain antibodies to HIV. In most countries, efforts have been made to test all blood donations for HIV since 1985.

There is a very small chance that an occasional transfusion may contain the virus, since an HIV- infected donor might have been in the “window” period (test negative) when giving blood.

You cannot get HIV from donating blood (as long as you insist on a fresh needle).

XX What happens to a baby born to a woman with HIV infection?

The baby may be born infected with the virus. An infected mother can also pass the infection to her baby during breast-feeding after childbirth.

About 20-40 per cent of babies born to infected mothers will acquire the HIV virus. Some of those will develop AIDS during the first year of life. The majority of HIV-infected babies will not survive to their second birthday. However, some may survive up to 7 years or even longer.

It serves little purpose to test babies born to HIV-infected mothers for HIV antibodies at birth. There are likely to be many false positive results because antibodies from the

mother are still circulating in the baby's bloodstream. Only at 18 months or older, can an antibody test result be regarded as reliable.

XXI Does breast-feeding transmit HIV?

Breast milk of an HIV-infected mother contains HN, which can be transmitted to the baby. However, because of the benefits of breast-feeding, the World Health Organization recommends that in situations where infectious disease and malnutrition are the main cause of infant deaths and the infant mortality rate is high, mothers should breast-feed their babies, even if they are known to be infected with HIV, as the risk to the baby is less than the risks involved in artificial feeding.

XXII What should I do if I think I might already have HIV?

If you think you might have HIV, or if you have had unprotected sex, you should ask your physician about getting an HIV blood test and some counselling. Both pre-test counselling and post-test counselling are important.

If you prefer to check it out yourself, many cities have testing centres where you can get an HIV test and some good confidential counselling. It is essential to know whether you have been infected. If you are infected, early detection will permit you to get full and proper medical care. With proper care, people with HIV infection can live for many years. It is also essential to know whether you are infected to avoid infecting others through blood donation, unprotected sex or through needle sharing.

XXIII What are the advantages and disadvantages of being tested for HIV?

The advantages of being tested are as follows:

- You can receive treatment and increase the quality and duration of your life.
- You can make the decision to take care of yourself and those around you.
- You can develop a social and emotional support system during the early stages of the disease.
- You can benefit from new types of medicine as they are developed.
- You can make informed decisions, for example, the decision to get pregnant, or not?
- You can inform your partner and take precautions so that he/she does not get infected.
- You can choose to abstain from having sex and indulging in other behaviours that may risk others' chances of getting infected.
- If you are not infected, you will be relieved and will want to protect yourself in the future.

Disadvantages of being tested are as follows:

- Learning that a person is infected with HIV can be very distressing. The degree of distress depends on how well the person is prepared for the news, how well the person is supported by family and friends and on the person's cultural and religious attitudes towards illness and death.
- A person who learns s/he is infected with HIV is likely to suffer from feelings of uncertainty, fear, loss, grief, depression, denial and anxiety, the person must make a variety of adjustments.

- Partners and family are likely to suffer from the consequences of HIV testing as well as the infected person, whether they are also infected or not.
- A person who has tested positive for HIV may be discriminated against, if the information is revealed.

XXIV What if I test positive for HIV?

If you test positive for HIV, the sooner you take steps to protect your health, the better. Prompt medical care may delay the onset of AIDS. There are a number of important steps you can take immediately to protect your health. See a doctor, even if you do not feel sick. There are now many drugs to treat HIV infection and help you maintain your health.

Also, you have the opportunity to make others more aware of the disease and to fight for tolerance and compassion for people living with HIV / AIDS.

XXV What should I do if I know that someone has HIV or AIDS?

People with HIV are part of society. They can continue their lives and do their jobs as well as they could before they were infected. They look and feel perfectly healthy for a long time. People with HIV should be treated just like anyone else. If you know that someone has HIV or AIDS, you should respect that person's privacy and not tell any one about his or her infection. We all need to learn to live with HIV and AIDS. This involves understanding people with HIV / AIDS and giving them love and support, not prejudice and rejection.

XXVI Do people living with HIV/AIDS have the same rights as other people?

People living with HIV / AIDS have the same rights and duties as anyone else. Though they face great disadvantage and discrimination due to the stigma of the disease, it is important to realize that they continue to enjoy the rights enshrined in the constitution of a country and any other bill of rights that has been signed by the government of the country.

Just like anyone else, people living with HIV / AIDS have the right to work, treatment, education, housing, marriage and divorce. Denial of these rights can be challenged in a court of law.

Women living with HIV / AIDS are often more likely to be denied their rights. Other marginalized groups such as homosexuals, sex workers, injecting drug users and children living in difficult circumstances are also likely to face discrimination and denial of their basic human rights.

Impact of HIV/AIDS

- Worldwide HIV / AIDS is the fourth biggest killer.
- The majority of new infections occur in young adults, and one third of those currently living with HIV / AIDS are aged 15 to 24.
- The Asian and Pacific region now accounts for 1 in every 5 new HIV infections worldwide.

- Over 8 million people in the region were living with the virus at the end of 2002.
- Of these 2.6 million were young people aged 15 to 24 years.
- Projections for 126 low and middle-income countries showed that an additional 45 million would become infected between 2002 and 2010. More than 40 per cent of those infections would occur in the Asia and the Pacific.
- Heterosexual intercourse is the main mode of transmission in the Asia Pacific Region.
- Several broad development dynamics are at play in the spread of HIV in the Asia and the Pacific Region. They include poverty, gender inequality, population mobility, lack of access to information and essential services, especially among youth and other vulnerable groups, including sex workers, IDUs and sex workers.
- In many countries, cultural factors inhibit open discussion of issues related to sex. It is difficult to address issues of sex and sexuality: unsafe sex, casual sex, multiple sex partnerships, homosexuality, bisexuality, use of sex worker services and paedophilia.
- 80 per cent of women in Asia who have been infected display no risk behaviour themselves but are likely to have been infected in what they regarded as "monogamous" relationships with their husbands and boy friends (UNAIDS 2002).
- The world's fastest growing HIV/AIDS epidemics are now raging in the Asia Pacific region.
- In most countries of the ESCAP region, Men who have Sex with Men (MSMs) endure social scorn, official harassment and institutional neglect. Sex between men is prohibited in many countries of the region (Human Rights Watch 2002).
- HIV transmission from mother to child is responsible for over 90 per cent of infections among children under the age of 15. A mother may infect a child during pregnancy, at childbirth or through breast-feeding. As the epidemic grows, mother to child transmission is a serious concern in the ESCAP region.

Gender and HIV/AIDS

- More than 44 per cent of the global population of people living with HIV/AIDS is women.
- Many women experience sexual and economic subordination in their marriages or relationships and are therefore, unable to negotiate safe sex or refuse unsafe sex.
- The power imbalance in the work place exposes women to the threat of sexual harassment.
- Women's access to prevention messages and services is hampered by illiteracy and cultural/religious taboos.
- Studies show the heightened vulnerability of women, compared to men, to the social stigma and ostracism associated with AIDS, thus leaving them marginalized and neglected.

Why are women more vulnerable?

Physiological susceptibility

- The vaginal walls of a woman have a large surface area which aids in the collection of fluid that can facilitate in the transmission of HIV. In contrast, the surface area of the penis is small.
- Walls of the cervix and vagina are thinner and are easily torn. Micro pores allow easy passage to the virus.
- Women have more chance of getting Reproductive Tract Infections.
- Often Sexually Transmitted Diseases in women remain asymptomatic which delays detection and treatment.

Socio cultural reasons

- Unequal access to education and economic resources.
- Women have less power than men in their social and sexual relationships.
- Women are more likely to experience rape, sexual coercion and circumstances that force them to sell sex for money.
- Gender related discrimination is often supported by laws and policies that prevent women from owning land, property and other productive resources. This enhances their economic vulnerability to HIV infection, limiting their ability to seek and receive care and support.
- Women with HIV/AIDS often experience more blame and stigmatization than men in the same position.
- In addition to their own increased risk of HIV, women also carry the social burden of the epidemic, in terms of providing care to the relatives and family members suffering from AIDS.

HIV Disease progression

Once HIV enters the body, it infects a large number of CD4 (T-4 lymphocytes) cells and replicates rapidly. There are various stages of disease progression:

Acute Sero Conversion – HIV spreads throughout the body within weeks of entry, especially the lymphoid organs – lymph nodes, spleen, tonsils and adenoids. The patient may complain of fever, headache, cough, skin rash, night sweats and swelling of lymph nodes around 2 to 6 weeks after entry of HIV virus. The flu-like symptoms last for 1 to 2 weeks.

Window period: it takes between 6 weeks to 6 months (average 3 months) for the person with HIV to test positive through standard HIV diagnostic tests. During this time, infected persons have the virus in their body and can spread the infection but do not test positive.

Asymptomatic stage: virus replicates in deep tissues such as testes and brain where it may remain without dividing for many months or years. It is those deep-seated reservoirs that appear to be responsible for the continued proliferation of the virus over many years. This is the stage of clinical latency, which might last for 3 months to 17 years depending on the immune status of individual patients.

Symptomatic stage: Progression, destruction and depletion of the CD4 lymphocytes disable the immune system. AIDS is defined in a person who has confirmed positive for HIV infection with any of the clinical infections – Weight loss (over 10per cent),

chronic diarrhoea (over 1 month), disseminated miliary tuberculosis, neurological impairment, candidiasis, Kaposis sarcoma.

Late stage: is characterized by the appearance of various opportunistic infections, such as tuberculosis, candida, herpes, pneumocytis, carnii, toxoplasmosis, cryptosporidiosis, crptococcus and cytomegalovirus.

Later still, the following symptoms may appear

Dry cough or shortness of breath	Swollen lymph glands
Diarrhoea	Lack of resistance to infection
Fatigue	Loss of appetite
Fever	Memory or movement difficulties
Furry white spots in the mouth	Night sweats
Significant weight loss	Red or purplish spots on the body
Skin rashes	

Death – Death is mainly due to the invasion of the brain, spinal cord and lungs by HIV and other opportunistic pathogens.

WHO guidelines for the diagnosis of AIDS

Major Signs	Weight loss of over 10 per cent of body weight
	Fever for longer than 1 month
	Diarrhoea for longer than 1 month
Minor Signs	Persistent cough for more than 1 month
	General itchy skin diseases
	Recurring shingles (herpes zoster)
	Thrush in the mouth and throat
	Long lasting, spreading and severe cold sores
	Long lasting swelling of the lymph glands
	Loss of memory
	Loss of intellectual capacity
	Peripheral nerve damage

Links between STIs and HIV/AIDS

The predominant mode of transmission of both HIV and other STI agents is sexual, although other routes of transmission for both include blood, blood products, donated organs or tissue and from infected mother to her child.

Many of the measures for preventing the sexual transmission of HIV and other STIs are the same.

There is a strong association between, the occurrence of HIV infection and the presence of certain STIs (Genital ulcer disease 10 times more chance, genital discharges 5 times more chances) making early diagnosis and effective treatment of such STIs an important strategy for the prevention of HIV transmission.

STI clinical services are an important access point for people at high-risk of contracting both AIDS and other STIs, not only for diagnosis and treatment but also for education and counselling.

STI prevalence rate in a community is a good indicator of the effectiveness of any HIV prevention programme effort.

Tests for HIV

Enzyme Linked Immunosorbent Assays (ELISA) – testing serum for antibodies to HIV with a standard ELISA is currently one of the most common, cost effective and accurate methods of screening for infection. Two consecutive positive tests are required from three different kits before a result is confirmed positive.

SPOT test – the other most commonly used HIV test with a high degree of accuracy (98 per cent). It again is a test for antibodies.

Polymerase Chain Reaction (PCR) – this is the only test available specifically for HIV and tests for the presence of HIV genetic material.

Western Blot Test – another accepted confirmatory assay for the detection of antibodies to HIV and considered the "gold standard" for validation of HIV results. Three positive ELISA test have the same accuracy as a Western Blot Test.

Care and Support

- People with HIV / AIDS need empathy, love and affection.
- They need ongoing counselling to cope with their HIV status.
- Referral services to organizations, groups that provide vocational training, financial support or other support services must be made available to people with HIV / AIDS.

Family members need to be taught how to take care of health, hygiene, nutrition and ailments of their loved ones through a home-based care approach.

Session 5.1
Getting to Know about HIV/AIDS

Expected Outcomes
Participants will become aware of the facts about HIV / AIDS.
Participants will know reality from myth.

I Know And I Don't Know

Objectives To know the levels of understanding on HIV / AIDS among the participants.
To enable the group to gain factual information on HIV / AIDS.

Materials Statement cards on HIV / AIDS, a container for mixing the cards, flip charts, markers.

Time 45 minutes.

Process Invite the participants to sit in a circle.

Explain that even though HIV / AIDS is a major illness, not many people are aware of it. Governments and many other organizations the world over have been fighting the battle against HIV / AIDS. Awareness among people is one of the most effective ways of combating the disease.

Explain that they are going to do an exercise to find out how much they know about HIV / AIDS.

Place the container with the statement cards in the centre of the circle. Ask each participant to pick up a card.

Start at one end of the circle, and ask the participants to read the statement on his / her card and give a response (whether the statement is true or false) Complete the circle. As each participant reads out his / her statement and gives a response, ask the rest of the group whether they agree with the response or not? Allow some discussion and give the correct response. Commend the participant if his / her response was correct.

Summarize by reinforcing the essential facts about HIV / AIDS: how it spreads, how it can be prevented etc.

Note for the Facilitator
This is a simple exercise to gauge the group's understanding of HIV / AIDS and provide information. The facilitator can adapt this exercise for a non-literate group by keeping the cards with him / her and reading them out, one by one. The rest of the process can remain the same.

List of statements for the exercise

Statements	Correct Responses
The full form of HIV is High In Vitamins.	False, the full form of HIV is Human-Immuno Deficiency Virus
HIV is caused by AIDS.	False, AIDS is caused by HIV. It is tiny, a thousand times smaller than the thickness of the hair, and looks like a rolled up porcupine. It belongs to the family of viruses called retrovirus. Viruses are the smallest and simplest living organisms. They are so small that they cannot be seen under a light microscope. One needs an electron microscope to see them. They cause different diseases in human beings, which include measles, polio, mumps, common cold and influenza.
There is no cure for HIV / AIDS.	True, although some very strong drugs are now being used to slow down the disease. They however, do not get rid of HIV or cure AIDS. These drugs are also very expensive.
People who have the HIV infection will develop AIDS.	True. AIDS is a medical diagnosis for a combination of symptoms, which results from a breakdown of theimmune system. "A" stands for acquired which means that it is obtained or received by a person and is something that is not genetically inherited. "ID" stands for Immuno Deficiency, which means there is deficiency in the immune system or that the immune system is weakened. "S" stands for syndrome. The word **syndrome** is used to emphasize that AIDS is not just one disease or symptom but presents as a group of diseases or symptoms. It cannot be diagnosed on the basis of one sign or symptom alone. All of the symptoms of AIDS such as high fever, diarrhoea, loss of weight, Tuberculosis, can be symptoms of other diseases too.
People with AIDS die from serious diseases.	True. In the final stages, the body has little or no immunity left and serious diseases like cancer or kidney failure lead to the demise of the person.
Only men can contract HIV.	False. Anyone who indulges in risk behaviours can get infected with HIV.
Sex is the only way of getting HIV.	False. Unprotected sex is just one of the ways in which HIV can be transmitted.

There is no protection against HIV / AIDS.	False. HIV / AIDS can be avoided through practicing safe behaviours such as abstinence, sex with a single uninfected partner etc.
If you are married you cannot get HIV / AIDS.	False. Marriage is no protection against HIV / AIDS.
HIV / AIDS can only affect people if they do not maintain good hygiene.	False. HIV / AIDS can infect anyone, at any time, if the person indulges in risk behaviours such as unprotected sex, multi partner sex and the use of unsterilized needles and syringes.
All sex workers are suffering from HIV / AIDS.	False. But sex workers are a high-risk group and more vulnerable to infections then others.
HIV / AIDS is a punishment for our sins.	False. HIV / AIDS is a disease caused by a virus that infects people when they indulge in unsafe behaviour.
You can get HIV / AIDS through sharing injecting-needles.	True.
You cannot get HIV / AIDS from a person who has it by holding his / her hand	True. HIV does not spread through everyday contact with people who are infected with HIV. So, we don't need to worry about things we do daily. It is not easy to get HIV / AIDS. Unlike many common diseases, HIV cannot get to us through air, food or water.
If you travel in the same bus as a person with HIV you will also be infected with HIV.	False. HIV does not spread through air, touch, sharing the same space or clothes.
Pregnant women can pass the AIDS virus to their unborn child.	True. HIV can be transmitted from an infected mother to her unborn child. There are about 30 per cent chances that the virus will be passed on to the unborn child. This means that if ten HIV infected mothers deliver babies, only three would be found HIV positive. Babies born to HIV positive mothers may become infected in the womb before birth, during delivery and sometimes through breast milk.
There is no risk in sharing razors with someone who has AIDS.	True. Though it is said that there may be a chance of infection, so far there has been no reported case of infection through sharing of razors.
The AIDS virus, HIV, is carried only through blood.	False. The HIV is also carried through other body fluids (semen, vaginal discharge, and saliva).

It is okay to share bedclothes and food with someone who has HIV / AIDS.	True.
It is possible to get HIV from a toilet seat.	False.
A person can get HIV by donating blood.	True. If the needles used are infected and unclean, then it is possible to become infected during blood donation.
Drug users can pass on the H IV virus to other drug users if they share needles.	True. HIV can also be transmitted through the use of unsterilized needles and syringes. Used needles and syringes are soiled with minute amounts of left over blood. Infected blood will directly transfer HIV into the blood stream. Some injection drug users such as those using heroin tend to share their needles and syringes with other addicts, without sterilizing them, to reduce the cost. This kind of sharing is also likely to transmit HIV, if anyone of the heroin addicts is HIV infected.
You can tell by looking at a person if he / she has the AIDS virus.	False. An HIV infected person looks no different than an uninfected person.
The risk of getting HIV increases if you have many sex partners.	True. Because you cannot ensure that all your partners are uninfected with the virus.
Using the condom reduces the risk of HIV / AIDS.	True. Condom prevents the exchange of body fluids thus reducing the risk of infection.
HIV is spread through kissing.	False.
Children cannot get HIV / AIDS.	False. Children are as vulnerable to HIV infection as anyone else.
If you take the birth control pill you will not get HIV.	False. Birth control pill is a contraceptive and offers no protection against HIV.
People with HIV / AIDS should be kept in prison.	False. Isolation and incarceration are no means of protection against the HIV virus.
You will not get HIV / AIDS if you do not have sex.	False. HIV infection can also be transmitted through blood transfusion, sharing of infected needles / syringes and from mother to child.

The statements used in this chart are not exhaustive. You can make up new statements to suit your needs and setting. The number of statements you use will depend upon the time you decide to devote to this exercise.

Helpline for the Peer Educator

The following information can be used for making a handout, posters, a presentation and for preparing for the sessions on HIV/AIDS.

HIV – what is it?

HIV causes reduction of the body's capability to fight against various infections in human beings. There are two different types of HIV. One is called HIV-l and the other, HIV-2. Persons infected with HIV-2 survive longer than those infected with HIV-l.

Immune Deficiency, Immunity and White Blood Cells: Immunodeficiency is the deficiency of the immune system. The body's ability to fight different infections and diseases lies in the immune system. Some of the body's defences are the intact skin, chemical defences in the bodily openings such as mouth or rectum and membranes in the nose, eyes and the tears in the eyes. The most crucial and highly effective specific defence system is hosted in the blood. White blood cells are the key cells in the fight against various diseases.

HIV is attracted to the white blood cells. It enters these cells and is incorporated into the genetic material present in the nucleus of the cell. Using the host genetic material, it produces virus particles of its own kind in the body.

Opportunistic Infections: Infections that develop because HIV has weakened the immune system are called opportunistic infections. These include respiratory infections such as Tuberculosis, Pneumocystis Carina Pneumonia and Gastro-intestinal Infections, such as diarrhoea and certain types of brain infections. In India, around 60 per cent of persons with AIDS develop Tuberculosis. However, one must bear in mind that all persons infected with Tuberculosis do not have AIDS.

HIV Positive person: A person who has the virus and is harbouring HIV infection. Such an individual is also called a sero positive individual for HIV. This person does not suffer from AIDS.

Unprotected sexual intercourse with an infected person: This is the most common way of transmission of HIV. Around 80 per cent of the people around the globe are infected through this route. HIV is present in high concentration in semen and in cervical and vaginal fluids including the menstrual blood of infected persons.

HIV infection through sexual relations is possible through direct contact between the penis and the vagina in heterosexual intercourse. It is also possible through homosexual contact – penis to anus and vagina to vagina.

A woman is more susceptible to HIV infection than a man. This is because the area of the mucous membrane exposed during intercourse is much larger in the woman than for the man, and the virus can easily penetrate the mucous membrane of the vagina. Also, the concentration of the virus is higher in the semen than the vaginal fluids. In addition, social factors like lower socio-economic status, economic dependence,

lower literacy rates, limited mobility and limited access to information put women at further risk of HIV infection.

STIs are sexually transmitted Infections. They are spread by having sexual intercourse with an infected person. Some of the symptoms of STIs are ulcers and sores in the genitals and a burning sensation during urination. STIs increase susceptibility to HIV infection. This is because semen or vaginal secretions of an HIV infected person can pass through the sores easily.

The HIV / AIDS virus cannot live outside our body for long. We can only contact HIV if the body fluids of an infected person enter our body. The body fluids with a high concentration of HIV in the infected person are: blood, semen and vaginal secretions including menstrual blood. Other body fluids like sweat, urine, tears and saliva do not contain the virus in high concentration. Therefore, there is no risk of transmission of virus from these fluids.

Session 5.2
Quick Spread of HIV virus

Expected Outcomes
Participants will become aware of the scope of the HIV virus and its ability to spread.

Spreads Like Fire

Objective To understand the speed with which HIV infection can spread.

Materials None.

Time 45 minutes.

Process Pre-select 3 participants, and ask them to scratch the palm of every person they shake hands with.

Ask the participants to move around in the room and shake hands with as many people as they want to.

Inform them that some of them will be scratched on the palms of their hands while shaking hands. Those whose palms have been scratched, must in turn, scratch the palm of everyone they shake hands with.

Ask the participants if they have any doubts and clarify accordingly. Allow the game to continue for 10 minutes.

Ask the participants to return to their seats and ask them:

- How many of you have had your palm scratched? Count the number.

Now inform them that initially there were only 3 people who were instructed to scratch the palms of others. Note that within the short span of the game a large number of people were scratched.

Ask the following questions:

- What were you thinking when you were asked to shake hands with others?
- What were your feelings when someone scratched your palm?
- What did you do after being scratched?
- How do you feel now that you understand the significance of the game?
- Did you know the identities of the initial "scratchers"?

Notes for the Facilitator
This game can be used to show the spread of HIV. This is a useful game to start the session on HIV/AIDS as it creates an environment for debate and curiosity. Alternatively, you could play the next game (Session 5.3).

Session 5.3
Quick Spread of the HIV Virus

Expected Outcomes
Participants will begin to appreciate the speed with which the virus can spread.

Oh! So Quick

Objective To help participants understand the speed with which HIV can spread.

Materials Slips of papers marked + and – Ensure that at least 25 per cent of the slips are marked + and 75 per cent are marked –

Time 45 minutes.

Process Fold all of the slips of paper in a box or container.

Make sure you have a slip for yourself that is marked +

Invite the participants to pick up one slip each from the box but not to read it.

Keep your slip with you and invite the participants to walk around the room and greet their friends in their own way. Do the same.

After few minutes, stop the activity, and ask everyone to look at his or her slip of paper. Include yourself in everything you ask the participants to do.

Ask all those who have a + on their slip to come forward. Explain that this game is pretending that these people with the + slip are HIV positive. Make sure that the participants understand that this is only a game and no reflection of reality.

Ask those who greeted the positive slip holders to come forward and join hands with them. Explain that these people are also at risk of being infected with the HIV virus. Once again emphasize that this is a game and HIV does not spread through handshakes.

Look around and see if any are left. Ask them to look at their slips and see if they have the – mark on their slips. Explain that this is a game designed to understand how quickly the HIV virus can spread and that it in no way implies that those with the + slips are actually infected.

Ask the participants the following questions:

- *How many people were originally infected with the virus?*
- *How many are at high-risk of being infected?*

- *How many others are at risk of being infected?*
- *How many remain uninfected?*
- *What does this tell us about the spread of HIV in our community?*

(You may share the HIV/AIDS statistics of your community, country or region at this point).

Note for the facilitator

This is a simple game, but if you are not sure of the participants' reaction to it and feel that it may worry them, do not use it. You must be a participant in this game, as it will reassure the participants and allay their fears. Point out that HIV/AIDS is an important issue for everyone, and we all have to join hands in its prevention and in the care of those who are already living with aids.

How can you tell if someone is HIV positive?

(This material can be used for the preparation of a poster or handout).

- People with HIV look exactly like people who are not HIV positive.
- On average, about half of the people with HIV around the world may still show no symptoms of AIDS. So, even though someone is infected, provided they are well, they can live full, healthy and productive lives.
- There is a difference between HIV and AIDS. People can carry the HIV virus for many years, without knowing they have it. They can look and feel entirely healthy before developing any symptoms of AIDS.
- Most of us do not know whether we are infected with HIV so everyone has to take responsibility for protecting others and ourselves from the virus.

Session 5.4
Facts and Myths about HIV/AIDS

Expected Outcomes

Participants will become aware that not everything they hear or believe about HIV/AIDS is true.
Participants will learn some facts about HIV/AIDS.

Myths And Reality

Objective To enable participants to distinguish fact from myth regarding HIV/AIDS.

Materials List of statements, flash cards, markers

Time 1 hour

Process Invite the participants to create some space in the training room to allow movement.

Explain that they will be doing an exercise on facts and myths related to HIV/AIDS.

Ask the participants to choose 2 ends of the room. One end of the room should be marked "I Agree" and the other end "I Do Not Agree". People who cannot make up their minds can remain in the centre.

Read out each statement, and invite the participants to take their stand. Ask them to justify their stand by giving reasons. Continue until the list has been completed.

Ask the participants to return to their seats in a circle. Have a small discussion using the following questions:

- *What did you learn from this exercise?*
- *Were you surprised at some of your responses? Why?*
- *How could you distinguish between myths and facts? What helped you in making the distinction?*
- *How can you share the information you have gathered from this exercise with your friends?*

Note for the Facilitator

This exercise is useful at the beginning of the session on HIV/AIDS. It allows the participants to check their knowledge/beliefs about the subject in a safe environment. It allows the facilitator to control the situation and plan the information segment on HIV/AIDS. You may have to assure the participants that this exercise is not a test or competition. As a facilitator, you should read up on the subject prior to doing this exercise, as you will be responsible for giving the correct responses to all statements.

List of statements that may be used for the exercise

People with HIV cannot lead productive lives.
People who have AIDS are eventually going to die.
Children who have HIV cannot attend school.
Coughing and sneezing do not spread HIV / AIDS.
HIV infection cannot be transmitted through the sharing of needles and syringes.
Parents with HIV always have children with HIV.
AIDS is caused by a virus called HIV.
Mosquito bites can spread HIV.
AIDS is not a disease, but a condition due to which a person becomes vulnerable to any infection.
Pregnant mothers can pass the infection to the baby.
AIDS is spread through sex with an infected person.
People with HIV can live a healthy life for many years.
People with HIV always look sick and unwell.
Recently a cure has been discovered for HIV / AIDS.
Before blood is given or taken, it should be tested for HIV / AIDS.
AIDS does not concern children.
Women are more susceptible to HIV than men.
We should never share food and clothes with a person who has HIV / AIDS.
People with HIV need good food and rest.
People who have HIV / AIDS should not be allowed to work.
Drug users should not be helped if they become HIV infected.
Only people with abnormal sexual habits get HIV / AIDS.
Sex workers deserve to get HIV / AIDS.
Only poor people can get HIV / AIDS.
It is difficult to get treatment and care for HIV / AIDS.
The government is doing enough for the prevention of HIV / AIDS.
Health care workers are more susceptible to HIV / AIDS infection.

Helpline for the Peer Educator

The following material can be used for the preparation of posters, handouts and presentations. The peer educator can also use the material for pre-training preparation.

Important facts

- Human Immunodeficiency Virus (HIV) causes AIDS.
- People who are infected with HIV often have no symptoms of disease for many years and therefore, can infect others without realizing it.
- AIDS refers to specific clinical manifestations seen during the later part of HIV infection when people are ill as a result of opportunistic infections.
- Although many of the opportunistic infections seen in AIDS can be managed, there is presently no cure for AIDS. Most people with AIDS ill eventually die of the syndrome.
- Prevention at present is the only cure. Health care workers have an important role in teaching their patients and their colleagues how HIV is and is not transmitted, and how people can protect themselves from being infected.

There are 4 modes of HIV transmission

Unprotected sexual contact: risk of transmission is about 1 per cent and can be transmitted from an infected man to woman, infected woman to man, infected man to another man, infected woman to another woman. It is possible to get the infection from a single sexual contact with an infected person.

Infected blood transfusion: risk of transmission is about 90 per cent.

Sharing of infected syringes and needles: risk of transmission is about 60 per cent.

From infected mother to child: risk of transmission is 25 to 40 per cent and may happen at the time of delivery and through breast-feeding.

Body fluids that contain large a viral load and can cause transmission of HIV. This includes – blood, semen, vaginal fluids, cerebrospinal fluids, amniotic fluids and breast milk.

Body fluids and HIV transmission

A	B	C
Blood **Semen** **Menstrual blood** **Vaginal fluid** **Breast milk**	**Sweat** **Tears** **Saliva** **Skin oils**	**Cerebrospinal fluid** **Amniotic fluid** **Faecal matter**

The fluids in column **A** contain a high enough concentration of HIV to infect and can be exchanged. The fluids in column **B** contain too small a concentration of the virus to infect, and the fluids in column **C** are not likely to be exchanged between people.

Prevention of HIV

HIV is a fragile virus and its transmission can easily be prevented by the avoidance of risk behaviour.

Sexual mode of transmission: The various methods of prevention of HIV through the sexual route include abstinence, non-penetrative sexual practices, maintenance of mutual faithfulness among partners, the practice safer sex and the use of a barrier method including condom. All these methods of prevention are equally true for homosexual relationships.

Parenteral: The methods of prevention of HIV transmission through parenteral route include the practice of universal precautions by health care workers, sterilization of needles / syringes, avoidance of needles / syringes sharing. Screening all blood / blood products before transfusion is also necessary.

Vertical transmission: The methods of prevention of HIV from infected mother to child include avoiding pregnancy, ensuring hospital delivery, avoiding breastfeeding and dispensing newer medication to prevent mother to child transmission.

Ways in which HIV cannot be transmitted

- Drinking water or eating food from the same utensils used by an infected person.
- Socializing or living with people with HIV / AIDS.

- Hugging, touching or kissing.
- Caring and looking after people with HIV / AIDS.
- Getting bitten by an infected person.
- Working in the same place as an infected person.
- Use of the same toilets as an AIDS patient or an infected person.
- Sharing telephone or computers.
- Sneezing and coughing.
- Getting bitten by a mosquito.
- Donating blood if sterilized equipment is used.

Session 5.5
Reflection of Self

Expected Outcomes
Participants will become aware of their own risk behaviour.

Do I Take Risks?

Objective To help participants reflect on their own behaviour regarding risk taking in general.

Materials Flip charts, markers

Time 1 hour or more depending on the number of participants

Process Invite the participants to sit in a circle. Explain that they will be doing an exercise to understand the concept of risk taking through a reflection of their own behaviours in life.

Ask the participants to make themselves comfortable. They can stretch, walk around or simply close their eyes and relax.

Invite them to reflect for about 10 minutes on their life and identify an incident or situation where they think they have taken a risk. It may be a small incident or a major situation. It may be that some participants may not be able to identify such a situation. This is not a problem. Give small hints and examples to help the participants.

Now, start at one end of the circle, and ask them to share their reflections. Even those who cannot remember an appropriate situation should share their experience. If all they have to say is, "I have never taken a risk" that is fine.

When everyone has finished sharing, ask them to answer the following questions (you may record the responses on a flip chart):

- *Why did you take a risk? What factors influenced you?*
- *What were your feelings at the time?*
- *What was the out come of taking the risk?*
- *Do you generally take risks?*
- *How do you view risk taking in others?*
- *What implication does this have for your attitudes towards HIV/AIDS?*

Note for the facilitator

Often, we feel that risk taking is all right and even courageous, if it turns out well. But, if things don't turn out well, we tend to look for someone to blame. When we do this we become harsh and judgmental. The fact is that we all take risk all the time – when we walk in a field at night, when we cross a road or give birth to a child. The important thing to remember is the consequences. Link this to risk taking behaviours that can lead to HIV infection.

Session 5.6
Understanding Risk-Taking Behaviour

Expected Outcomes
Participants will be able to identify behaviours that have a high-risk for HIV / AIDS.
Participants will know why some behaviour is classified high-risk.

Scoring The Risk!

Objectives To list various taboo behaviour / practices exhibited by young people. To be able to correlate these with the risk of transmission of HIV / AIDS.

Materials Small stones, flash cards, markers, flip charts

Time 1 hour

Process Invite the participants to sit on the floor in a circle. There should be a wide space at the centre of the circle for a person to move around.

Explain that the participants will be doing a simple scoring exercise in order to understand the risks linked to various behaviour / practices relating to the transmission of HIV / AIDS.

Young people take many risks and indulge in behaviours / practices that can lead to HIV infection. These behaviour / practices may include sexual activities, such as vaginal intercourse and anal sex and non sexual, such as injecting drugs.

Ask for a volunteer. Invite him / her to sit in the centre of the circle. Place some flash cards and markers next to him / her.

Ask the participants sitting in the circle to call out behaviour / practices that young people indulge in. These practices should be unacceptable in society or viewed as dangerous to their health and others' health. As each behaviour or practice is called out, ask the volunteer to depict it on a flashcard either using words or drawings. The volunteer can seek help from the other participants in doing his / her task.

Ask the volunteer to place the cards on the floor in a vertical line. Ask the participants to count the number of cards on the floor. Tell them that they will now score each behaviour / practice from the list. The scoring should be done on the basis of the risk involved with each behaviour in relation to HIV infection.

For this purpose, the highest score will be the total number of cards. For example, if there are 15 cards, the highest score that the group can

give will be 15. Ask the group if they would like to make the lowest score possible zero or one.

Ask them to decide whether they will use low scores to depict low risk and high score to depict high-risk. Once the decision has been made, ask some volunteers to use small stones (leaves, seeds or pebbles) as markers.

Ask the volunteer to start at the top of the vertical line and proceed downward. The volunteer should read out each of the cards and ask the group what score it would like to give to the behaviour written/shown on the card. The scores must be based on consensus. At all times, remember that the behaviour is being scored on the basis of the risk involved (risk of contracting HIV/AIDS).

Let the group finish the exercise while you observe and facilitate only when necessary.

You may have to point out to the group that there is behaviour that may not be acceptable to some participants, but the scoring should be done only on the basis of the risk involved.

Note for the Facilitator

The facilitator may have to add certain behaviour to the list if they do not emerge from the group. This exercise is simple and can be done in a mixed group. It allows the group to discuss the positives and negatives of each behaviour and practice. The facilitator can enhance the quality of the discussion by asking some questions. Please remember that the scoring will reflect the participants' perspective on what they consider low or high-risk. It is the facilitator's responsibility to give the correct information on the emerging perspectives. The facilitator may use the following material to guide his/her inputs:

Table showing behaviour that young people experiment with and the associated risk for becoming infected with HIV:

Behaviour/practice	**Risk of HIV transmission**
Anal sex	High-risk
Vaginal sex	Medium to high-risk
Oral sex	Possible
Vagina to vagina contact	No risk
Masturbation	No risk
Mutual masturbation	No risk
Kissing (deep mouth)	No risk
Breast sex (penis between breasts)	No risk
Thigh sex (penis between thighs)	No risk
Body rubbing	No risk
Pornography	No risk
Cyber sex (sex on the internet)	No risk
Telephone sex	No risk
Fantasy sex (thinking/dreaming about	No risk

having sex)	
Smoking cigarettes and marijuana	No risk
Sniffing glue	No risk
Injecting drugs into the blood stream	High-risk
Visiting sex workers or undertaking sex work	High-risk
Drinking alcohol and having sex	Medium risk
Tattooing	Low risk activity if needles are sterilized. The chances of infection through tattoo needles are very low, but one must not eliminate the chances of infection, especially in cases of group tattooing.
Sharing needles with a group of injecting drug users	High-risk. Sharing needles increases the chances of HIV transmission, as the needles can contain minute amounts of blood that might contain the virus.
Having many sexual partners	High-risk. A high number of partners increases the possibility of acquiring HIV.
Sharing a needle cleaned with water	High-risk. Just cleaning the needle with water or spirit does not prevent HIV transmission. The needle and syringe have to be cleaned twice with water, twice with bleach and again twice with water or should be boiled for twenty minutes before using. Sharing a needle should be avoided.

This table is indicative of the behaviour that young people may list. The list will vary from group to group, and there is no need to force the group to include all the examples. As this is a participatory exercise, the assumption is that the group will list only those behaviours that are practiced by the members of the group or that they are aware of within their peer group.

Session 5.7
Understanding Non-Sexual Ways of HIV Transmission

Expected Outcomes
Participants will know that HIV can be transmitted through non-sexual behaviour.

Other Ways Of Getting It

Objective To know about the non-sexual ways of HIV / AIDS transmission.

Materials Flip charts, markers.

Time 30 minutes.

Process Invite the participants to sit in a circle.

Explain that there are many ways to become HIV infected. Some of these ways are sexual and some are not. This exercise is concerned with the non-sexual ways of HIV / AIDS transmission.

Write on a flip chart – What are the non-sexual ways of contracting / transmitting HIV / AIDS? Read the question out loud.

Ask the participants to discuss with the person sitting on his / her right. Allow 2 minutes.

Ask them to call out their responses.

Record the responses on a flip chart.

Use the following questions for a short discussion:

- *What are the chances that a young person would become infected with HIV/AIDS through these means? Why?*
- *Have you ever indulged in any of the behaviour and practices listed here? How do feel knowing that this could lead to an HIV/AIDS infection?*
- *Can you list ways in which you can help yourself and your friends in protecting themselves against HIV infection?*

Note for the Facilitator

Non-sexual behaviour and practices that may lead to HIV / AIDS infection are also common among the young people. One way to increase the value of this exercise is to bring out the gender dimension in some of the behaviour and practices. For example, injecting drug use is primarily seen as a man's problem, but this is not true. Women also inject drugs and find it extremely difficult to access clean needles and syringes.

Session 5.8
Understanding Protection against HIV/AIDS

Expected Outcomes
Participants will learn methods they can employ to protect themselves and others from becoming infected with HIV/AIDS.

Protection

Objective To learn ways that people can protect himself or herself from contracting HIV/AIDS.

Materials Flip charts, markers, blackboard/white board.

Time 1 hour.

Process Divide the participants into 3 groups.

Group 1 should draw up a list of safe behaviour/practices related to sexual intercourse.

Group 2 should draw up a list of safe behaviour/practices related to unsterilized needles and syringes.

Group 3 should draw up a list of safe behaviour/practices related to blood contact and use of blood products.

Ask the groups to go to three different locations in the room for this exercise. Give the groups 30 minutes to do this exercise. Encourage them to use drawings in their presentations.

When the groups return, ask them sit on the floor in a circle. One member from each group should come to the centre of the circle, spread their charts out (one by one) on the floor and read them out.

Ask the participant to discuss each behaviour written/shown on the charts, and focus on the reasons that they are acceptable or unacceptable for protecting themselves from HIV/AIDS.

Note for the facilitator

While the participants discuss each behaviour/practice, record their responses on a flip chart. The discussion may bring out issues like the inability to say "No", peer pressure, expectations of parents, fear of society or fear of contracting HIV, poor self image, desire to gain acceptance amongst friends, being assertive and aware, and exercising the right to make a choice. Tell the participants that it is normal to have such responses, and that during the course of the training they will be able to learn about ways and means of enhancing certain behaviour/practices and changing some others.

The exercise may not bring out the ways in which a pregnant woman can protect her child against infection from HIV/AIDS. If this occurs, include it in your summary.

Session 5.9
Basics of HIV/AIDS – Distinguishing between Safe and Unsafe Behaviour

Expected Outcomes
Participants will be able to test their comprehension of the preceding exercises. Ascertain what to emphasize in the forth-coming sessions.

Safe! Unsafe!

Objectives To reinforce the ability to distinguish between safe and unsafe behaviour / practices.

Materials 4 previously prepared scenarios (given at the end of the exercise), flash cards (two different colours), flip charts, markers.

Time 45 minutes.

Process Ask the participants to divide into 4 groups.

Explain that HIV / AIDS is transmitted in various ways as learnt during the course of the day. This exercise will help us test our learning and clarifying any doubts and questions that still remain unanswered.

Give one scenario sheet to each group with two different colour flash cards and markers.

Ask each group to read their scenario sheet, discover the safe and unsafe behaviour in it and get ready for their presentation. Tell them that they should use one coloured flash card for writing the unsafe behaviour and a different coloured card for safe behaviour. For example, if yellow cards are used for the unsafe category, then all 4 groups should use yellow cards. All groups should write safe behaviour on the green cards.

While the groups are busy with their work, put flip charts up on the wall. Mark one “SAFE” and the other “UNSAFE”.

When the groups come back, ask them to put their safe behaviour cards on the “SAFE” charts and the unsafe behaviour cards on the “UNSAFE” charts.

Ask the groups if they were able to identify the safe and unsafe behaviour easily. Why / Why not?

If there are any errors, correct them and explain.

Note for the facilitator
This is a quick exercise to help participants recap their learning on HIV / AIDS.

Given below are the 4 scenarios that may be used by the peer educator for this exercise:

Person A has a relationship that involves kissing, hugging, touching and at times having oral sex without using a condom or barrier. She uses birth control pills. She also plays many sports that involve sharing clothes and bathing facilities.

Person B has sexual intercourse with her boyfriend and insists on using a condom. Her boyfriend has not told her that he has had sex with a number of partners without using a condom. At times, he shares needles with his friends while injecting drugs. She does not know this either.

Person C used un-sterilized needles when she got her ears pierced. She has a boyfriend with whom she watches movies, holds hands and sometimes enjoys sexual pleasure through mutual masturbation.

Person D has a lover of the same sex who is HIV positive. They use condoms while having sex, enjoy rubbing each other's body and reading pornographic material. However they share razors, clothes and utensils.

Session 5.10
Vulnerability to HIV/AIDS

Expected Outcomes

Participants will understand what circumstances can lead to HIV infection.
Participants will understand the multiple and complex reasons for the choices people make and the affect they have on their lives.
Participants will learn that certain people are more vulnerable to HIV infection than others.

Who Is More Vulnerable?

Objective To explore the vulnerability of certain people to STIs and HIV, as it relates to a number of economic and social issues. To explore risk taking, as it pertains to particular behaviour.

Materials Flip charts, markers, case studies (the case studies are given at the end of the exercise).

Time 2 hours.

Process Ask the participants to divide into 4 small groups.

Explain that each group will receive one case study. They should read the case study, and answer the questions asked at the end.

They have 30 minutes to do this exercise.

They should write each question and the answer on a flip chart and get ready for their respective presentations.

Visit each group while they work and encourage them to discuss the issues raised in the case study. Ensure that active discussion takes place and that answers are based on consensus.

When the groups reassemble, ask them to put the flip charts up on the wall. Start the presentations, and discuss the emerging points after each presentation.
The issues that you may want to focus are as follows:

- Higher vulnerability of certain groups of people to STIs and HIV.
- Social/personal attitudes towards sexuality.
- Impact of economic conditions on people's vulnerability and risk taking behaviour.
- Accessibility of STI and HIV prevention education and relevant services.
- Risk taking behaviours and safe behaviour.
- Power versus vulnerability.
- Rights and duties.

Note for the Facilitator

This is an effective exercise to encourage discussion on issues that usually get left out of an HIV/AIDS training curriculum, i.e., issues of alternative sexuality, vulnerability, poverty, access, power, gender, rights and duties. HIV/AIDS is intrinsically related to all of these issues. Therefore, it is essential that people examine their own prejudices and beliefs about these issues. Be patient and sensitive while facilitating the discussion. Help the participants explore their responses through your questions.

Case studies should be prepared from real experience. Hypothetical case studies do not serve any purpose. You can find appropriate case studies from newspapers, magazines, journals, publications of various NGOs/INGOs and research studies. If possible, use case studies from newspapers and magazines read by the people in your locality. The case studies used should be place and culture specific. The case studies given below are indicative of the case studies that can be used for this exercise.

Case 1

Rahim's Story

Rahim is 17 years old and alone in a large metropolitan. He lost his parents when he was 12 years old and has been working at odd jobs since. Somewhere along the line, he began selling sex for money. He is not proud of what he does but feels weighed down by his circumstances. He feels that he has no other option because he has limited skills. Today is one of the days he is completely broke. His health has been bad and he feels weak. Nevertheless, he decides to go to the park where other boys like him hang around and get picked up by men who want to have sex with men.

Dheeraj is a businessman. He is 32 years old and has been married for two years. He likes to have sex with men and pays for it if necessary. He visits the park where Rajesh waits for his clients. Dheeraj is not comfortable with his sexuality and is frightened that people will find out. Because of his anxiety and fear he is often rough with his partners. He knows about the dangers of having multiple partners, STIs and HIV, but believes that it cannot happen to him. He rarely uses condom and dislikes anyone asking him. As he walks around the park looking for a potential partner, he meets Rajesh. He asks Rajesh to come with him for a few hours and offers to pay a good price. Rajesh does not feel comfortable with this man but decides to go with him since he badly needs the money.

Questions for discussion

- *Why does Rajesh work as a sex worker?*
- *Why is Dheeraj uncomfortable about his sexuality?*
- *Why does Dheeraj ignore his knowledge about contracting STIs/HIV?*
- *Do you think Rajesh is working in a safe environment? What are his chances of contracting STIs/HIV and being physically beaten or abused?*

Case 2
Marriage of Maria and John

Maria and John have been married for 2 years. Their marriage was arranged by their families. Maria is 17 years old, and John is 26 years old. John has been working in a garment factory in a metropolitan city since he was 20 years old. Maria grew up in a small village, far removed from the city. After the wedding, she came to live in the city with her husband. Maria has heard from her neighbours that John used to have many girl friends. One day she asks him about it, and he beats her. John is feeling very depressed and worried. He is feeling weak and unwell but is unable to talk with anyone. He comes home late at night, or not at all. Maria is very concerned about his late nights and drinking habit. She decides to talk to one of the elderly woman in her neighbourhood who has been very kind to her. She feels that Aunty Rachel will be able to guide her. Rachel is a nurse in the local health care centre.

When Maria tells her about John and the problems they have been having, she advises Maria to avoid having sex with her husband. She tells Maria to ask John to get himself checked for the health problems he has been having. She also tells Maria about contraceptive methods and the possibility of John having contracted a STI. Maria is frightened of the possibilities and of her husband's reaction if he finds out about her talk with Aunty Rachel. She is unable to refuse sex with her husband, and she is not able to talk with him. Meanwhile, John is getting more and more violent and unhappy.

Questions for discussion

- *Why do you think Maria is unable to speak with her husband?*
- *Why is John so violent and depressed?*
- *How can Maria and John find a solution to their problems?*
- *Who should they seek help from?*

Case 3
Running away from home

Saira ran away from home when she was 15 years old. She wanted to become a film star. She is now 20 years old and working in a bar as a waitress. She is very popular with the other girls who work in the bar. However, Saira feels alone and depressed. She is aware that she has not been able to achieve her dream. Over the years she has been involved with many men. Some promised her a break in the films, while others said they loved her, but nobody has come through on their promises. She often has sex for money but on her own terms. She goes for regular health check ups and insists on the use of condom while having sex. However, she is using drugs to deal with her depression and loneliness. Her dependence on drugs is increasing, and one day she finds herself injecting drugs with a group of friends. She believes that she is only experimenting and that she will be able to kick the habit. Anna is her close friend and she is worried. Anna tries to warn Saira about the dangers of her life style.

Questions for discussion

Why is Saira in this situation?
What are the dangers of her life style?
How can her friend Anna help her?
What do you think are the consequences of unrealistic aspirations?

Case 4

Ling's story

Ling is the only daughter. She has one brother who is in the eleventh grade. Her father is an engineer and works in a private company. Her mother is a housewife. Her father believes that girls should not be highly educated, so he stopped Ling's education after the twelfth grade. The home environment has never been good. The mother and father fight almost every day, and the father drinks a lot. Ling never felt close to her mother and father and found affection in a friend of her father. He often came to her house and showered her with gifts and attention. Eventually she became very close to this man. He told her that he would marry her and love her forever. He was already married but promised to divorce his wife, as she could not have a baby. Ling believed him and trusted him completely. She became involved in a physical relationship with him and started having sex with him. He duped Ling and refused to marry her. She realized that he would never marry her and that he had many such relationships with other young women. Ling wanted to expose his behaviour, but he threatened to ruin her family and her reputation. She was very scared and ashamed. She did not tell her parents about the relationship, and the man also stopped visiting her house.

Ling decided to move on with her life, but she became ill and had to go to a doctor. She was diagnosed with a tumour in the stomach and surgery was advised. The tests revealed that she was infected with HIV, and the surgery could not be done. She was asked to go to some other clinic where people like her were admitted. She did not reveal the results of the test to her parents because she believed that this would hurt them. She searched for an organization or person that could help her and guide her. Often she thought of killing herself, but she found a counselling centre. Eventually she joined the centre as a part time counsellor. Now she feels that she has come to terms with her situation and is in a position to help other girls who may be in a similar predicament. She also plans to tell her parents about it.

Questions for discussion

- *Why did Ling get involved with an older, married man?*
- *How could she have avoided getting into this situation?*
- *How did she handle the situation?*
- *Does our society force us into certain situations? In what ways?*
- *What is the impact of our society on our behaviour?*

Session 5.11
Becoming Sensitive to Others

Expected Outcomes

Participants will begin to appreciate that people can have sexual preferences that may be different from their own.
Participants will know that for some people it is difficult to do the things that most of us take for granted.
Participants will become aware that certain groups of people in society are more vulnerable to exploitation and diseases than others.

I Feel, I Believe, I Think!

Objectives To explore attitudes about different sexual orientations.
To raise awareness about the difficulties that people with different sexual orientations face.

Materials Chalks, flip charts, markers, 7 to 8 identity statements.

Time 2 hours.

Process Explain that the exercise will enable the participants to explore their attitude toward people with varying sexual identities and allow them to see how the social environment restricts or marginalizes certain peoples' access to services and other benefits of being a citizen.

Assure the participants that there is no need to feel scared or inhibited in their responses; no one will ridicule or look down on them.

Ask the participants to divide into 6 groups.

Draw a table with 6 columns and 10 rows on the floor with a piece of chalk. The number of columns will depend on the number of small groups, so you may have 4 columns (or 5 or 6 or 8).

Tell the groups that the 10 rows represent 10 questions that can be answered only "yes" or "no".

Each group will be given an identity card, and they must respond to the questions from the assumed identity's point of view.

Ask the groups to stand at the head of each column. Each question will be directed to all the groups. They can take 2 minutes to discuss their response as a group. If the response is "yes," they can move one step forward, and if it is "no," they stay where they are.

All questions are related to the levels of empowerment and marginalization of the characters in the context of the larger society. To help the participants understand the exercise, use the first question

as an example. Help the teams work out their responses. If their response is "YES," make sure they take a step forward, and if it is "NO," they must stay in the same place.

After the teams respond to each question, discuss their reasons for their response.

Upon completion of the exercise, ask the participants to come back to the larger group.

Use the following questions for discussion:

- *How did the groups feel about the position of the individual they were representing?*
- *Did they feel happy, unhappy, discriminated against or frustrated?*
- *Did they feel surprised by the outcomes?*
- *Why do certain groups of people in society feel helpless and marginalized?*
- *Are these groups more vulnerable to STIs and HIV? Why/Why not?*
- *Do feelings about self have an impact on behaviour? Why/Why not?*

Note for the Facilitator

This exercise requires sensitivity. Encourage the participants to discuss their responses and the reasons for the responses. Summarize the outcomes of the exercise. If they exhibit signs of embarrassment or hesitation, reassure the participants. Sometimes, it may be necessary to do this exercise with separate groups of men and women. Observe the comfort level of the participants and then decide. Usually men and women have different responses to the questions, and it might be interesting to compare the gender-based differences.

List of identities that can be used for this exercise

Choose the identities depending on the number of groups that are formed.

i. A 13-year-old girl who sells her body for survival.
ii. A young male (17 or 18) who feels attracted to members of his sex.
iii. A young woman who is homosexual and open about her sexual preference.
iv. A middle aged married corporate executive who occasionally goes to public parks and pubs for sex with other men.
v. An exclusively heterosexual woman who is unmarried and believes that any other sexual identity is unnatural.
vi. An exclusively heterosexual male, educated and liberal in his thoughts, who is married and comes from a well to do family.
vii. A young bisexual woman who works in a brothel.
viii. A young male student who is open about his homosexual identity.

*** When choosing the identities, be certain that one group gets the purely heterosexual identity. While others are optional, this is a necessity.**

Questions for the exercise;

i. Someone threatens to expose your homosexual identity to your family and friends. Can you respond with confidence that it does not matter to you?

ii. Are you friends with other people who share similar sexual behaviour or identities?
iii. Can you talk comfortably to everyone you know about your sexual behaviour and identity?
iv. Would it be easy for you to find relevant information about sexual health in a local/government clinic?
v. Are there social spaces like bars, cafes, discos, and parks, where you can meet other people who share the same identity as you?
vi. Would it be easy for you to insist that a condom be used during sex?
vii. Could you have a long term and fulfilling relationship?
viii. Could you leave that person?
ix. Do you think you could give up your identity and live happily?
x. Can you pass for heterosexual in public?

Helpline for the peer educator

This material can also be used to make handouts and posters.

I. Definition of Sexuality

Human sexuality begins at birth and ends at death and is a function of your whole personality. It includes the following:
a) How you feel about yourself as a person.
b) How you feel about being a woman or a man.
c) How you get along with members of the same sex and the opposite sex.

Sexuality includes genital and reproductive processes, such as intercourse and childbearing, but it is much more than this. Human sexuality includes desires, feelings, acts, values and attitudes. It involves:
a) Biological aspects.
b) Psychological aspects.
c) Social aspects.

Sexuality is, in its broadest sense, a psychological energy that finds physical and emotional expressions in the desire for contact, warmth, tenderness and love. Sexuality is the part of a person that cannot be removed from the all other parts.

The scope of normal sexuality is very broad and includes; relationships, affection, intimacy, body image, touch, feelings, caring, sharing, intimacy, personality, identity, emotions, thoughts and actions. Having a sexual dimension to our personality is normal. There are innumerable ways of being sexual, for example, looking at each other, talking together, sharing work, holding hands, embracing, necking, petting, fondling or kissing.

II. "Normal" sexual behaviour

It is now recognized that there are many variations of sexual behaviour. Normal for one might be abnormal for another. Culture, tradition, society and our own emotions and experiences have conditioned our thinking. Whatever our beliefs or personal views may be, we must learn to be non-judgmental with regard to alternative sexual behaviour.

III. Criteria to evaluate what is "normal" in a relationship could be:

a) Consent between the two partners to enact what gives them mutual pleasure including oral sex, variations in coital positions or anal sex.
b) Any sexual activity that does not cause physical or mental harm.
c) It should be a private affair (not public).
d) The activity should not be exclusive, e.g., one partner insisting that only one kind of sexual act be performed.

IV. Various kinds of safer sexual practices

Kissing	Individual or mutual masturbation
Fondling	Sex with underclothes on
Talking, writing or reading about sex	Sex with other parts of the body (thighs or breasts)
Watching sexy movies & live shows	Penetrative oral, vaginal and anal sex with condom.

V. Sexual practices and their risk of HIV transmission

Sexual Act	***Risk of HI V transmission***	***Grading of risk (1-5)***
a) Anal Sex	Yes	4
b) Oral Sex	Possible	2
c) Vaginal Sex	Yes	3
d) Tribidism	No	1
e) Masturbation	No	1
f) Mutual Masturbation	No	1
g) Kissing (deep mouth)	No	1
h) Rimming (mouth to anus)	Possible	2
i) Breast Sex (penis between breasts)	No	1
j) Thigh Sex (penis between thighs)	No	1
k) Frottage (body rubbing)	No	1
l) Water Sports (golden shower)	No	1
m) Sadomasochism (whips, chains, handcuffs, etc.)	No	1
n) Pornography	No	1
o) Cyber sex (sex on the internet)	No	1
p) Telephone sex (sex on the telephone)	No	1

**** Note: 1 denotes no risk and 5 denotes high-risk.***

VI. Sexual health

Sexual health is the integration of the somatic, emotional, intellectual and social aspects of the sexual being in ways that are positively enriching and that enhance personality, communication and love.

It is the capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic. It is also the freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships. It is also the freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.

To obtain sexual health, a person must

a. Be able to say “yes” or “no” to sexual encounters and respect a partner's wishes.
b. Have proper information about sex.
c. Be physically well and free from sexually transmitted diseases.

Session 5.12
Understanding Safe Sex

Expected Outcomes
Participants will learn that certain sexual behaviour is safe and some is unsafe.

Sex Is Safe!

Objective To review safer sex messages for HIV transmission.

Materials Flash cards, markers, flip charts.

Time 45 minutes.

Process Ask the participants to sit in a circle on the floor. Give them a stack of flash cards and markers.

Explain that they should draw up a list of sexual practices using one card for one practice. They may use the colloquial terms for describing these practices.

Once they finish the list, ask them to place these cards in order of decreasing safety, starting with the safest practice and ending with the least safe practice (safe and unsafe are in the context of STI and HIV infection).

Encourage the participants to share their reactions and ideas about each practice. Focus on the benefits and risks of each practice in terms of STI / HIV transmission.

Note for the Facilitator

The facilitator should be prepared to give his / her feedback on each practice regarding its safety and risk potential. Safe lifestyle practices are abstinence, monogamy, sex with one uninfected partner, and sex using condoms.

During the facilitation of this exercise, remember that it is a participatory exercise. Therefore, the arrangement of cards should be based on the participants' consensus after discussion on each point. It may be that the participants place a card with high-risk behaviour at a place that shows it as low risk behaviour. Do not make corrections while the participants are still doing the exercise. After the exercise, inform the group that the card they placed in the low risk place is actually a high-risk card and give the reasons. The group should discuss the issue and change the position of the card (if so decided).

If the group you are working with is comfortable, try the following.

It is an interesting activity and a valuable tool to discover what sexual experience the participants have had. Use an anonymous method to get a more accurate indication of the variety of practiced.

One option is to have a series of boxes. There should be labels with different types of sexual behaviour on the boxes. The boxes should be arranged in a separate room or behind a screen. (Make sure the boxes are secure and one cannot see through them or retrieve the slips).

Give a few strips of plain white paper to each participant. Ask each participant to visit the room with the boxes, (they will be behind a screen) and put their slips of paper in the boxes that correspond to their preferences / experience. After all of the participants have had a turn, the facilitator can count the slips in each box and announce the results.

The other option is to use a questionnaire such as the following:

	Male	Female	Yes	No
Have you ever masturbated?				
Have you ever had oral sex with someone?				
Have you ever had penetrative vaginal sex with some one?				
Have you ever had anal sex?				
Have you ever been attracted to a person of the same sex?				
Have you ever had a pleasurable sexual experience with a person of the same sex, even if it is just a kiss or caress?				
Do you like having sex with the same sex person?				
Do you have sex with someone regularly?				
Do you like reading sexually arousing materials?				
Do you like watching pornographic movies?				
Do you visit sex workers?				
Has someone ever forced you to have sex?				
Have you had a violent sexual experience?				
Do you like talking about sex?				

Pre/Post Test Questionnaire to gauge the participants' level of understanding of HIV/AIDS (you can use this questionnaire either before the start of the session on "Understanding the Basics of HIV/AIDS" or after you finish the session. In the first instance, the results will be a baseline and training needs assessment tool that will allow you to design your sessions. In the second instance, the results will allow you to test whether the participants have absorbed the information given during the session).

1. How much do you think you know about HIV / AIDS?

2. List the modes of HIV transmission.

3. Is there a difference between HIV and AIDS?

4. Is HIV / AIDS preventable? How?

5. Can you guess the number of people infected with HIV / AIDS living in the country? How many of these are in the age group of 15 to 24 years?

6. How can the spread of HIV be reduced or prevented among youth?

7. List some of the implications of HIV / AIDS for the youth?
8. Is there a link between STIs and HIV? What?
9. Can HIV / AIDS be cured?
10. What tests are available for HIV diagnosis?
11. Where should people living with HIV / AIDS go for treatment?
12. Who is responsible for the care of people living with HIV / AIDS?
13. What are the rights of people living with HIV / AIDS?

Module 6
Drugs and Substance Use

FLOW CHART

Content Flow at A Glance
Module 6: Drugs and Substance Use

Subject/topic/activity	Objective	Page No.
Introduction to drugs and injecting drug use.	To give a background of the drug use in the Asian and Pacific Region and to establish the link with HIV / AIDS.	6-2 to 6-4
Some critical concepts	To explore the answers to some basic questions on substance use.	6-5 to 6-18
Exercise – Exploring substance use.	To develop a common understanding of substance use.	6-19
Exercise – Myths and facts about drugs.	To provide correct information about drugs and drug use.	6-20 to 6-23
Exercise – I am choking!	To raise awareness on smoking and tobacco use.	6-24 to 6-27
Exercise – I feel woozy!	To demonstrate the affect of alcohol use.	6-28 to 6-30
Exercise – Scoring and ranking the reasons.	To understand the reasons for drug use among young people.	6-31 to 6-34
Case Study – Story of Woo.	To raise awareness on the consequences of drug use.	6-35 to 6-36
Role-plays – Resolving an issue.	To make and practise strategies for dealing with risk situations.	6-37 to 6-38
Exercise – No, thank you.	To practise negotiation and refusal skills.	6-39 to 6-41

Module 6
Drugs and Substance Use

"Live neither in the entanglements of outer things, nor in inner feelings of emptiness".

Sengstan

I Introduction

The consumption and injecting of illicit drugs is increasing around the world, involving perhaps 20 million people in more than 120 countries. Patterns of production, consumption and administration of illicit drugs have changed rapidly in the past and continue to change rapidly. Countries where the most rapid changes are occurring, involving the biggest populations, are in the developing world, especially in south and South-East Asia and Latin America. Many Western countries experienced epidemics of heroin injecting beginning in the late 1960s and continuing through the 1980s and 1990s. Many Asian countries began to experience such epidemics in the late 1980s, and this trend is continuing.

The injecting of heroin is now a problem in over 100 countries world wide, with an estimated 10 million people regularly injecting heroin globally; over 80 of these countries have reported HIV infection among these injecting drug users (IUDs).

II Injecting Drug Use and HIV/AIDS

The three epidemics – of drug use, of injecting drug use, and of HIV infection among injecting drug users– can develop extremely quickly, and often unexpectedly.

The diffusion of HIV among injecting drug users (IDUs) has been most pronounced in drug producing and transport countries in South-East Asia. Epidemics of HIV, that can literally be called explosive, have been documented among IDUs in Thailand, Burma, Malaysia, Vietnam and Northeast India. The prevalence of HIV infection among injecting drug users has often reached 60 to 90 per cent within six months to a year from the appearance of the first case. In many countries, these explosive epidemics among IDUs then form epicentres for wider diffusion of the HIV epidemic to other parts of the community.

Several communities in Asia have had HIV infections among IDUs for some time and are now in the grip of multiple ongoing epidemics:

- Of drug use and its consequences
- Of HIV infection among IDUs
- Of HIV transmitted from IDUs to their sexual partners and their children
- Of subsequent AIDS and of Tuberculosis.

As HIV transmission among IDUs can be extremely rapid, approaches to intervene and obstruct the spread of HIV infection has required exploration by many countries. What has emerged, both within the developed and developing world, is

the approach of "Harm Reduction". Harm Reduction can be viewed as the prevention of adverse consequences of licit and illicit drug use without necessarily reducing their consumption. A broad range of programs have been implemented to foster harm reduction principles and to prevent HIV infection among IDUs. These include:

- The provision of information programs to inform IDUs of the risks.
- The establishment of drug treatment substitution programs, such as methadone for opiate dependent persons.
- Outreach education using peer educators.
- Sterile needle/syringe exchange, distribution and disposal programmes.
- Over the counter sales of injecting equipment.
- Counselling and testing for HIV among IDUs.
- Increasing access to primary health care.
- Removing the barriers to safer injecting, including laws and police practices.
- Targeting special groups and circumstances.

All of these programs aim to change behaviour and thereby reduce the risks of HIV infection among IDUs.

The injecting of illicit drugs exists in most countries, and in at least 80 countries there are epidemics of HIV infection among IDUs. The majority of these infections result from sharing contaminated needles and syringes, which happens for many reasons. Such epidemics can occur with explosive rapidity, and, having occurred, can form a core group for further sexual and vertical transmission. It is therefore very important to include effective prevention measures against HIV transmission among IDUs in any comprehensive AIDS strategy. IDUs are a hidden and stigmatized group because of their illegal behaviour; often they also engage in other risk behaviour for HIV, such as commercial sex work or paid blood donation, because of the cycle of poverty and the cost of the drugs. The strategies, which have been demonstrated to be effective, in both the developed and the developing world, are those based on the principles of harm reduction. The primary aim of harm reduction for IDUs is to reduce the harm associated with the injecting of drugs, especially the transmission of HIV and other blood borne viruses, without necessarily diminishing the amount of drug use. This is an approach entirely compatible with sensible demand and supply reduction approaches, and sees drug use as a public health rather than a land order issue. As with all effective community responses, it acknowledges the humanity and worth of the IDU, and creates a partnership with the IDU and his or her community to protect their common health.

In the context of injecting drug use and HIV infection, the following points need to be highlighted:

- Illicit drugs are injected in many parts of the world.
- The reuse of contaminated needles and syringes by different persons is common in many settings where injecting drug use takes place.
- HIV is efficiently transmitted by this sharing of injecting equipment.
- The reasons for sharing are various - poverty, lack of availability or access to needle and syringes, cultural factors and ignorance.
- Aspects of enforcement of prohibition of illicit drugs promoted conditions for transmission of HIV among IDUs.
- HIV spreads from IDUs to their sexual partners and children.

The scale of HIV spread among IDUs, their sexual partners and their children depends on a wide variety of factors. These include the following:

- The drugs injected and the frequency of injecting.
- The social organization of drug injecting, especially the existence of "shooting galleries" or professional injectors.
- Knowledge on the part of IDUs of HIV / AIDS, hepatitis viruses and other infections that can be associated with unsterile injecting.
- The availability of sterile injecting equipment or of the means to sterilize equipment.
- The availability and accessibility of drug treatment programs.
- The availability and accessibility of welfare and health programs for IDUs.

An action plan responding to HIV among IDUs should include:

- A situation assessment using both qualitative and quantitative approaches among the at-risk populations. Essential questions include:
  - Why are the IDUs injecting / using drugs?
  - What drugs are being injected?
  - What is the prevalence of HIV / AIDS among IDUs?
  - What is the level of knowledge about HIV / AIDS and its transmission?
  - Where do IDUs go to inject or buy drugs?
  - How much sharing of injecting equipment is there?
  - Why do the IDUs share their equipment?
  - What kind of health care and drug treatments are available? Where?
  - What are the legal and logistical barriers to behaviour change?

Research and education performed in collaboration with the affected community is the most effective. IDUs are as varied as the community they come from; many are not in treatment or prison, so outreach is very important. Peer education is the most effective form of education.

Identification and removal of legal and policing barriers to behaviour change, such as laws related to the sale and purchase of injecting equipment or punitive policing of IDUs, which do not decrease drug use but often increase sharing of needles / syringes.

Development of national and local policies, which achieve a balance between attempts to reduce supply and use of illicit drugs with the reduction of unsafe use – recognition of the role of law and the police in reducing spread of HIV.

The basic elements of an effective response programme for IDUs are:

- Education, especially peer education.
- Promotion of the use of sterile injecting equipment for every injection: increasing availability of equipment, removing barriers to access and use of sterile equipment.
- Increasing drug treatment availability, accessibility and options.
- Increasing access to and appropriateness of primary health care.

Behaviour, which put IDUs at risk of HIV infection, is not random; they result from the social, political and cultural context.

IDUs in prisons, among ethnic minorities, sex workers and women are at an increased risk of HIV infection.

Much of what follows is adapted from the ESCAP HRD Course on Drug Use and its Relationships with Sexual Abuse and Sexual Exploitation of Children and Youth, (ESCAP, 2000).

III Some Critical Concepts

a) What are 'drugs'?

The word "drug" refers to any substance or product that affects the way people feel, think, see, taste, smell, hear, or behave. The World Health Organisation (WHO) defines "a drug" as "any substance, solid, liquid or gas that changes the function or structure of the body in some way". Often, the term "substance use" is preferred, so that all things that affect the way a person feels, thinks, sees, tastes, smells, hears and behaves are included. Thus, glue is a substance used by many street children and methamphetamines are substances used by many young people who go to discos and bars.

Sometimes we use the phrase "psychoactive substance" for drugs to emphasize the fact that the substance produces a change in mental processes.

A drug can be a medicine, such as morphine, or it can be an industrial product, such as glue. Some drugs are legally available, such as approved medicines and cigarettes, while others are illegal, such as heroin and cocaine. Each country has its own laws regarding drugs and their legality.

The use of drugs may have a little or a large effect on a person's life and health. The extent of the effect depends on the person, the type of substance, the amount used, the method of using it, and the general situation of the person.

b) Why do young people use drugs?

People, including young people, take drugs for their immediate and short-term effects. Usually many young people use drugs because they either add something to their lives or help them to feel that they have solved their problems, however fleeting this feeling might be. Drug use may also be influenced by a number of factors, such as:

The individual: Adolescence is a time of immense physical and emotional change. Young people often feel awkward and self-conscious. They may feel caught between conformity and the urge to be different or the urge to fit in with the peer group. Often, young people do not have the skills necessary to deal with the stress and pressures of life, and drugs may be seen as a way of dealing with them.

Family and friends: Young people may learn about drugs and their uses from their family and friends. Often, children living in families where smoking, drinking alcohol and taking prescription drugs, or any other stimulant, is considered a part of

life end up believing that drugs are normal. They also believe that drugs are helpful in releasing stress or worries. Friends and peers have a great influence on young people and drug use may be considered normal and part of growing up.

Society: Mixed messages from media, peers, parents, school, sport and work often contradict or conflict with young people's experiences of themselves. Often, young people receive messages that encourage and discourage drug use. Young people usually start using drugs as an experiment in social gatherings with friends and for recreational reasons.

Environmental factors: These include laws that control the supply and availability of drugs, advertising and promotion of alcohol and drugs and availability (access).

c) Some examples of why young people use drugs and the effects these drugs produce:

Reasons for drug use	*Effects of drug use*
Hunger	Lessens hunger pangs
Boredom	Creates sense of excitement
Fear	Generates a feeling of bravery
Feelings of shame, depression, and hopelessness	Helps to forget
Lack of medicine and medical care	Self-medication
Difficulty falling asleep because of noise or overcrowding	Produces drowsiness
Need to stay awake for job or protection	Help user to stay awake
No recreational facilities	Offers entertainment
Social isolation	Provides a sense of connection with other drug users
Lack of sexual desire to engage in sex work	Can enhance sexual desire
Loneliness	Promotes socializing
Physical pain	Relieves physical pain

Source: ESCAP HRD Course on Drug Use and its Relationships with Sexual Abuse and Sexual Exploitation of Children and Youth, (ESCAP, 2000).

d) What are some of the possible consequences of drug use?

Using a psychoactive substance or drug can have many different consequences. Some of the consequences are insignificant, while others are extremely serious. Substance use has effects on the body, the life of the user and the whole community. It has emotional, economic, social, legal and fatal consequences.

Intoxication is the state of being under the influence of one or more substances. When a person becomes intoxicated, there is a change in the person's alertness, thinking, perceptions, decision-making, emotions or behaviour. They may have trouble thinking, speaking, or working. They may giggle or laugh at strange times, or their mood may switch quickly between highs and lows. Some may be more aggressive. Often, intoxicated people behave in ways they normally would not.

An intoxicated person will behave differently depending on the quantity and type of drug that has been consumed. Moreover, the same amount and type of drug can affect different people in very different ways, dependent on the circumstances of use. For example, the same amount of alcohol can make some people laugh and others cry.

Different substances present different degrees of risk. Very toxic substances include leaded petrol, some solvents and coca paste.

Drug use can be expensive to maintain, cause problems at school or college and at the place of work. Drug use affects the ability of a person to maintain relationships and leads to isolation and feelings of persecution.

Drug use can harm health. Drugs can affect the body so users are more likely to become sick, to injure themselves or someone else, and to have trouble recovering from an emotional or physical problem. Some users are particularly vulnerable to malnutrition, infections, mental disorders, diseases of the internal organs, and respiratory diseases. Use of drugs can lead to deadly infections, such as HIV and Hepatitis B. Injecting drug use is one of the major reasons for the increasing number of HIV infections among youth.

In addition, while they are under the influence of drugs, young people may be more vulnerable to violence and exploitation. They may also be more likely to engage in sexual activities that put them at risk for sexually transmissible infections, including HIV.

Drugs can make the lives of young people difficult in other ways as well. Since many drugs are illegal, drug use may lead to problems with the police and with drug traffickers. Even social and welfare agencies designed specifically for youth may turn away people who use drugs. Often, young people do not know what the short-term or long-term consequences of drug use might be.

Consequences for the community

Everyone, including young people, occasionally have conflicts with family members, loved ones, friends and strangers. Most people also enjoy the excitement of taking a risk from time to time. The use of drugs, however, can sometimes make these normal experiences much more unpleasant or even dangerous. Important responsibilities can be forgotten and disagreements can become emotionally or physically destructive.

Drug users with little income are constantly faced with the problem of finding money to purchase their drugs. Some of them may steal or use violence to get the money. Others might join illegal businesses, such as the sex industry, to earn enough money.

e) What is dependence?

Dependence (or dependency syndrome, often referred to as addiction) occurs when a person becomes dependent on one or many drugs. It is defined by WHO as “a cluster of physiological, behavioural and cognitive phenomena of variable intensity, in

which the use of a psychoactive drug (or drugs) takes on high priority, more than other behaviours that once had value".

Dependence may be defined as:

- A strong desire or sense of compulsion to take the drug;
- Difficulties in controlling drug-taking behaviour;
- A physiological withdrawal state when drug use has ceased or been reduced;
- Evidence of tolerance, i.e., increased doses required to achieve effects originally produced by lower doses;
- Progressive neglect of alternative pleasure or interests due to substance use, increased amount of time needed to obtain or take the substance or to recover from its effects;
- Persisting with substance use, despite clear evidence of harmful consequences (e.g., liver damage, depression, and impaired cognitive functioning).

f) What is detoxification and withdrawal?

If a person has been using a drug heavily or for a long time, the user might experience a difficult period of transition when he or she stops using or reduces the amount of use. The person may have psychological and/or physical problems until adjustment to the absence of the drug is complete. This transitional process is called detoxification and the adjustment problems are called withdrawal symptoms.

Unless they have been using large amounts of drugs for a long time, young people rarely need medical help to detoxify. More typically, young drug users need to be in a safe place where they can be assessed with their full cooperation. The most dangerous withdrawals are from alcohol and hypnosedatives, which may trigger convulsions and delirium tremors.

g) Are there any major patterns of drug use among the youth?

Patterns of drug use vary greatly among youth, and may change over time. Some develop a regular pattern of use while others may be quite haphazard and opportunistic. *Just because a young person starts to use one drug does not mean that he or she will automatically progress to using other drugs or to more intensive use.*

While recognizing the variability of drug use by the youth, it can be useful to try to classify their use according to the level of use and risks or problems experienced.
It has been suggested that there are 5 kinds of drug use:

Experimental use: *Y*oung people go through a period of development that involves experimentation, exploration, curiosity and identity search. Part of such a quest usually involves some risk taking, which can include experimenting with drugs. They are curious about drugs and want to experience new feelings and sensations. It is important to note that, following some experimentation, most young people stop using drugs.

Functional use: For the majority of young people, drug use is not mindless or pathological, but functional. Drugs have a specific purpose in their lives, such as recreation, providing relief from anxiety or boredom, to keep awake or to get to sleep, to relieve hunger and pain, to feel good and to dream. Such use is often controlled and limited to specific circumstances and situations. Young people may vary the type of drug they use, depending on the situation, to achieve the desired effect. They are sometimes experienced users and know what, when and how to use drugs. If their drug use is not causing serious problems for them, there is little motivation for these functional users to stop using drugs.

Dysfunctional use: Dysfunctional use is drug use that leads to impaired psychological or social functioning. Typically, such use affects personal relationships. As a result of their drug use, some young people may become involved in fights or arguments with others or family members. It may interfere with his or her education or work. S/he may not be able to accomplish important survival tasks, such as finding adequate food and avoiding violence. This behaviour may cause further alienation, including rejection by other members of the peer group or family. Because of these increasing difficulties, there may be some motivation to think about quitting drugs. However, the benefits they perceive in using drugs may make it difficult for them to break the habit.

Harmful use: In harmful use, drugs cause damage to physical or mental health. These harms include traumatic injuries from accidents and violence, overdose and poisoning, suffocation, burns and seizures. Other harms result from the way in which the drug is used. Injecting drugs is particularly dangerous because of the risk of hepatitis, HIV and other infections from contaminated needles and syringes, along with collapsed veins and overdose. Smoking drugs can result in disorders of the respiratory system and burns. Some drugs are particularly toxic and can cause health damage in even small amounts. Such drugs include leaded petrol, benzene and coca paste.

Although health damage is more likely to occur in individuals who use drugs regularly and intensively, it can also occur in experimental and occasional users, usually as a result of intoxication. As most young people have not been using drugs for long enough, it is unusual to see them with such disorders as alcohol-related liver disease or smoking- related lung cancer, which tend to occur late in life.

Dependent use: Drug dependence is the name given to the most intensive type of drug use. Users who are dependent on drugs often have poor control over their intake. They may continue to use drugs despite very serious consequences. In addition, they may spend more and more of their day in activities related with drugs; earning money or trading sex for them, purchasing them, using them, recovering from them, and planning to get more of them.

Dependent users may develop a tolerance for certain drugs, that is, their bodies may adjust to the drugs so that the same amount of the drugs no longer produce the same effect and they require more of the drug to get the effect previously experienced. A dependent user may also experience withdrawal symptoms, if s/he goes too long without the drugs.

The young people who are dependent on drugs will need a lot of support to change their behaviour. Establishing good links with local health agencies that deal with drug users is important. If workers are in isolated areas and there are few health resources in the local community, links will need to be formed with helpful professionals in other locations.

Being dependent on drugs can be like being very dependent on other people, food or exercise. The drug can be like a reliable friend who usually gives what a person wants or needs. Giving up the drug can be like losing a best friend. Grief and loss issues need to be dealt with.

h) What are the names and types of substances commonly used by young people?

There is an enormous number of substances that can be used. The generic name of a drug is standard and used throughout the world. However, most drugs are marketed under various trade names and also have many street names. *Trade names* usually begin with a capital letter. For example, a commonly used drug to reduce anxiety is *diazepam* (generic name) and is sold in some countries as Valium (trade name). Another example is *diacetylmorphine, which* is the generic name for Heroin, and has the street names, "brown sugar" in India, and "smack" in the USA and Australia. It is also common for street names to change regularly.

The three main types of drugs, classified by their effects on the central nervous system are:

- Depressants.
- Hallucinogens.
- Stimulants.

Depressants slow down, or depress, the central nervous system. They do not necessarily make the user feel depressed. Depressant drugs include:

- Alcohol
- Opiates and opioids including heroin, morphine, codeine, methadone, and pethidine
- Cannabis including marijuana, hashish and hash oil
- Tranquillisers and hypnotics, including Rohypnol, Valium, Serepax, Mogadon, and Euhypnos
- Barbiturates, including Seconal, Tuinal and Amytal
- Solvents and inhalants including petrol, glue, paint thinners and lighter fluid

In moderate doses, depressants can make users feel relaxed. Some depressants cause euphoria and a sense of calm and well-being. They may be used to wind down or to reduce anxiety, stress or inhibition. Because they slow the nervous system down, depressants affect coordination, concentration and judgment.

In larger doses, depressants can cause unconsciousness by reducing breathing and heart rate. Speech may become slurred and movements sluggish or uncoordinated. Other effects of larger doses include nausea, vomiting and, in extreme cases, death. When taken in combination, depressants increase their effects and the danger of overdose.

Hallucinogens distort perceptions of reality. These drugs include:

- LSD (lysergic acid diethyl amide); trips, acid, microdots
- Magic mushrooms (psilocybin): gold tops, mushies
- Mescaline (peyote cactus)
- Ecstasy (MDMA / methylenedioxymethamphetamine)
- Cannabis in stronger concentrations, such as in hashish and resin can act as an hallucinogen in addition to being a central nervous system depressant;
- Ketamme also known as K or and Special K.

The main physical effects of hallucinogenic drugs are dilation of pupils, loss of appetite, increased activity, talking or laughing, jaw clenching, sweating and sometimes, stomach cramps and nausea. Drug effects can include a sense of emotional and psychological euphoria and well-being. Visual, auditory and tactile: hallucinations may occur, causing users to see or hear things that do not actually exist. The effects of hallucinogens are not easy to predict. The person may behave in ways that appear irrational or bizarre. Psychological effects often depend on the mood of the user and the context of use.

Negative effects of hallucinogens can include panic, paranoia and loss of contact with reality. In extreme cases, this can result in dangerous behaviour like walking into traffic or jumping off a roof. Driving while under the influence of hallucinogens is extremely hazardous. It is common for users to take minor tranquillizers to help them come down from a hallucinogenic drug.

Stimulants are used by millions of people every day. Coffee, tea and cola drinks contain caffeine, which is a mild stimulant. The nicotine in tobacco is also a stimulant, despite many smokers using it to relax. Other stimulant drugs, such as ephedrine, are used in medicines for bronchitis hay fever and asthma. Amphetamines and other ATSs (Amphetamine-type Stimulants, such as, forms of methamphetaime known as "ice", "shabu", and *"ya ba"*) and cocaine are illegal in most countries. The use of ATS is becoming a major problem in most countries and has begun to overshadow heroin use in some (e.g., Thailand).

Stimulants speed up or stimulate the central nervous system and can make the user feel more awake, alert or confident. Stimulants increase heart rate, body temperature and blood pressure. Other physical effects include reduced appetite, dilated pupils, talkativeness, agitation and sleep disturbance.

Higher doses of stimulants can over stimulate the user, causing anxiety, panic, seizures, headaches, stomach cramps, aggression and paranoia. Prolonged or sustained use of strong stimulants can also cause these effects. Strong stimulants can mask the effects of depressant drugs, such as alcohol. This can increase the potential for aggression and poses an obvious hazard if the person is driving. . Mental health difficulties (e.g., psychosis) can be associated with problematic ATS use.

Details of some drugs commonly u sed by young people are given below:

Amphetamines belong to a group of drugs called psycho-stimulants, which speed up the messages going to and from the brain to the body. Most amphetamines are produced in illegal backyard laboratories and sold illegally. These laboratories are unhygienic and harm can result from impurities that remain in the drugs.

Amphetamine drugs are chemically manufactured drugs that are powerful stimulants of the central nervous system.

Amphetamines were first used to treat narcolepsy, a condition in which a person has uncontrollable periods of sleep. Amphetamines later became popular as appetite depressants. They were also popular as a means of staying awake for long periods of time. The use of amphetamines closely parallels that of cocaine in the range of short-term and long-term effects.

Amphetamines can be diluted in juice, snorted or injected into a vein. Due to the unknown strength of street amphetamines, some users have overdosed and died. Amphetamines can increase breathing and heart rate, raise blood pressure and dilate pupils. High doses can cause rapid or irregular heartbeat, tremor, loss of co-ordination and collapse. With increasing doses, users can often be aggressive and potentially violent. Withdrawal symptoms include fatigue, disturbed sleep, irritability, hunger and severe depression.

The term ATS (Amphetamine-type Stimulant) is now used to group chemically related synthetic substances, such as amphetamines, methamphetamines, Ecstasy (MDMA) and other related substances. The common names for these substances include “speed”, “whiz”, (mostly for amphetamines) “ice”, “crystal”, and “shabu” for methamphetamines and *”ya ba”* for mixed chemicals often containing methamphetamine.

Cannabis, commonly known as the dried plant form marijuana, can have a slight effect on one person and a much greater effect on another person. The initial effect for a new marijuana smoker can be a strong rush. Some people say they feel nothing. For some people cannabis use is a pleasant experience. For others there are unpleasant side effects. There are negative health effects which result from continued use.

Marijuana comes from the hemp plant, Cannabis sativa, which grows throughout most of the world. The cannabis plant is prepared for consumption in various ways. Three common forms of cannabis are marijuana, hashish, and hashish oil. The term marijuana refers to the cannabis plant and to any part or extract of it that produces somatic or psychic changes. Drying the leaves and flowering-tops of the plant produces the tobacco-like substance. Hashish and hash oil are prepared from the resin of the cannabis plant.

Some people become psychologically dependent on marijuana and must exert considerable effort or even obtain medical treatment to stop using it. When marijuana is smoked, the effects are felt within minutes, reach their peak in 10 to 30 minutes, and may linger for two or three hours. The most obvious and verified effect of marijuana on humans is a dose-related, temporary increase in heart rate, as high as 160 beats per minute. A reddening of the eyes is also a common physiological reaction to acute marijuana use.

A “high” from cannabis can last for several hours. During this time' most users feel relaxed and self-confident, and have altered perceptions of time and space. Some new users and heavy users experience confusion, anxiety and panic.

While marijuana-intoxicated, a user shows many indications of impaired psychological functioning, including effects on memory, thinking, speaking, various kind of problem solving, and concept formation. Most of these effects seem to share in common an impairment of short-term memory the leads to fragmented speech, disjointed thinking and a tendency to lose one's train of thought.

While the drug is active in the body, driving a vehicle or operating machinery puts the user and others at increased risk of accident. Some new users, particularly adolescents and people who use a lot regularly, can experience psychosis. People with schizophrenia or tho se with a family history of psychosis are at increased risk. Long-term heavy cannabis use is likely to have a negative effect on your health. These effects include:

- Respiratory diseases such as bronchitis and cancers commonly associated with smokers.
- Some loss of memory and mental capacity.
- Potential risk to children when women use cannabis during pregnancy.

Users can become dependent on cannabis and have great difficulty controlling their use of the drug.

Cocaine mainly comes in a white powder called cocaine hydrochloride. Cocaine in this form is usually snorted or injected. Cocaine is often mixed with other substances, such as, mannitol or some other sugar to increase the profitability of a deal.

Effects of cocaine, which can last for minutes or ho urs, happen very quickly and can include an extreme feeling of well-being, increased heart rate, agitation, sexual stimulation, alertness, energy, unpredictability and aggressive behaviour. The inside of the nose can be severely damaged if you regularly inhale cocaine through the nose. Cocaine or coke is highly dependency creating and, as with other stimulants, reduces hunger, thirst and natural needs for rest, food and water. Death can occur as a result of overdose or an accident.

Ecstasy: the chemical Methylenedioxymethamphetamine (MDMA) is a drug that can cause users to see things that are not seen by other people and produces a feeling of tranquillity, increased confidence and feeling close to people, which is why it's also known as the love drug. Users can also experience jaw clenching, teeth grinding, dry mouth and throat, nausea and loss of appetite, anxiety, paranoia and confusion.

Ecstasy is regarded as a dangerous drug for people with heart or breathing conditions or with depression or psycholog ical disorders. The next day, a severe hangover may leave the user feeling “burnt out”. Symptoms include: loss of appetite, sleep problems, aching and confusion.

Overdose can occur resulting in very high blood pressure, increased heartbeat and body temperature. Many people take ecstasy at dance or rave parties. Ecstasy can raise the body temperature to dangerous levels. Not much is known about the long-tern effects of ecstasy, but there is some suggestion that it may damage some types of brain cells. Few people seem to use ecstasy for long periods. Ecstasy is one of a growing number of “designer drugs” and many new variations are already available.

Gamma-hydroxybutyrate (GHB), also known as liquid ecstasy, is a depressant drug, which works by slowing down the activity of the brain and central nervous system.

That is, they slow down the messages going to, and from the brain. GHB commonly exists as a colourless, odourless liquid usually sold in small bottles. It has also has been seen in powder and capsule form. It is mostly taken orally. However, it can be injected.

People have reported the following effects after taking GHB: euphoria, drowsiness, nausea, increased confidence, and dizziness. With increased doses, the initial euphoria is replaced by powerful sedative effects, which can include: confusion, agitation, hallucinations, seizures, vomiting / nausea, stiffening of muscles, disorientation, convulsions, unconsciousness / coma, and respiratory collapse. Users can become both physically and psychologically dependent on GHB.

Prolonged use of high doses of GHB may lead to withdrawal symptoms. Some people have experienced agitation / anxiety, insomnia and tremors after stopping regular use of GHB. Withdrawal symptoms are usually experienced for three to twelve days.

Heroin is derived from the opium poppy and usually comes in a rock or powdered form that is generally white or pink / beige in colour. The purity of heroin sold on the street can vary enormously from as low as 25-30 per cent to 85-90 per cent depending on fluctuations in the unpredictable illegal drug market.

It is a powerful painkiller that is widely used by doctors to treat pain in cancer and heart attack patients. Used medically, pure heroin is a relatively safe drug. Pure heroin is a white powder. Street names include “skag”, “smack”, “H”, “horse”, “harry”, “junk”, “henry”, and “brown sugar”.

Heroin can be smoked, sniffed or injected. It is rarely swallowed, as this method is relatively ineffective. When heroin is heated over a candle or a match on a piece of tin foil or a spoon, the smoke generated is inhaled, often through a small tube (known as “chasing the dragon”). Injection directly into the veins gives an immediate short-lived pleasurable sensation (known as a “rush”). Heroin is the most commonly injected illegal drug.

Users say heroin, in the beginning, makes them feel warm, loved and safe. Heroin provides an extremely intense rush and a high that usually lasts for 6-10 hours. In its pure form, in controlled clinical conditions heroin is relatively non-toxic to the body, causing little damage to body tissue and other organs. However, regular users are very likely to become dependent upon it. Some long-term effects include constipation, menstrual irregularity and loss of sex drive.

Impure street heroin is usually a mixture of pure heroin and other substances, such as sugar. Sometimes other drugs like speed or sedatives are also mixed in. This is very poisonous. Impure heroin causes collapsed veins, tetanus, abscesses and damage to the heart, lungs, liver and brain. Because the user usually doesn't know the strength of the heroin s / he is using, it is easy to accidentally overdose and die.

Complications associated with heroin use can include tolerance, which means that the user needs more quantity to get the same effect. Using heroin can result in both psychological and physical dependence on the drug. Heroin dependence is extremely expensive and is a major reason for many crimes, as the dependent heroin

user needs more money to support the "habit" and just feel normal. Life can become an endless circle of finding money, obtaining the drug and usage.

Inhalants: Some drugs turn to gas in the air and when the fumes are inhaled can cause the user to feel high. These are inhalants. Many household products are used as inhalants such as glue, aerosol spray cans, lighter fluid, paint thinner, chrome based paint or petrol.

After a high the drug slows down the central nervous system or the messages going to and from the brain to the body. Most effects pass within an hour of use. Using many times may make users pass out, get bad cramps, not know what's going on or even die. The drug in some of these products can cause heart failure particularly if the user is stressed or does heavy exercise. Some users have been known to pass out and suffocate in the plastic bag they inhale from. Like most street drugs, use of inhalants can lead to dependence, although almost all who try inhalants only use them once or twice.

LSD (Lysergic Acid and Diethylamide), the best known of the hallucinogens. As a synthetic drug, it is one of the most potent mind-altering chemicals. LSD is most commonly seen in tablet form or the tablet incorporated into some other dose form, such as, a capsule or occasionally confectionery. LSD appears to cause little or no physical dependence with no withdrawal symptoms having been observed, even after long periods of use. However, users can develop psychological dependence.

Methamphetamine is an ATS. The use of methamphetamine produces similar, but mostly stronger behavioural and physiological effects to cocaine and other stimulants. These effects include euphoria, increased alertness, the perception of improved self-esteem and self-confidence, impaired judgment, and impulsiveness. Acute and chronic use of methamphetamine typically results in nervousness, irritability, restlessness, and insomnia.

The major difference between cocaine and methamphetamine is duration of action. The half-life for cocaine's euphoric effects is less than 45 minutes, for methamphetamine it is three to six hours. Therefore, the period of stimulant-induced euphoria may be much longer in methamphetamine users, and likewise, the period of impaired judgment will be longer. Permanent neurological changes and deficits can result from chronic methamphetamine use.

i) Are there any connections between drugs and sex, sexual exploitation and sexual abuse?

The connections between drugs and sex, sexual exploitation and sexual abuse are well established. Due to this nexus many young people find themselves vulnerable to HIV infection as well. Some examples of this are as follows:

- Some young people may run away from their home or village due to the drug use of family members and/or other adults who may become violent when intoxicated (some of this violence may be in the form of sexual abuse) or neglect their needs.
- Some young people are sold by their parents for money to buy drugs.

- Some young people who use drugs may engage in sex work for money to buy drugs.
- Some young people may get paid in drugs for sex work.
- Some pimps and brothel owners may give drugs to young people to get them to have sex (so they are less likely to refuse or to get them sexually aroused).
- Some pimps and brothel owners may give drugs to young people to keep them working (i.e., get them physically and psychologically dependent so that they stay "on").
- Some pimps and brothel owners may give drugs to young people to make them semi-conscious when not working so they do not run away or leave.
- Some customers may give young people drugs and then have sex with them (e.g., as payment, to increase pleasure, for certain sexual acts or to decrease the chances that the young persons could identify them later).
- Some young people are drugged so that they can be more easily involved in pornography (e.g., photos or videos) or perform sexual acts.
- Young people may take drugs so that they can cope with sex work or certain sexual acts (so they will perform the acts or to reduce the pain of the acts).
- Some young people may take drugs so that they can cope with the effects of sex work (e.g., shame and guilt).
- Some young people may take drugs to make sex feel better.

j) Are there any symptoms that identify a person who may be using drugs?

Yes, it is possible to get an indication if a person is using drugs through some symptoms. But one has to be careful in any enquiry, and drug use should not be presumed unless confirmed otherwise. The following symptoms are indicative of drug use and may not always be related to drug dependence:

Marked personality change: a placid, soft-spoken person suddenly becomes noisy and abusive. The change may be gradual and only apparent when one thinks about it. Sometimes, this may occur the other way around i.e., an outgoing and talkative person may turn silent and withdrawn.

Mood swings: Mood may swing from high to low and back again, seemingly, without reason. There may also be extreme behaviour precipitated by the most innocuous events or statements.

Change in physical appearance or well-being: A change in weight, sleep patterns and other signs, may be sudden or gradual. Other physical symptoms may include slurred speech, staggering gait, sluggish reactions, pinpoint or dilated pupils, sweating, talkativeness, euphoria, nausea and vomiting.

Change in school or work performance: For students a significant deterioration in performance, especially when the student has been diligent, may be an indicator of difficulties. Equally, a rapid change from poor performance to diligence may be important.

An increase in secretive communication with others: This is often seen as cryptic telephone calls. Remember that some of this may just be typical behaviour of adolescents.

Intuition: Call it "gut feeling" or "guesswork", but this warning sign is based on the awareness you have of a young person you know well. You may not be able to be specific, or clearly verbalize your hunch, but you will know there is something wrong. You may find yourself telling others of the change observed in a person you know.

An excessive need for or increased supply of money: Buying drugs costs money, and the more drug dependent the person becomes, the greater their need for money to finance their "habit". Money, however, is not the only transferable commodity for young people. For example, baseball caps, sport shoes and sex are commonly traded for alcohol and other drugs.

k) Can drug dependence be treated?

Yes, drug dependence is treatable. Research into existing drug treatment programmes and clinical practice has yielded a variety of approaches to drug treatment. The U.S. National Institute on Drug Abuse identified the following principles of effective treatment:

- No single treatment is appropriate for all individuals.
- Treatment needs to be readily available.
- Effective treatment attends to multiple needs of the individual and not just his / her drug problem.
- An individual's treatment must be assessed from time to time and modified to accommodate his / her changing needs.
- Continuing with the treatment for an adequate period of time is critical for the effectiveness of treatment.
- Dependent / Addicted or drug using individuals with mental disorders should be treated for both the problems in an integrated manner.
- Medical detoxification is only one stage of treatment and by itself does little to change the long-term drug use.
- Drug treatment need not be voluntary to be effective (there are approaches that differ with this view and believe that treatment can only begin when the person is ready).
- Treatment programmes should provide assessment for HIV / AIDS, hepatitis B and C, tuberculosis and other infectious diseases, and counselling to help patients modify or change behaviour that places them or others at risk of infection.
- Recovery from drugs can be a long-term process and frequently requires multiple episodes of treatment.

l) What are 'life skills' and how can life skills training help in reducing drug/substance use?

Life skills are abilities for adaptive and positive behaviour that enable individuals to deal effectively with the demands and challenges of every day life (WHO 1994). Based on the positive experience with life skills approaches in substance / drug use prevention, life skills are a promising approach to strengthen protective factors in treatment and aftercare, induding relapse prevention.

Life skills applied to drug/substance use prevention are supposed to facilitate the practice and reinforcement of psychosocial skills that contribute to the promotion of personal and social development such self awareness, empathy, communication skills, interpersonal skills, creative thinking, critical thinking, coping with emotions and coping with stress. In drug/substance use prevention, which should also be part of treatment programmes, this means imparting skills in drug/substance resistance/refusal and critical thinking, social competence and communication skills to explain and reinforce personal anti-drug commitments.

Session 6.1
Substance Use – Our Understanding

Expected Outcomes
Participants will know what constitutes substance use.
Participants will know the affects of substance use on their lives.

Exploring Substance Use

Objective To develop a common understanding on drug / substance use.

Materials Flip charts, markers, tape.

Time 30 to 40 minutes.

Process Invite the participants to sit in a circle. Explain that the use of drugs / substance among youth is an emerging concern.

Ask the participants to divide into 2 groups.

Ask the 2 group members to pick up a chart each and some markers.

Ask both groups to discuss within their group and come up with a definition of the term "drug". This definition should be based on their common understanding and knowledge.

Allow 15 minutes to do this exercise.

Invite both groups to display their respective definitions and ask them to present.

You could use the following questions to facilitate a discussion after the groups have made their presentation:

- *Have you heard the term "drug use"?*
- *When did you first hear the term, and from whom did you hear it?*
- *If you think someone you know is abusing drugs, what would you do?*
- *Why do we prefer the term "substance dependence" to "addiction"?*

Note for the Facilitator

The definition for the term is given in the question answer section at the beginning of this section. You can present that definition after the two groups have made their presentation. After facilitating the group discussion you can make a short presentation on the status of drug / substance use among the youth in your country / region or locality. Emphasize that drug /substance use is also linked to another emerging health concern among the young people – namely HIV / AIDS. Point to the fact that HIV / AIDS is a real threat for young people who inject drugs, as HIV / AIDS is transmitted through contaminated needles. HIV / AIDS is also transmitted through unprotected sex and from infected mother to child.

Session 6.2
Beliefs and the Reality of Drugs

Expected Outcomes

Peer educator will know the level of knowledge and beliefs that the participants have on the subject of drugs.
Participants will learn to distinguish between myths and facts regarding drugs.
Participants will know some basic facts about drugs.

Myths And Facts About Drugs

Objective To provide correct information about drugs.
To enable the participants to analyze the information they already have about drugs.

Materials "Myth and fact statements" and information / answer key for myth and fact statements, flipchart paper, markers, cloth bag or a small box.

Time 30 to 40 minutes.

Process Invite the participants to sit in a circle.

Explain that they will be learning some facts about drugs through a game. Create the mood by asking some questions for example: Do you know of anyone who uses drugs? Why do young people experiment with drugs? Have you ever thought of experimenting with drugs?

Now ask the participants to divide into two teams and sit facing each other on the floor or chairs.

Place the bag or box with the myth and fact statements in the middle of the two teams.

Explain that each team will draw a statement from the bag alternatively.

The team that draws and answers correctly will get 10 points. If the team draws and fails to give the correct answer, they will get 0 points. If the team draws and passes, then the other team will get 20 bonus points on a correct answer. If both teams fail to give the correct answer, you will provide the answer.

Put a flip chart up to keep scores. Ask for a volunteer to help you if required.

Allow the teams to discuss their answer for 1 minute or so.

After each round encourage discussion by asking the teams to give reasons for their answers.

You may want to use the following questions for discussion after the game:

- *Did you learn anything new from this game? What?*
- *Were you surprised or distressed by anything that you learnt? What and why?*
- *Why do you think there are so many myths related with drug use?*
- *Why is drug use among young people becoming a major cause for concern?*
- *What do you see as the links between substance use and sexual behaviour, especially HIV/AIDS and STIs?*
- *Can you think of ways that you can spread awareness about drug use? What can you do?*
- *If you have a friend who is using drugs how will you help him/her?*

Note for the Facilitator

This is a useful exercise to build awareness and allows participants to explore their beliefs and knowledge about the subject. Encourage discussion, but at the same time, look for signs of discomfort among the participants. . Note the preference for the term "dependence" instead of "addiction", and avoid words like "addict" and "alcoholic". There latter terms can be discriminatory and marginalizing. It is now not acceptable to call people with disabilities "cripples" – they are "a person with a disability". Likewise, for substance use, they are a "person dependent on heroin or methamphetamine". Make sure that you reinforce the negative impacts of substance/drug use and clarify any misunderstandings that participants may have about the subject. You may follow up this exercise with a small groups exercise on the impact of drug use. You may have to prepare the myth and facts statements based on the reality of the locality, country or region.

Fact and myth statements that may be used for this exercise are as follows

Fact and myth statements	Answer key for the facilitator
You cannot become dependent on alcohol; it is not a drug.	**Myth:** alcohol is a drug like any other drug; you can become physically and psychologically dependent on alcohol.
It is okay to use drugs for recreation.	**Myth:** drug use for any reason can lead to problems and possibly dependence.
Driving after using cannabis/marijuana is much safer than driving after drinking alcohol.	**Myth:** Like alcohol, cannabis/marijuana affects motor coordination, slows reflexes and affects perception (the way we see and interpret events around us). Any of these changes increase the likelihood of an accident while driving.
A person can become dependent on cigarette smoking.	**Fact:** most people who smoke become dependent on nicotine.
Many drug users say that smoking marijuana was their first step towards their use of other drugs.	**Fact:** Usually people who become dependent on drugs start with a drug that is cheap and readily available and one they feel that they can control, like cannabis/marijuana or amphetamines.
People who become drug dependent have no will power.	**Myth:** drug dependence is not only mental but physical as well.
A cup of strong coffee and cold	**Myth:** Only time will cause a person to become

shower are enough to make a drunken person sober.	sober. It takes one hour for the liver to process one-half ounce of pure alcohol.
Drugs help a person to deal with his/her problems.	**Myth:** Drugs help people forget about their problems or reduce the pain caused by problems. The problems do not go away, and they often get worse.
Steroids should be used only after prescription.	**Fact:** Steroids can have very serious health consequences, such as liver disease, heart disease, sexual dysfunction and mood swings leading to aggressive or depressive behaviour. Sharing needles for steroid use can transmit HIV, the virus that causes AIDS.
One cannot become dependent on drugs prescribed by a doctor, such as painkillers and sleeping pills.	**Myth:** often people taking such prescription drugs become dependent on them.
Coffee and tea also contain stimulants/drugs.	**Fact:** Coffee, tea and many soft drinks contain caffeine, which is a stimulant. Caffeine can cause headaches which are a common sign of withdrawal.
More young people use alcohol than any other substance.	**Fact:** In many countries, alcohol is the most frequently used substance among teenagers. Approximately 50 per cent of males and 20 per cent of females begin drinking before 20 years of age in these countries. Alcohol can also be expensive, and so, many street children use glue or other inhalants more than they would use alcohol. Where use of alcohol is against the main religious or cultural beliefs of the county, there is much less use of it and tobacco may be the most used substance by young people.
Alcohol dependence is a disease.	**Fact:** Alcohol dependence is sometimes seen as a disease just as diabetes or epilepsy are diseases. It can respond to treatment, which might include eliminating all alcohol consumption.
If you use drugs without injecting, you will not contract HIV.	**Myth:** Drinking alcohol or using other drugs can inhibit your ability to use condoms correctly or they may make us forget to use condoms at all.
It is rare for a teenager to be alcohol dependent.	**Myth:** In some countries, approximately 30 per cent of young males and 20 per cent of young females use alcohol more than three times a week. They may or may not be dependent on alcohol, but they certainly are at "risk" of dependence and many other health and social problems, by drinking at that level.
Inhalants are basically harmless even though people make a big deal about them.	**Myth:** Using inhalants such as thinners, glue, or cleaning fluids, can cause permanent damage to organs like the liver, brain or nerves. They are also extremely flammable and can cause serious injury if matches are lit nearby.

Anyone using oral contraceptive (birth control pill) has to be careful about prescription medicines.	**Fact:** Girls and women who are using oral contraceptives to prevent pregnancy need to tell their doctor if s/he prescribes antibiotics. Some medications make oral contraceptives ineffective and pregnancy could result.
Cigarette smoking can be harmful for the pregnant woman but not for the child in her womb.	**Myth:** smoking is equally harmful for the child in the womb.
Alcohol is a sexual stimulant.	**Myth:** Alcohol can actually depress a person's sexual response. The drug may lessen inhibition with a sexual partner, but it causes problems such as lack of erection, loss of sexual feeling or inability to have an orgasm. In addition, alcohol or drugs may cause a person to do something sexually that he or she would not do when sober.
Cannabis/Marijuana is used legally to treat severe pain (in cancer and other chronic illnesses).	**True:** In most countries cannabis/ marijuana is against the law. However, in some countries cannabis preparations are being trialled for wasting conditions (where a person in final stages of cancer or HIV-related illness become very thin from not eating or being unable to eat) and glaucoma.
Heroin use can cause dependence, but not cannabis/ marijuana.	**Myth:** Experts believe that long-term use of cannabis/marijuana is potentially dangerous and may lead to a decrease in motivation, memory loss, and damage to coordination, impaired judgment, damage to the reproductive system and throat, lung irritation and mental health problems.
Experimenting with drugs is a part of growing up.	**Myth:** drugs are a matter of choice and have nothing to do with the growing up process.
Drug dependence can lead to homelessness and loss of life.	**Fact:** Many drug users loose their social and economic status and can loose their life to overdose and other complications.
Taking amphetamines or methamphetamines only once can cause problems.	**Myth:** Any drug use can cause difficulties for new and regular users. Much of what is sold as amphetamine or methamphetamine (e.g., *ya ba*) is a combination of many chemicals, mostly mixed in illegal laboratories. Users may never really be sure of what they are buying or taking. The mix can be toxic.
Drugs like alcohol, cannabis/marijuana and ecstasy shouldn't be a problem for young people	**Myth:** Drugs can interrupt normal growth and development for youth, be associated with problems in relationships and result in unintended pregnancies of STD/HIV because their use can lead to risk taking.
HIV infection among young injecting drug users is on the rise.	**Fact:** research shows that HIV infection rates are high and increasing among young IDUs.

Session 6.3
Smoking and Health Concerns

Expected Outcomes
Participants will know the health affects of smoking.
Participants will start thinking about the harm of smoking and eventually quit smoking.

I Am Choking!

Objective The participants will analyze ways in which smoking, or the use of tobacco, interferes with health, general well-being and achieving personal goals.

Materials Straws covered with wrappers, small narrow straws, white paper.

Time 45 minutes.

Process Invite the participants to sit in a circle. Explain that they will be doing an interesting exercise to experience some of the effects of smoking. Participants who are asthmatic or prone to breathlessness should not take part in the exercise.

Ask the participants to take a deep breath and exhale. Ask them to repeat this three times.

Give a straw (wrapped in its cover) to each participant. After the participants have their straws, ask them to remove the wrapping. Ask them to pinch their nostrils closed so that they cannot inhale or exhale through their nose.

Ask each participant to place a straw in his/her mouth. Each participant is to keep his/her nostrils pinched closed while inhaling and exhaling through the straw. Explain that, if they have any difficulty exists with breathing they can stop the activity at any time. Participants are to breathe through the straw for one minute.

Request the participants to describe what it was like to breathe through the straw. Most likely, they will explain that it was difficult. In order to inhale the same amount of air that they normally inhale each minute, they needed to inhale more often. This raised the heart beat rate and became tiring. Explain that this is what happens when a person smokes cigarettes.

Provide each participant with a smaller narrower straw. Repeat the strategy. Ask the participants to pinch their nostrils closed so that they cannot inhale or exhale through their nose. Ask each participant to place the small narrower straw in his/her mouth. Each participant is to keep his/her nostrils pinched closed while inhaling and exhaling

though a straw. Explain that if any difficulty exists with breathing, they can stop the activity at any time. Participants are to breathe through the narrow straw for one minute.

Explain that the long-term effects of smoking cigarettes are very serious. They have just experienced what it is like to have chronic obstructive lung disease, which is characterized by progressive limitation of the flow of air into and out of the lungs. Emphysema and chronic bronchitis are two examples of chronic obstructive lung diseases.

Pass out a small sheet of white paper to each participant and have him or her think of five reasons why it is harmful to use tobacco products. Have them roll their papers in the shape of a cigarette. Collect the paper cigarettes. Distribute them to the participants, giving each participant a paper cigarette other than his/her own. Have the participants take turns reading what is written on their cigarettes. Explain that we never know what problems may occur from our actions but, if we know that problems are likely to occur, we should use prevention tactics to keep them from happening.

Further explain that cigarette smoking has also been linked to lung cancer, laryngeal cancer, coronary heart disease, atherosclerotic peripheral vascular disease, oral cancer, esophageal cancer intrauterine growth retardation, low birth weight babies, leukaemia, unsuccessful pregnancies, increased infant mortality, peptic ulcer cancer of the bladder, cancer of the pancreas, cancer of the kidney, and cancer of the sto mach. Smokeless tobacco use increases the frequency of localized gum recession and oral cancer.

After the exercise, use the following questions to facilitate a group discussion:

- *Is it easy for you to take deep breaths?*
- *How did you feel after taking deep breaths?*
- *What was it like to breathe through the large straw? Was it easier or more difficult than deep breathing?*
- *What was it like to breathe through the small straw? Was it easier or more difficult than breathing through the large straw?*
- *How did you feel after breathing through the small straw?*
- *What are some things that may prevent you from taking deep breaths? (Pollution, sickness, etc.)*
- *Do you know someone who cannot breathe easily? Why can't they breathe easily?*
- *If you cannot breathe easily, what are some of the activities that you may not be able to do? How do you think you would feel if you could no longer do these activities?*

Note for the Facilitator

Often young people have the impression that the harmful consequences from smoking cigarettes are experienced only after many years of smoking. Explain that smoking cigarettes can interfere with short-term goals. For example, the effects of

cigarette smoking decrease performance in athletic activities. Have the participants brainstorm other activities may be affected by smoking. You may want to use the following exercise in addition to the above, to demonstrate the effects of smoking on the lungs.

Additional exercise to reinforce the ill affects of smoking

Place cotton balls inside a clear plastic bag. Insert a straw through the top of the bag. Attach the top of the bag to the straw with a rubber band. The straw will represent the air passage to the lungs. The bag represents a lung. The cotton balls represent the alveoli or air sacs in the lungs.

Light a cigarette and without inhaling blow the smoke through the straw into the bag. Allow the smoke to exit from the bag. Continue to puff smoke into the bag several more times. Have the participants observe what is happening. They will notice that the cotton balls in the bag are turning brown.

Emphysema is a type of chronic obstructive lung disease in which the limitation of airflow results from changes in the smallest air passages and the walls of the alveoli, the tiny air sacs of the lungs. These tiny air sacs are destroyed from smoking cigarettes. Then, it becomes difficult for the lungs to bring oxygen and remove carbon dioxide. As a result, the heart must work harder to get oxygen to the cells.

Chronic bronchitis is a type of chronic obstructive lung disease in which the bronchial tubes in the lungs have become inflamed. The walls of the bronchial tubes become thickened, and there is increased production of mucus. This narrows the air passages.

Explain that the brown colour is tar, which is a substance in tobacco. When a person smokes, tar covers the alveoli in the lungs. The exchange of air from the alveoli to the bloodstream becomes difficult. This is one reason that people who smoke cigarettes have difficult breathing. By observing the cotton balls, it will be obvious that tar was collecting on them. Explain that there is also a relationship between tar and the development of cancer.

As an additional follow up activity, have the participants look at the national heath statistics for lung disease and see how many may be related to cigarette smoking? Have the participants think about the cost to the government and society for caring for these persons. Also look at the costs for conducting no smoking campaigns. Which is cheaper?

Effects of smoking on the body can include

- Loss of appetite
- Bronchitis, pneumonia, worsened asthma
- Coughing, wheezing
- Emphysema
- Lung cancer
- Heart disease and strokes
- Physical and psychological dependence
- Decreased physical fitness

Effects of smoking on non-smokers can include:

- Increased respiratory illnesses (bronchitis, pneumonia) in infants and babies up to 18 months of age.
- Increased chance for middle ear problems in children
- Increased coughing and wheezing, worsened asthma in children
- Low birth weights and lower survival rates in newborn babies due to smoking during pregnancy.

Session 6.4
Effects of Alcohol on a Person's Abilities

Expected Outcomes
Participants will know the effect alcohol can have on their physical and mental health.

I Feel Woozy!

Objective To demonstrate how alcohol can affect a person's ability to function.

Materials Pencils, paper.

Time 30 minutes.

Process Ask the participants to sit in a circle. Explain that they will be doing a short exercise to understand the effect of alcohol and other substance use.

Ask the participants to take one marker and one sheet of paper.

Ask them to write their names on the sheet of paper.
Then, ask them to once again write their names using the other hand (one not normally used by the participants). Thus, a person who usually writes with his/her left hand will write with his/her right hand and vice versa.

After the participants have the opportunity to do this activity, have them analyze what occurred. Have them compare their writing samples with each other.

Explain that what the participants experienced was an experiment in which their hand muscles did not work as they usually do. By writing with the opposite hand, they could not function as they normally would. If alcohol were inside a person's body, that person would not be able to use his/her body muscles the way they usually work in a smooth and coordinated manner. That is, it would be similar to writing their name with their left hand, if they normally wrote with their right hand and vice versa.

You may want to link this experiment with wider issue of substance use.
The following questions may be used for discussion:

- *With which hand did it take you longer to write your name?*
- *Are the letters of your name as clear as the letters you write with the hand you normally use?*
- *What are some of the activities you would not be able to do if you were drunk or under the influence of drugs?*
- *Imagine one activity that you like doing and would not be able to do if you were drunk or under the influence of drugs.*

- *What would the consequences for your family and dear ones be, if you become drunk or begin taking drugs?*

Note for the Facilitator

This is a very subtle exercise and may not be dramatic enough to make the point about alcohol and drug use. Do not worry, the effects of drug use and alcohol use are also subtle, and it takes a long time for the effect to become pronounced. Use the exercise to your advantage to make these points.

The following exercise also aims to demonstrate the effect of alcohol on a person's ability to function. As a peer educator, you can use both of the exercises to demonstrate the effect of alcohol on a person's ability to function.

Look Where You Are Going!

Objective To demonstrate how alcohol can affect a person's ability to function.

Materials Old pairs of sunglasses, Vaseline, two balls made of a sheet of crumpled paper.

Time 20 minutes.

Process Invite the participants to sit in a circle. Explain that they will be doing a short exercise to understand the effect of alcohol on their ability to see and coordinate.

Ask the participants to call out some effects of alcohol consumption. Record these responses on a flip chart.

Ask for 3 volunteers to stand in the centre of the circle. Give two of the volunteers sunglasses with a layer of Vaseline on the lenses. Ask them to wear the sunglasses. Ask the third volunteer to stand 1 meter or so away (s/he should be visible but not clearly) from the 2 volunteers wearing sunglasses. Give him/her the 2 paper balls.

Ask the volunteer with the ball to throw the balls to the two volunteers with sunglasses. The volunteer to whom the ball is thrown must try and catch the ball. Repeat the throw and catch process a few times.

Invite more participants to try out the experiment. Then, return to the circle for discussion.

You may want to use the following questions for the discussion:

- *How did you feel wearing the sunglasses with Vaseline?*
- *Were you able to see the ball thrown at you? How easy or difficult was it? Why?*
- *Do you think alcohol has a similar effect on your ability to see and coordinate? Why/ Why not?*
- *Have you ever thought about the effects of alcohol use on your ability to drive?*

- *Do you know of any other stimulant that may produce similar effects?*
- *Have you ever had a bad experience due to being drunk? Would you like to share it with the group?*

Revert to the flip chart with participants' responses on effects of alcohol consumption and summarize the discussion. Point out that alcohol use results in uncoordinated movements, blurred vision and mental lethargy. These effects are somewhat similar to those experienced by the participants when they tried to catch a ball wearing glasses smeared with Vaseline.

Note for the Facilitator

This is a simple exercise for demonstrating some of the effects of alcohol use. It produces laughter and a feeling of ease among the participants and relaxes them for a discussion on use of stimulants. You could use this exercise to lead into a detailed discussion on effects of drug use. You could also collect some facts and figures on alcohol related accidents and crimes, and share them with the participants.

Session 6.5
Why Do Young People Use Drugs?

Expected Outcomes

Participants will understand the reasons for drug / substance use among their peers.
Participants will explore how these reasons can be reduced or removed, so as to prevent drug / substance use among their peers.

Scoring And Ranking The Reasons

Objective

To list, score and rank the reasons young people may have for abusing drugs.
To discuss means through which these reasons can be reduced or removed.

Materials

Flash cards, markers, small stones / pebbles / seeds.

Time

1 hour.

Process

Ask the participants to sit in a circle. Explain that they will do an exercise in order to understand the reasons for drug / substance use among young people.

Ask each participant to take one flash card and marker.

Invite the participants to write one reason (according to their understanding and knowledge) why so me young people use drugs?

Allow 5 minutes for this activity.

Invite the participants to place their cards on the floor in a vertical line.

Ask them to group similar cards.

Now, for the purpose of scoring the reasons, invite the participants to gather some small stones (flowers, seeds or leaves) to use as markers.

Count the number of cards in the vertical line. For example, if there are 12 cards in the line then the fixed score from which scores can be assigned will be 12.

Start at the top of the line, and ask the participants to arrive at a consensus on how many points they would give that particular reason for drug use. Remember that the scoring represents preference. Therefore, the most preferred reason for drug use would receive a high score and the least preferred

reason a low score. The scores are based on the preference of the participants and the criteria they use for determining the preference will also be their own. For example, the participants may agree to give the reason a score of 10 out of 12. Ask the participants to place 10 markers in front of the card. Then proceed to the next card and repeat the process.

Each time the score will be given out of a total of 12 or whatever the total number of cards in the line is.

The scores can only be assigned by consensus.

The highest score that can be given will be 12 or the total of the cards in the line and the lowest will be `0".

After the participants finish scoring all of the cards, invite them to sit in a circle around the cards.

Ask them to give reasons for the scores assigned for each card.

Next, ask the participants to rank the cards on the basis of whether the reason for drug/substance use stated on the card could be reduced or removed (so that young people could be prevented from using drugs). This means that the card that has the most possibility of being reduced or removed will be ranked first and the one next to it second, and so on. Rank all of the cards.

As the participants to rank the cards, encourage them to discuss the reasons for their actions. Remind the participants that ranking should also be based on consensus.

Close the exercise with a summary of the outputs. Ask the participants to display the out puts on the wall. These may be used for future reference during the sessions on drug and substance use.

Note for the Facilitator

Listing, scoring and ranking are participatory tools that encourage discussion and clarity on a given subject of concern. Scoring determines preference, and ranking determines priority. These tools enable the participants to analyze their own knowledge and understanding of the subject, increasing their participation and stake in the process and result. There are no right or wrong answers in this process, but if the facilitator has something to add or share, then s/he should suggest it. The group may or may not accept the suggestion.

If the peer educator feels the group is really involved in the exercise, the process can be extended. You could choose the three most preferred (or all if the group prefers) reasons for drug/substance use and work on the solutions for those reasons. A similar process of listing, scoring and ranking of solutions can be undertaken. You could also undertake only listing and scoring or only listing and ranking. The choice

of the tools will depend on the objective of the exercise, the time available and the enthusiasm of the group.

Helpline for the peer educator

Some reasons why young people use drugs are as follows:

- Pressure from commercials/advertisements (alcohol/tobacco)
- Influence of role models (film stars or singers who smoke or drink alcohol)
- Curiosity (a typical trait of youth)
- To relax (alcohol, other drugs)
- Have fun (most drugs)
- To avoid physical pain or psychological problems (heroin, opium)
- To stimulate, to make one energetic (caffeine, cocaine, amphetamines, methamphetamines)
- To reinforce physical power (steroids)
- Stay awake (amphetamines)
- Possible effects of using drugs are as follows:
  - Dependence on the drug
  - Loss of job or interruptions in education
  - Debt burden, due to mounting cost of drug use
  - Problems with law enforcement agencies for procuring illegal substances and stealing
  - Loss of social status and friends and family
  - Loss of good health
  - Depression, loneliness and suicidal tendencies
  - Indiscriminate sexual activity; i.e., sex for money
  - Make sex better (cocaine and Ecstasy)
  - High risk of HIV infection
  - Memory loss or loss of decision making capacity
  - Heightened emotions and mood swings
  - Enhanced enjoyment of music and dancing (ecstasy and methamphetamine)
  - Feelings of shame and guilt

The World Health Organisation (WHO) analyzed research on risk and protective factors from more than 50 countries and concluded the following for Asia (WHO, 2001):

Risk factors for adolescent drug/substance use	Protective factors for adolescent drug/substance use
▪ Conflict in the family ▪ Friends who use drugs/substance	▪ A positive relationship with parents (family) ▪ Parents provide structure and boundaries (family) ▪ A positive school environment (community) ▪ Having spiritual beliefs (individual)

Risk and Protective Factors Exist on Several Levels

At an individual level, life experiences play a more significant role in substance / drug use than genetic traits. Important factors are the level of support and care from a parent or other adult at an early age and the quality of a child's school experience. In addition, personal and social competence, such as, feeling in control and feelings about the future are important factors. Also, personal beliefs play an important role. At the peer level, the selection of peers and nature of peer support is crucial.

Factors arising from the family level include a history of substance use or lack of effectiveness of family management including communication and discipline, structure of coping strategies, the level of attachment parents and children, nature of rules and parental expectations, and the strength of extended family network. Adolescents who have a positive relationship with their parents and whose parents provide structure and boundaries are less likely to use drugs / substance. However, adolescents in families where there is conflict are more likely to use substance / drugs.

At societal and community levels, factors include the prevailing social norms and attitudes toward s substance / drug use. Social competency skills, communication and resistance skills also play an important role.

At the school level, adolescents who have a positive relationship with teachers, who attend school regularly and who do well in school, are less likely to use substance / drugs.

(Source: Global Youth Network, 2002; NIDA 1997; WHO, 2001)

Session 6.6
Consequences of Drug/Substance Use

Expected Outcomes
Participants will understand the various ways in which drug/substance use can affect a person's life.
Participants will know that there is a link between drug/substance use and HIV infection.

Story Of Woo

Objectives The participants will become aware of the consequences of drug use.
The participants will become aware of the risk of HIV infection related to drug use.

Materials Flipchart paper, markers.

Time 30 minutes.

Process Ask the participants to divide into 4 groups.

Explain that each group will work on the same case study but will answer different questions. All of the groups will make a presentation on their work and the discussion that occurred within the group. They should use flip charts and markers to make the presentation.

Hand out the case studies and allow 20 minutes to do the exercise.

Invite all of the groups to display their outputs and present their work one by one.

Encourage the groups to question each other and discuss. Facilitate the discussion by asking relevant and open-ended questions. Base your questions on the answers given by the 4 groups based on the case study.

The following case study can be used for this exercise. The peer educator can also prepare another case study for use, if so desired.

Case of Woo
Woo is a 17-year old Chinese Buddhist girl who was born in Lushai. She is the youngest in her family, and her parents are alive and live in Lushai. Her father was a rebel but has changed his ways. Her mother is a nurse.

Woo worked in a department store in Mandarine and lived with her aunt. While living with her aunt Woo made new friends and started enjoying the nightlife offered by the city. She would often go to bars with her friends after work hours. One night, one of her friends offered her some amphetamine tablets. Her friend told her that they would make her energetic and lively and that she would be able to enjoy

her time out. Woo was tempted to try the tablets but resisted the first time. Eventually, she began using the tablets.

Gradually, she discovered that the tablets were no longer enough and she needed to take something more powerful. She was finding it difficult to continue with her job, and the cost of the habit was increasing day by day. Her family wrote to her, but she did not respond. They thought she was sick and unable to write back.

Meanwhile, Woo met an elderly lady at one of the bars who offered to help Woo earn more money. Woo was desperate, and she agreed to have sex for the money it would bring her. Often, she would have sex without using a condom.

Her friends were becoming worried about her but she had stopped responding to their concern. Her aunt was very worried and asked her to talk to someone. She once discovered syringes and drugs in her room, and she was worried that Woo had become dependent on drugs and could possibly be infected with HIV/AIDS.

Woo continues to live with her aunt, but she no longer works at the department store. She is out of the house most of the day and night and finds it increasingly difficult to cope with her life. She is confused and feels helpless. She wants help but is too scared to ask for it. She is aware of the stigma attached with the kind of life she is leading. She frequently remembers her mother telling her about HIV/AIDS and asking her to be careful. Should she go for a test and counselling? She is unable to make a decision.

Questions for group 1
Why did Woo begin taking drugs?
Can you think of other reasons that might lead a person to take drugs? List as many as you can?

Questions for group 2
What impact has drug use had on Woo's life?
Can you think of other impacts that might occur? List as many as you can.

Questions for group 3
What are the chances that Woo has been infected with HIV? What should she do?
Make a list of things she should do to find out about her HIV status.

Questions for group 4
Why are Woo's friends and aunt worried about her?
What can they do to help?

Note for the Facilitator
Depending on the participants and the socio-cultural setting you could make your own case study. Prepare your notes on different types of drugs, reasons why young people may use drugs and possible treatment opportunities for drug dependence. You can use the material given at the beginning of the module in the form of question answers. You can also use the outputs from session 6.4 for this session.

Session 6.7
Ways of Dealing with Risk Situations

Expected Outcomes

Participants will know how to deal with situations where they might be offered drugs.
Participants will be able to handle situations that pressure them to use drugs.

Resolving An Issue

Objective To formulate and practice strategies (ways and methods) for dealing with situations involving risk.

Materials Scenarios for role-plays (given at the end of the exercise).

Time 1 hour.

Process Ask the participants to divide into groups of 4 to 5. Explain that you will be giving each group a situation, and the group should prepare a role-play showing multiple strategies (ways and methods) of dealing with the situation.

Ask each group to list different strategies to deal with their situation and produce a 2 to 3 minute role-play to demonstrate different *ways* of resolving each situation.

After about 20 minutes, ask each group to present their scenario to the entire group.

After each role-play, encourage discussion on the types of strategies depicted. Whether there may be other strategies of dealing with the situation? Whether anyone in the group has used that type of strategy in their life?

You may want to use the following questions to generate debate and discussion:

- *What kinds of strategies were used in the different situations? Can you think of any others?*
- *Which situation was the most realistic?*
- *Which strategy is the most useful? Why?*
- *Which strategy is the least useful? Why?*
- *How would you resolve a similar situation in your life?*
- *Would you be able to use these strategies in your life situations? Why /Why not?*

Note for the Facilitator

Be ready to help out with strategies and suggestions for the role-plays. Think about strategies that are assertive, aggressive and manipulative, and about threats and persuasion.

The following scenarios can be used for this exercise. The peer educator can also make new scenarios based on his / her awareness and socio-cultural realities of young people in his / her area / country region.

Scenario 1

A friend invites you to a disco where it is rumoured that (meth)amphetamines and other drugs are widely available. What might be happen if (a) you accept the invitation, or (b) you refuse the invitation?

Scenario 2

You meet an old friend whom you haven't seen for some time. She / he lights a marijuana cigarette (a "joint") and offers it to you?

Scenario 3

You go out with some friends and someone offers you a tablet. They insist that it will make you feel great, that everybody is taking them and that, surely, you do not want to be left out. What should you do? What would you say?

Scenario 4

You are with your friends. Someone offers you some alcohol and some capsules, which someone suggests will take away the effects of the alcohol. How would you respond?

Scenario 5

One of your friends is becoming increasingly involved with another group. You have heard that this group regularly uses solvents and amphetamines. What do you do?

Scenario 6

A friend has been spending a lot of time (and money) at the local video game arcade (store).
She / he asks to borrow some money from you. What would you do?

Session 6.8
Learning To Make Sensible Choices

Expected Outcomes

Participants will know how and when to use negotiation and refusal skills.
Participants will apply negotiation and refusal skills to protect themselves from negatives influences and situations.

No Thank You

Objective The participants will learn and practice negotiation and refusal skills. The participants will be able to analyze the method and appropriate time to protect themselves from the influence of others.

Materials Flipchart paper, markers, plain paper, pencils.

Time 1 hour.

Process Invite the participants to sit in a circle. Explain that they will be doing an exercise to learn negotiation and refusal skills.

Ask the participants to help write the following messages on flipchart paper and post them around the room.

Just one more for the road.	*Real men drink to the bottom!*
What are you afraid of? Only sissies, goody-goodies and nerds don't drink.	*Drinking is better than worrying about something.*
No alcohol, no fun.	*All your friends smoke. Why don't you?*
Just have one for my sake. *Discos and drugs go together.*	*Just try this pill and you will be on top of the world.* *Don't be a goody-goody.*
There is no harm in smoking marijuana, once in a while.	*If you don't take this tablet, I will think that you don't love me.*
Would I give you something harmful? I am your best friend.	*You are my friend only if you prove it by smoking this joint.*

Arrange small groups of 4-5 persons each. Each group must select one of the messages above.

Allow the groups 15 minutes to prepare a role-play on the message they choose.

The role-plays should focus on responses to the messages they choose. The group should be able to display multiple ways of handling the situation.

When the groups are ready, invite them to present their role-plays to the other groups.

After each group has presented its role-play, the observers must state the message that the role-play is in reference to and the method the group used to solve the problem. Do they think the method was appropriate? What would they suggest?

You may want to use the following questions for discussion and summarization:

- *How did you feel about the role-plays? Why?*
- *If you faced similar situations would you be able to refuse? Why/Why not?*
- *Why is it so difficult to refuse friends?*
- *How can you counter peer pressure and make your own choices?*
- *What do you think are the consequences of drinking alcohol or using drugs?*
- *Do you think that the problem solving methods that your friends presented are appropriate for you? Why? Do you have any other methods?*
- *If there is no way that you can refuse your friends, what can you do to help yourself?*
- *What skills did you build or strengthen from this activity?*

Note for the Facilitator

The facilitator should be prepared to suggest alternative methods of solving the problems in the role-plays and "counter statements". The various issues that come up should be recorded to be later used in large group discussion. For example, the issue of different attitudes towards drinking that may come from culture or tradition, social status, religion, or gender. You may want to use the following information to make a presentation on the impact of alcohol and drug/substance use.

You can also have each of the participants write a counter statement to the statements that have been pasted around the room. They should evaluate whether their statements are appropriate or not and think of the consequences of their words.

Invite the participants to choose a partner and practice the counter statements. They should give feed back to each other on their work. If you use the exercise in this manner, you will allow space for practice, and the participants will learn to make sensible choices in pressure situations.

Possible results of alcohol and other drug use on a person's well being, (especially if it is regular and extensive). Substance use can:

Mental and Emotional Health Decrease learning and performance, in school or on the job. Intensify moods and feelings. Interfere with decision-making. Intensify stress. Be linked to most violent crimes. Be linked to suicides and most suicide attempts.	**Safety and Injury Prevention** Cause dizziness and disorientation. Increase the risk of accidents, drowning or falling. Lead to coma and even death when alcohol and other drugs are combined. Cause forgetfulness. Be linked to HIV infection.
Relationships Interfere with effective communication. Intensify arguments. Increase likelihood of violence. Depress the brain and respirator centre.	**Diseases and Disorders** Cause cirrhosis of liver. Cause heart disease. Increase risk of cancer when combined with cigarette smoking. Increase risk of kidney failure. Increase risk of general communicable diseases due to depressed immune system.
Physical Health Destroy brain cells. Decrease athletic performance. Interfere with coordination. Lower / increase body temperature. Dull the body senses. Increase heart beat rate and resting blood pressure. Interfere with appetite. Interfere with vitamin absorption.	**Economics** Be linked to many missed days of school, college and work. Be costly to procure and continue use. Increase the health care cost. Be costly to the community, as treatment and detoxification centres have to be run and law enforcement efforts have to be strengthened.

Module 7
Life Skills

FLOW CHART

Content Flow at A Glance
Module 7: Life Skills

Module 7
Life Skills

"Know thyself"

Socrates

I What are Life Skills?

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

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

Life skills are essentially those abilities that help promote mental well-being and competence in young people as they face the realities of life. Most development professionals agree that life skills are generally applied in the context of health and social events. They can be utilized in many content areas: prevention of drug use, sexual violence, teenage pregnancy, HIV/AIDS prevention and suicide prevention. The definition extends into consumer education, environmental education, peace education or education for development, livelihood and income generation, among others. In short, life skills empower young people to take positive action to protect themselves and promote health and positive social relationships.

II What are the Core Life Skill Strategies and Techniques?

UNICEF, UNESCO and WHO list the ten core life skill strategies and techniques as: ***problem solving, critical thinking, effective communication skills, decision-making, creative thinking, interpersonal relationship skills, self-awareness building skills, empathy, and coping with stress and emotions.*** Self-awareness, self-esteem and self-confidence are essential tools for understanding one's strengths and weaknesses. Consequently, the individual is able to discern available opportunities and prepare to face possible threats. This leads to the development of a social awareness of the concerns of one's family and society. Subsequently, it is possible to identify problems that arise within both the family and society.

With life skills, one is able to explore alternatives, weigh pros and cons and make rational decisions in solving each problem or issue as it arises. It also entails being able to establish productive interpersonal relationships with others.

Life skills enable effective communication, for example, being able to differentiate between hearing and listening and ensuring that messages are transmitted accurately to avoid miscommunication and misinterpretations.

III What are the Main Components of Life Skills?

The World Health Organisation (WHO) categorizes life skills into the following three components:

a) Critical thinking skills/Decision-making skills – include decision-making/problem solving skills and information gathering skills. The individual must also be skilled at evaluating the future consequences of their present actions and the actions of others. They need to be able to determine alternative solutions and to analyze the influence of their own values and the values of those around them.

b) Interpersonal/Communication skills – include verbal and non-verbal communication, active listening, and the ability to express feelings and give feed back. Also in this category, are negotiation/refusal skills and assertiveness skills that directly affect ones' ability to manage conflict. Empathy, which is the ability to listen and understand others' needs, is also a key interpersonal skill. Teamwork and the ability to cooperate include expressing respect for those around us. Development of this skill set enables the adolescent to be accepted in society. These skills result in the acceptance of social norms that provide the foundation for adult social behaviour.

c) Coping and self-management skills refers to skills to increase the internal locus of control, so that the individual believes that they can make a difference in the world and affect change. Self esteem, self-awareness, self-evaluation skills and the ability to set goals are also part of the more general category of self-management skills. Anger, grief and anxiety must all be dealt with, and the individual learns to cope loss or trauma. Stress and time management are key, as are positive thinking and relaxation techniques.

UNICEF promotes the understanding that the life skills approach can be successful, if the following are undertaken together:

a) The Skills -This involves a group of psychosocial and interpersonal skills (described in section 3) which are interlinked with each other. For example, decision-making is likely to involve creative and critical thinking components and values analysis.

b) Content - To effectively influence behaviour, skills must be utilized in a particular content area. "What are we making decisions about?" Learning about decision-making will be more meaningful if the content is relevant and remains constant. Such content areas as described could be drug use, HIV/AIDS/STI prevention, suicide prevention or sexual abuse. Whatever the content area, a balance of three elements needs to be considered: knowledge, attitudes and skills.

c) Methods - Skills-based education cannot occur when there is no interaction among participants. It relies on groups of people to be effective. Interpersonal and

psychosocial skills cannot be learned from sitting alone and reading a book. If this approach is to be successful, all three components, life skills, content and method should be in place. This effectively means that life skills can be learnt through the use of certain methods and tools.

IV Criteria for using Life Skills.

UNICEF identifies the following criteria to ensure a successful life skills-based education:

- It should not only address knowledge and attitude change, but, more importantly, behaviour change.
- Traditional "information-based" approaches are generally not sufficient to yield changes in attitudes and behaviours. For example, a lecture on “safe behaviour” will not necessarily lead to the practice of safe behaviour. Therefore, the lecture should be substantiated with exercises and situations where participants can practice safe behaviour and experience its effects. The adult learning theory emphasizes that adults learn best that which they can associate with their experience and practice.
- It will work best when augmented or reinforced. If a message is given once, the brain remembers only 10 percent of it one day later, and when the same message is given six times a day, the brain remembers 90 percent of it. Hence the need to repeat, recap, reinforce and review.
- It will work best if combined with policy development, access to appropriate health services, community development and media.

V How can Life Skills Help Young People make Better Choices concerning their Health?

Developing life skills helps adolescents translate knowledge, attitudes and values into healthy behaviour, such as acquiring the ability to reduce special health risks and adopt healthy behaviour that improve their lives in general (such as planning ahead, career planning, decision-making, and forming positive relationships). The adolescents of today grow up surrounded by mixed messages about sex, drug use, alcohol and adolescent pregnancy. On one hand, parents and teachers warn of the dangers of early and promiscuous sex, adolescent pregnancy, STDs / HIV / AIDS, drugs and alcohol, and on the other hand, messages and behaviour from entertainers and peer pressure contradict those messages. Often, they even promote the opposite behaviour. It is through life skills that teenagers can fight these challenges and protect themselves from teenage pregnancy, STDs, HIV / AIDS, drug violence, sexual abuse, and many other health-related problems.

Hopefully, developing life skills among adolescents will empower girls to avoid pregnancy until they reach physical and emotional maturity, develop in both boys and girls responsible and safe sexual behaviour, sensitivity and equity in gender relations, prepare boys and young men to be responsible fathers and friends, encourage adults, especially parents, to listen and respond to young people, help

young people avoid risks and hardships and involve them in decisions that affect their lives.

VI What does Research say about the Outcomes of Life Skills-Based Education?

Programmes aimed at developing life skills have produced the following effects: lessened violent behaviour; increased pro-social behaviour and decreased negative, self-destructive behaviour; increased the ability to plan ahead and choose effective solutions to problems; improved self-image, self-awareness, social and emotional adjustment; increased acquisition of knowledge; improved classroom behaviour; gains in self control and handling of interpersonal problems and coping with anxiety; and improved constructive conflict resolution with peers, impulse control and popularity. Research studies have also shown that sex education based on life skills was more effective in bringing about changes in adolescent contraceptive use; delay in sexual debut; delay in the onset of alcohol and marijuana use and in developing attitudes and behaviour necessary for preventing the spread of HIV / AIDS.

Session 7.1
Exploring Life Skills

Expected Outcomes

Peer Educator will become aware of the life skills that the participants possess and use in their day-to-day life.
Participants will know about life skills and their use in day-to-day life.

What Skills Do I Have?

Objective

To explore the concept of life skills.
To know the life skills used by the participants in their day-to-day life.

Materials

Flash cards, markers, flip charts, gum / tape.

Time

1 hour.

Process

Invite the participants to sit in a circle. Ask them if they have heard of the term "life skills"? What do they know about it?

Explain that all of us possess certain skills that allow us to live our lives. For example, the skill to write, work with others or make a decision.

Pass out one flash card to each participant, and ask him / her to write the most important skill he / she possesses.

Allow the participants 5 minutes to do this exercise.

Invite the participants to display their cards on the floor. Ask them to group similar cards.

Ask if the cards represent most of the skills required for leading a healthy and productive life. If not, ask them to add the remaining skills.

While the participants are busy doing their work, prepare three flash cards with the headings – "All of us have", "Some of us have" and "None of us have".

After the participants finish writing and grouping the flash cards, ask them to arrange the flash cards in a horizontal line on the floor.

Place the three cards, which you have prepared, in a vertical line next to the horizontal line of cards. Once this is done, you should be able to draw a matrix of rows and columns on the floor.

You should have 4 rows and as many columns as there are skill cards.

Now, ask the participants to start from the top and fill the matrix. Move from the left to the right.

Once the matrix is complete, ask the participants to discuss the reasons for its outputs. For example, why is it that only some people have certain skills, and why are certain skills absent?

Request volunteers to copy the matrix on a chart, and put it up on the wall.

Summarize and close the discussion by using the WHO definition of life skills.

Notes for the Facilitator

This simple exercise creates a mutual understanding of the concept of life skills and ascertains the level of life skills available within the group. The WHO categorization of life skills is given at the start of the module. This categorization can be used for the summarization of the exercise and as a handout.

Session 7.2
What Use are Life Skills?

Expected Outcomes

Participants will understand why life skills are critical for a healthy and productive life.

Analyzing The Matrix

Objective

To learn about the importance of life skills in our lives.

Materials

The matrix from the previous exercise (session 7.1), flip charts, markers.

Time

45 minutes.

Process

Ask the participants to take the matrix chart off the wall, and place it on the floor.

Invite the participants to divide into three groups – communication/interpersonal skills group, decision-making/critical thinking skills group and coping/self-management skills group.

Ask the three groups to look at the matrix and record the skills pertaining to their group.

Explain the task to the groups as follows:
Discuss and list the benefits of possessing the life skills that have been noted by each group.
Discuss and list the problems one would face if s/he did not have these life skills?

Then, ask the three groups to sit in three different locations. Give them flip charts and markers.

Allow 30 minutes to do this exercise.

Invite the groups to display their work and make presentations.

Encourage discussion and cross questioning in the groups.

Summarize and close the exercise by emphasizing the importance of life skills.

Note for the facilitator

This useful exercise emphasizes the utility and importance of life skills. You can use the information given in section 7.5 and 7.6 at the beginning of this module. Point out why life skills are important for young people. Make special mention of their importance in relation to protection against HIV / AIDS and STIs. You can present the list of the ten life skills necessary for protection against HIV / AIDS, STIs and drug use. These life skills include problem solving, critical thinking, communication skills, decision-making, creative thinking, interpersonal relationship skills, self awareness building skills, empathy and coping with stress skills.

Session 7.3
Life Skills, STIs and HIV/AIDS

Expected Outcomes
Participants will be able to identify the life skills that are essential for protection against STIs and HIV / AIDS.

Skills I Need

Objective

To learn about the essential skills required for protection against STIs and HIV / AIDS.

Materials

The matrix output from session 7.1, red marker pens.

Time

20 minutes.

Process

Invite the participants to sit in a circle.

Explain that, of the life skills previously discussed, some are critical for protection against STIs and HIV / AIDS.

Ask the participants to take a look at the life skills displayed in the matrix output from session 7.1.

Allow the group 10 minutes to discuss the life skills they consider most important for protection against STIs and HIV / AIDS.

Invite a volunteer to take a red marker, and circle the life skills identified "most important" by the participants.

Then, look at the matrix once again and see how many people possess each skill.

Close the exercise with a summary of the outcomes, and point out that the participants will get an opportunity to learn and practice some of the life skills discussed in this module.

Note for the facilitator

This exercise effectively focuses on the skills that young people need to possess in order to protect themselves against HIV / AIDS and STIs. Once again, emphasize the ten essential life skills listed as for protection against HIV / AIDS, STIs and drug use. These life skills have been listed in the facilitator's note given at the bottom of the previous exercise.

Module 8
Learning and Practising Core Life Skills

FLOW CHART

Content Flow at A Glance
Module 8: Learning and Practising Core Life Skills

Subject/topic/activity	Objective	Page No.
Games and exercises on exploring the self.	To analyze the sources of life skills. To enable analysis of one's environment. To look within. To become aware of others perspective of our self.	8-3 to 8-9
Exercise on values and behaviour.	To know the concepts of value and behaviour. To become aware of the sources of values one develops in life.	8-10 to 8-13
Exercise - Being responsible	To explore the meaning of responsibility.	8-14 to 8-15
Exercise – Journey of our lives.	To become aware of the factors that shape one's life.	8-16 to 8-17
Exercises on analyzing situations for risk and difficulties.	To become aware of situations that pose a risk. To identify situations that are difficult to cope with.	8-18 to 8-21
Exercises on assertiveness.	To learn to say "No". To practice making assertive statements and responses.	8-22 to 8 -26
Exercise – I Really Care.	To emphasize that there are many ways of showing affection without taking risks.	8-27 to 8-28
Exercise – Stop now.	To learn about decision-making.	8-29 to 8-30
Exercise - Condom use	To become familiar with a condom. To learn to use a condom.	8-31to 8-37
Energizer	To energize the participants.	8-38
Game – Open Sim Sim!	To practice persuasion skills.	8-39 to 8-40

Module 8
Learning and Practising Core Life Skills

"My legacy-what will it be?
Flowers in spring,
The cuckoo in summer,
And the crimson maples of autumn ".
Zen poem of Ryokan

Session 8.1
Core Life Skills and Our lives

Expected outcomes
Participants will learn that core life skills are shaped by our environment.
Participants will learn that core life skills are also about attitudes and behaviours.

Where Do They Come From?

Objective
To analyze the source of life skills.
To list the elements of life skills.

Materials
The outputs from session 7.1 and 7.2, flip charts, markers, tape.

Time
1 hour.

Process
Divide the participants into 4 groups.

Explain that using the list of core life skills identified earlier they will now try and identify the source of those skills.

The participants will also identify the elements that make up a life skill. For example, the skill of decision-making has the elements of knowledge, attitude and behaviour. Most skills are comprised of these three elements. Help the participants learn to identify these elements.

Invite each group to record 3to 4 skills from the outputs of session 7.1 and 7.2.

Ask the participants to take flipcharts and markers and complete 2 tasks –
1. Identifying the source of each life skill.
2. Identifying the elements that make up each core skill.

Allow 30 minutes for this exercise.

After 30 minutes, ask each group to display their work on the floor or on a wall.

Ask them to present their work briefly. Give each group 2 to 3 minutes for their presentation.

Sum up the presentations, and emphasize that life skills are learnt form various sources such as our family, our school, from books or from trainings. Different people learn their life skills from different sources but family and society play a major role. Life skills are comprised of knowledge, attitudes and behaviour. Attitudes and behaviour are also the key to protection against HIV / AIDS and STIs.

Note to the facilitator

This exercise will become the link between the theoretical understanding of life skills and day-to-day practice. Use this opportunity to sum up the main points that emerged from session 7.1, 7.2 and 7.3. Point out that in the prevention of HIV / AIDS and STIs, the major problem lies in the area of attitudes and behaviour. Most young people show an awareness of HIV / AIDS and STIs and the means of protecting themselves, but they do not practice the behaviour needed to protect themselves. This is why we emphasize life skills during a course on prevention of HIV / AIDS and STIs.

Session 8.2
Analyzing My Relationship with the Environment around Me

Expected Outcomes

Participants will understand that the environment plays an important role in their lives.
Participants will understand that the environment influences their life skills and life choices.

My World

Objectives To enable analysis of ones environment.
To learn a new skill for analysis.

Materials Chalk of different colours.

Time 1 hour.

Process Explain to the participants that they will be undertaking an exercise to analyze their environment.

This analysis will be done with the aid of a Venn diagram. This diagram has two main elements – circle and distance. Participants can use circles of varying sizes to show the importance of something, and they can use distance to show their relationship with the circles.

Explain that with the aid of this diagram they will analyze their relationship with other groups, institutions and organisations in the society.

Divide the participants into small groups. You could divide the groups based on gender, age or occupation. The groups should be based on some common element.

Ask each group to use chalk and the floor for this exercise.
Observe the groups as they proceed with the diagram. The following tips for facilitating might help:

- *Make a list of groups, organizations and institutions that exist in your social environment. For example, family, peer group, library, music group, school, college, factory, debating club etc.*
- *Assign a circle to each. If the group is very important, make the circle big, if it is of little or no importance make the circle small. If many are of equal importance, make similar size circles.*
- *Tell participants to put the chosen group at the centre and place the different sized circles around it. Decide on the distance based on their relationship with the circles.*

- *Explain that this is a group exercise so it should be based on discussion and consensus. If there are some strong individual differences, they should be noted and presented at the time of the presentation.*

Invite the groups to visit each other's diagrams. Each group should present their diagram to the others.

During the discussion on the diagrams you may want to use the following questions:

- *How was this exercise?*
- *Why did you make the circles the sizes you did?*
- *Why did you place the circles the way you did?*
- *What roles do these institutions, groups, organizations play in your life?*
- *What did you learn from this exercise?*
- *Where else can you use an exercise like this?*

Note for the Facilitator

This can be a very stimulating exercise for the participants, as they learn to examine the reasons behind the choices they make. It also teaches them to work in a group and to work through consensus. You could alternatively use this exercise for analyzing personal relationships. You could ask each participant to draw his/her own Venn diagram. This time they could use the circles for showing the importance of a person (avoid the use of names) and distance for showing their relationship with the person. In a large group, individual Venn diagrams could be very time consuming. You could ask the participants to do it at home and bring it back the next day for display and discussion.

Session 8.3
Looking within

Expected outcomes
Participants will know themselves better.
Participants will learn a creative method for dealing with their emotions.

Me! This Is Me!

Objective To get an insight into the characteristics, qualities, interests, weakness, and strengths of self.

Materials Good quality chart paper, markers, crayons, glue, scrap paper, old magazines / news papers, scissors, cutters, pencils, stapler, paints.

Time 1 hour 30 minutes.

Process Explain that each person will be using his / her creativity to create a collage entitled "Me!"

Ask them to use any material they want to create the collage provided it is available within the learning environment. Tell them about the materials available.

Explain that the collage should be representative of who they think they are – the things they like, the clothes they wear, the work they do, the places they visit, the friends they have, the strengths and weaknesses within them, dreams, aspirations and other qualities.

Inform them that they should not write their names on the collage.

Allow 45 minutes for the task.

After the collages have been complete, find a place where they can be displayed for everyone's viewing pleasure.

Try to get the participant to guess who made which collage.

Ask the participants to briefly explain their own collages.

The following questions could be used to generate a discussion:

- *Was it easy to identify who made which collage? Why or Why not?*
- *Was it difficult to find the materials/pictures/ideas that represent you? Why or why not?*
- *Which elements in the collage represent personal happiness? Why did you choose them?*
- *Which elements in the collage represent sadness, anger or discontent? Why?*

Note for the Facilitator

This exercise is really effective in bringing out the creative energies of the participants. It also allows them to show their inner selves to others while reflecting upon the quality of their lives. This exercise may be done over an extended period, if the participants meet over a period of time. It would be useful to use more than one facilitator for this activity. The facilitator needs to look out for signs of low self-esteem, depression, over confidence and other signs that might reflect the need for attention. In such cases, the facilitator may need to provide extra time and support to such individuals after the training or refer them for further attention to appropriate persons.

Session 8.4
Seeing inside and outside of ourselves

Expected Outcomes

Participants will learn that the way their view themselves is sometimes not the way they appear to others.
Participants will learn that the views of others play an important part in who we are and how we behave.

I Am A Stone

Objective To get an insight into how we see ourselves and how others see us.

Materials As selected by the participants.

Time 45 minutes.

Process Ask the participants to take 5 to 10 minutes to explore the training space.

While they walk around they should think about themselves and find something that they think symbolizes who they are.

Each participant should come back to the room with one symbol. If someone is unable to find an appropriate symbol s/he could simply state what the symbol is.

Ask the group to sit in a circle.

Explain that each participant should display their symbol to the group and tell them why s/he thinks the symbol is representative of them.

Start with a volunteer and give him/her two minutes to explain.

Ask the rest of the group to choose another image/symbol that they think will suit the person better. Ask them to give a reason for their choice.

Ask the person if he/she is able to accept what the others are saying. Why or why not?

Repeat this with each participant.

You could use the following questions to generate a discussion:

- *How did you feel when your view of self did not match the way others saw you?*
- *What did you learn about yourself?*
- *How do you cope with people's varying perspectives of you?*
- *Is the way others see you important to you? Why or why not?*

Note for the Facilitator

This exercise is fairly simple to conduct, but it requires sensitive handling during the discussion period. The learning from the discussion is dependent on the way the facilitator guides, encourages and prompts the participants. Before the start of the exercise, emphasize that the participants should not feel targeted or ridiculed during the exercise. Everyone must adhere to the norms of listening and giving feedback. Discourage sarcasm and disparaging remarks.

Session 8.5
Values and Behaviour

Expected Outcomes

Participants will understand the concept of values and behaviour.
Participants will understand that values and behaviours form an important part of life skills.

I Believe Therefore I Do

Objective To help participants explore the concepts of "values" and "behaviour".

Materials Flip charts and markers.

Time 1 hour.

Process Divide the participants into small groups of 5 to 6.

Ask them to come up with a definition of "values" and "behaviour" and at least three examples of each.

Give them 25 minutes to do this.

Ask them to come back to the large group.

Invite each group to share their definitions.

Note for the Facilitator

It is advised that you use both of these concepts while conducting the exercise. Often people confuse the two concepts, so it is useful to explore both and emphasize how values often define behaviour. "Values" are the code of behaviour, principles, ethics, morals or standards by which we live our lives. "Behaviour" can be defined as conduct, way of acting, response, manners, bearing, actions, function and operation.

Values and behaviours are critical components of life skills. These two elements are the key to the practice of "safe behaviour" which is essential for protection against HIV / AIDS and STI infections.

Session 8.6
Learning our Values

Expected Outcomes
Participants will have an insight into their attitudes – where they come from and how they influence their lives.

Imbibing!

Objective To help participants identify values that they receive from their social environment.

Materials Cards with "value" statements, blank flash cards, markers.

Time 1 hour.

Process Invite the participants to sit in a circle on the floor.

Tell them that they will be sorting value cards on the basis of the source of those values i.e., where they learnt those "values".

Empty out the card container in the centre of the circle and ask the participants to proceed.

Encourage them to discuss and sort the cards; they can use markers and blank flash cards for writing the source of the "values".

They should use the floor to display the diagram that will emerge from this exercise.

You may want to use the following questions for facilitating a discussion on the out come of the exercise:

- *Do you believe in any of the values you just sorted out? Why and why not?*
- *Are values important? Why and why not?*
- *What are the values that you will never compromise on? Why?*
- *Do values are defined by our socio-cultural environment? Why and how?*
- *How do values impact our behaviour? Give some examples.*

Note for the Facilitator

We absorb "values" through various sources such as friends, teachers, parents, books, religious ceremonies and books, films or stories. These values have great bearing on our behavio ur and it is important to explore them. Behaviour change is a very time consuming process. It requires great patience and will. Often, behaviour changes only when we begin to explore and question our values. The facilitator should use this exercise within this context and encourage the participants to find these links (between values and behaviours). You could alternatively ask the participants to think about behaviour that can result from the "values" that are on the cards. Ask them to make a list of probable behaviours next to each "value". This could also be done in small groups by giving a set of cards to each group.

Some "value" statements that may be used for making the cards for this exercise:

Stealing is bad
Love our fellow beings
Cheating is okay because everyone does it
Talking back to our elders is bad manners
Lying is bad
It s okay to buy goods from the black market
Bribes are normal
It's a dog-eat- dog world
By hook, or by crook, I will succeed
Women are not as good as men
Men are more intelligent
Women are "things"
Poor people are worthless
People are poor because they are lazy
Everyone is equal in God's eyes
Family is more important than my principles
Everything is fair in love and war
Men and women can never be equal
It is okay for a man to have multiple sex partners
Women should not smoke or drink
Truth is divine
Compromise is the way of life
Life is for living
Everything is fine as long as no one knows
Education is useless
Money is the new God
If I have money, I can get anything
Helping others is good
Charity begins at home
Laughing at others expense is bad
Variety is the spice of life
God is watching so be good
Sex is immoral and impure
Success is all that matters
Honesty is the best policy
Beauty lies in the eye of the beholder
What goes down must go up
Everything has a price

Blood is thicker than water
Crying is for women
A man never cries
Children are a woman's responsibility

Session 8.7
What does being Responsible Mean?

Expected Outcomes
Participants will understand the characteristics of a responsible person.
Participants will know whether they are responsible people, or not?

Being Responsible

Objective To explore the meaning of "responsibility".

Materials Chalk.

Time 45 minutes.

Process Ask the participants to sit in a circle on the floor.

Explain that they should close their eyes for a minute and think of someone they consider "responsible".

Ask them share one characteristic of the person they just thought of.

Each participant should say only one characteristic.

Ask for a volunteer to come into the middle of the circle and write the characteristics on the floor with chalk. If it is difficult to write on the floor ask him/her to use flash cards and markers.

When each person has said one characteristic, ask them to group the ones that are similar.

Arrange these on the floor in a vertical line. Explain that according to them, a responsible person should have these characteristics. It would be interesting to see how many of these they have within themselves.

Ask each participant to pick up a piece of chalk and place a tick mark against the characteristic they think is present in them.

When all participants finish you will have tick marks against many of the identified characteristics – some will have more ticks and some less, and some may not have any.

Ask why this is the case?

Explain that within the group, as a whole, almost all the characteristics are present, but they may not be present in every individual. Ask if they know anyone who has all the characteristics or most of these? How can they help each other in developing the characteristics of a responsible person? Do men and women require

different types of characteristics to be responsible? If yes, what and why?

Note for the Facilitator

This is an effective exercise for creating self-awareness among the participants. Do not be worried about the fact that you will not know who has which characteristic. The participants will know how they have faired in the responsibility department. If you have time, you could extend this activity further by asking the participants to draw up a list of actions/behaviours against each of the characteristics and ask them to discuss how they fair.

Session 8.8
The Journey of our Lives

Expected Outcomes

Participants will understand that all of them have had experiences that have left a mark on their lives.
Participants will understand that experiences have an impact on one's outlook, behaviour and life style.

Timelines

Objective To get an insight into the factors that shape our lives.

Materials Flip charts, markers, crayons.

Time 1 hour.

Process Invite the participants to sit in a circle.

Explain to the participants that they will be drawing a personal timeline of their lives to the present. Explain that all of us have had experiences that have left a mark on us and shaped us into who we are.

Ask the participants to reflect on the memories that they think have had an impact on their lives and are in someway connected to their present day lives.

Ask them to make use of the flip charts, markers and crayons to do this exercise.

Explain that they should start from their first memory as a child and progress towards the present.

They can use words or drawings to describe the memory. Inform them that they have 30 minutes to do this exercise.

Ask them to display their respective timelines on a wall.
Then give the participants 15 minutes to view each other's timelines.

You may use the following questions for a discussion:

- *How did you feel while doing this exercise? Why?*
- *Did you see any common elements in the timelines? If yes, what do you think about it? If not, why do you think that is?*
- *How have these incidences/relationships/occurrences had an impact on your life?*
- *Do you think you can shape your own future from now on? If yes, how? If not, why?*

Note for the Facilitator

This exercise is effective for opening a session on life skills. It allows the participants to reflect on their life course and get a glimpse into the lives of others around them. The exercise also allows the facilitator to get to know the participants quickly.

One can extend this exercise further, if one is interested in helping the participants in charting a future life course. You could ask the participants to use the same timeline to depict the course of their lives for the next however many years? Alternatively, you could use a similar exercise to help the participants draw a road map of their future. It would include where they would like to be and how they could get there.

Session 8.9
Dealing with Risks

Expected Outcomes
Participants will learn that risk situations and behaviour are part of everyday life.
Participants will become aware of the pitfalls of risk behaviour.

Playing Safe

Objective To help participants consider situations that involve risk-taking behaviour/practices and to help them think of other ways to handle those situations through analysis of the circumstances.

Materials Role-play scenarios (given at the end of the exercise).

Time 1 hour.

Process Ask the participants to divide into three groups.

Explain that they will be doing role-plays to depict risk behaviour/practice scenarios.

Hand out the role-play scenarios to the groups and ask them to prepare to act it out. Explain that they should choose their own words, songs, dance, and body language so that it describes realistic, typical circumstances and actions that could lead to sex and other risk behaviour.

Explain that they may feel embarrassed about acting out the scenarios, but remind them that we all feel fear and embarrassment at times. If we accept that we feel certain things and act in certain ways, we can also discover ways of dealing with it and changing. We have all come together to help each other learn and deal with issues most important to us. Ask each group to take 20 minutes for preparation and then come back for their presentations. Encourage each group to present their role-play and after each has done so help them in the discussion.

You can guide the discussion by asking the following questions:

- *Why did the characters in these role-plays engage in risk behaviour?*
- *What pressures or circumstances lead to their behaviours/actions/practice?*
- *Could they imagine a situation where they could be in similar situation and not want to partake in risk behaviours/actions?*
- *What kind of responses would they give if they were placed in similar situations?*
- *How would they handle the situation differently and attempt to avoid risk behaviours?*

Note for the Facilitator

Role-plays are an effective method of experiential learning. The participants are free to display a real life scenario without being threatened. The role-play scenario allows the participant to decide on the outcome of the situation that the protagonist finds himself/herself in. The discussion at the end of the role-plays is critical for this exercise so allow enough time for the discussion and keep it focused by using questions and appropriate interventions.

The following scenarios can be used for this exercise.

Scenario 1: There is a young 18-year old woman who has very strict morals and believes that sex should only be practiced after marriage. She is in college and has friends from different backgrounds. She wants to be popular with her friends. She feels attracted to a boy in her class and develops a friendship with him. She really begins to like him and spends time with him. Eventually he asks her to have sex with him.

Scenario 2: There is a young 16-year old boy who has just joined a new place of work. The workplace is far away from his home and he has to live in a dormitory for working men. He is lonely and wants to make new friends. He starts going out with his fellow boarders. They take him to bars and brothels and make fun of him because he is shy and withdrawn. He starts drinking, and eventually one of his friends offers him drugs.

Scenario 3: There is a young person, 17 to 18- years old, who is very carefree and confident. He likes to experiment, to have different experiences, multiple sex partners, do drugs, and drink. Life is one big party. His parents are rich and provide money for all his needs. He begins falling ill frequently and is loosing weight.

Session 8.10
Exploring the Situations

Expected Outcomes
Participants will become aware of their ability to cope with difficult situations.
Participants will learn to make appropriate responses in order to avoid risk behaviour and situations.

Hey! This Is Easy

Objective To identify situations we find difficult to cope with.
To identify situations we find easy to cope with.

Materials A list of situation statements (given at the end of the exercise).

Time 1 hour.

Process Invite the participants to sit in a circle. The facilitator should also be part of the circle.

Inform the participants that you will be reading out some statements and the participants have to think about them and respond.

They say "easy" for the statement that they think they can handle and "difficult" for the situation they think they will not be able to cope with.

Ask them to speak out or act out their response to the statement.

Reassure the participants that this is not a competition.

Go around the circle. Ask each participant about his/her response at least once.

After each statement, take time to seek differing viewpoints. Ask why certain people find a situation difficult and why certain people can cope. Ask how some people cope? You can ask the participants to act it out.

Note for the Facilitator
This exercise requires careful attention as it is dependent on the responses of the group and does not have a pre-planned format. The facilitator should adapt the statements to the mood and socio-cultural background of the participants. Usually, for every person who can handle the situation, there will easily be someone who would find the same situation difficult to handle Invite both parties to present their views and reasons.

Some statements that can be used for this session are as follows:

- *I like going to parties and outings. My friends often drink and smoke. They offer me drinks and cigarettes.*
- *I am new in my school/college. I want to make friends. I especially want to be friends with ……(use a name depending on the socio-cultural setting). She is very beautiful and popular. She asked me to come to a party at her place. At the party she introduced me to her friends and during the course of the party one of them tried to touch me intimately.*
- *I have a regular boy friend and I think I love him. We go for walks and do things together. Lately he has been asking me to have sex with him.*
- *I am very shy and withdrawn but I hang out with other boys of my age. Everyone makes fun of me. They say I am not a man. If I were a man, I would accept their dare and have sex with a sex worker.*
- *I am alone at home and my brother's friend comes looking from him. He tries to molest me.*
- *My girlfriend wants to make love with me but I have been resisting. She thinks I am gay.*
- *I like a boy in my class. He has asked me out for movie.*
- *My friends often use drugs and alcohol. They ask me to experiment and enjoy life.*
- *My parents are pressuring me to get married. I want to continue my education.*
- *My family is constantly pushing me to be the best. They want me to be the best in everything I do. If I don't perform according to their expectations they mock me and scold me.*
- *I work in a small shop and go to school at night. I feel exhausted and tired. One of my colleagues at the shop says if I start smoking marijuana I will feel on top of the world.*
- *My friends have asked me to come with them for a picnic.*
- *I am only 17 years old. My girl friend wants us to get married.*
- *My close friend is a lesbian. She wants to become intimate with me. She says that it will make our friendship stronger.*
- *My boy friend likes to express his affection by kissing me and hugging me.*
- *My friends often go out, but I have to stay home because my parents do not like it.*
- *My father drinks all the time but gets mad if I drink.*
- *My mother lectures me all the time and disapproves of my clothes and my friends.*
- *My sister is very good in her studies, but I want to learn music and play in a band. My parents think I am useless and good for nothing.*
- *My friends say I am beautiful and a good friend.*
- *Yesterday my colleagues at work gave me a birthday present.*
- *My girlfriend claims that she loves me very much, but she forgot my birthday.*
- *My teacher says I will never be successful because I lack discipline.*

Session 8.11
Learning to Say 'No'

Expected Outcomes
Participants will learn to deal with being pressured in an appropriate manner.
Participants will reduce the risk of HIV / AIDS and STIs in their lives.

No Means No!

Objective To practice responses for dealing with being pressured.

Materials Sheets with statements that persuade young people to say "YES" when they may want to say "NO", markers, sheets of paper.

Time 1 hour.

Process Ask the participants to break into groups of 4.

Tell them that you will be giving them statements that they often hear from their peers and friends. These statements usually persuade young people to say "YES" when they may want to say "NO". In their groups they will develop appropriate responses for dealing with such statements.

Assure them that this exercise will help them learn ways of dealing with persuasion.

Ask them to discuss the statements in the group and come up with as many responses as they can in 20 minutes. Give them paper and marker / crayons etc. for preparing their responses.

When the groups come back, ask them to demonstrate their responses. They may do this through a dialogue or a quick role-play. Every person should get the opportunity to demonstrate at least one response.

Encourage the participants to discuss the responses. Ask them if they found it easy to come up with their responses? Did they enjoy the task? Will they be able to give such responses in a real life situation? If yes, how? If not, why?

Note for the Facilitator
This exercise is fun and allows room for creativity. Young people enjoy coining phrases and using them although it requires practice. In the small groups they get the chance to discuss their difficulties and reservations. However, this exercise should be done only after the participants are comfortable and at ease with each other. You could also do this exercise in pairs. You may give more than one phrase card to each group so as to allow maximum participation.

For every reason to say "NO", someone has found a way to persuade you to say "YES"**. This exercise will be very effective if you facilitate it after session 8.10. The statements for which the participants need to frame their responses:**

You cannot get pregnant the first time. Let's just do it once.
You do not think I have a disease, do you?
Come on, you are not a kid anymore.
I know you want to, you are just feeling shy.
We are more than friends. I love you so much.
Come on, just have one drink. It will relax you.
Smoke this joint and you will be in paradise.
No one will know about it, it's just you and me.
Look, I am feeling aroused, you'd better do something about it.
You may not get another chance like this.
Why not, everyone else is doing it.
Do it or goodbye.
Nothing will happen, its all right.
Do you think I will hurt you? You are my love.
You owe me.
I can hurt you if you don't.
If you really loved me, you would do it.

Session 8.12
Using Assertive Messages

Expected Outcomes
Participants will be able to use assertive messages when being pressured.
Participants will know the effects of behaving and communicating in assertive, aggressive and submissive manners and learn to choose appropriately.

I Really Mean It

Objective To learn to use assertive messages, especially when you want to say "No".

Materials Word cards, flip charts, markers.

Time 1 hour.

Process Invite the participants to sit in a circle.

Explain that communication is about using speech, actions, body language, expression, seeing and listening.

This exercise will allow the participants to practice their communication skills to make them more effective.

Start at one end of the circle and ask the participant to pick up two cards.

Pass the container to the next participant and continue until each participant has 2 cards each.
Ask each participant to read their cards and think of a sentence that includes the words on the cards.

Give the participants 5 minutes to prepare. Start at one end of the circle moving from one participant to the next. Each member of the circle will have a chance to participate.

Encourage the participants to be creative Let them use words, facial expressions and body language for maximum effect.

After each participant has presented his / her sentence invite the group to give feedback.

Ask them to confine their feedback to whether the sentence was effective in conveying an assertive message? Why?

After all the participants have had a chance to practice their two sentences, facilitate a discussion. You may choose to use the following questions for the discussion:

- *How did you feel practicing your assertive statements? Why?*
- *Are there moments in your life when you want to say "No" and end up saying "Yes"? Why?*
- *What are the key characteristics of an assertive person?*
- *What are the advantages and disadvantages of being assertive?*
- *Are girls usually less assertive than boys? Why?*

Note for the Facilitator

Young people find it difficult to be assertive in their peer group, especially in situations when they are being pressured. Often, young women find themselves being submissive because of they do not know how to assert themselves. This exercise encourages young people to examine their ability to be assertive using speech and body language. The feedback from observers should be carefully channelled so that it is not counter productive. Ask the participants to give feedback only on the sentence and the way it was delivered.

Word cards that may be used for this game are as follows:

I feel that we can	I will not	Listen I am
Sadness	Happiness	Sex is
It is so good	I am not at all	I think it will
Love What do you	Dislike I told you	Future is Of course I
Life is	Tomorrow	Protection is
No, I am	I want to	Hold and hug
Yes, darling	Just wait for	Can you
It is so	I feel	I have to
You should	Think	I will

You may have to duplicate these cards to have enough for all the participants. You can also make other cards using your own imagination and knowledge of the participants.

Helpline for the peer educator

Aggressiveness means expressing your feelings, opinions or desires in a way that threatens or punishes the other person. You tend to insist on your rights while denying the rights of others. It is often a dominating behaviour and includes shouting, demanding, leaning forward, pointing fingers, threatening, and fighting. It is not a very effective method of communication, as it puts the other person on the defensive or provokes them to retaliate or to switch off.

Assertiveness means telling someone exactly what you want, in a way that does not seem rude or threatening. You stand up for your rights without threatening the rights of others. It is usually a balanced position and the behaviour includes making clear "I" statements, looking the person in the eye, standing at ease and sticking to your position. This is a very effective method of communication, as it encourages listening and speakin g. It allows both parties to state their viewpoints in an amicable manner which leads to continued dialogue and resolution.

Submissiveness means giving in to the will of others and hoping to get what you want without actually having to say it. It can also mean an inability to decide for yourself and allowing others to decide for you. This is a poor position to take in a pressure situation and the behaviour includes talking quietly, mumbling, looking down and away, sagging shoulders or hiding the face with the hands. Submissiveness often leads to unhappiness and regret, as you hand over your power and rights to others around you.

Peer Educator can use the following exercise as an energizer in case the participants are feeling lethargic and bored.

Yes! No!

Objective To relax the participants and demonstrate the differing ways we can say "YES" and "NO"

Materials None.

Time 15 to 20 minutes.

Process Ask the participants to stand up and split into two groups. Both groups should form a line, and stand facing each other in the centre of the training room.

Explain that one group is "YES" and one group is "NO". Allow them to choose the group they would like to be.

Inform them that the "YES" group can only use the word yes and the "NO" group can only use the word no.

Each group should try to convince the other group that their statement is true, but can use only one word; yes or no.

After few minutes ask the groups to swap roles. The yes group now says no and the no group says yes.

After a few minutes, ask the participants to describe how they felt doing this exercise. Explain that laughter is also an important means of expression.

Note for the Facilitator

There are many ways to say yes or no, depending on the emotions at the time. As many young people have trouble either saying yes or no effectively this activity is interesting to try. The facilitator can help the participants to become aware of this effect. Essentially this is a fairly stress-free exercise and can be used as an energizer to rejuvenate the participants.

Session 8.13
Learning to Care Without the Risk of HIV/AIDS

Expected Outcomes
Participants will understand that they can show affection and love for a person without having to indulge in risk behaviour.

I Really Care

Objective To emphasize that there are a number of ways to show affection without sex.

Materials Flip charts, markers.

Time 30 minutes.

Process Ask the participants to divide into small groups of 4 or 6.

Explain that love and affection are important to human survival and there are various ways of expressing these feelings. Sexual intimacy is only one way of exhibiting love and affection.

Invite the groups to pick up some flip charts and markers for their task.

Ask each group to describe ways of showing affection without having sex.

Tell them that they can use words and pictures to do so.

Allow 15 minutes for this exercise.

When the groups return, ask them to make small presentations on the work done in the small groups.

After the presentations, invite the participants to sit in a circle for a discussion on their presentations. Make sure the presentation outputs are visible to the participants as they discuss.

You may want to use the following questions for the discussion:

- *How did you feel doing this exercise?*
- *Do you agree that love and affection can be shared without sex? Why or why not?*
- *If there are so many ways of showing affection, why don't we use them more often?*
- *Is sexual pleasure possible without risk behaviour/practice? How?*
- *Are there cultural and social restrictions on receiving sexual pleasures without having penetrative sex?*
- *What can be done to reduce the socio-cultural restrictions?*

Note for the Facilitator

This exercise is simple and generates interesting debate on various methods of displaying affection. It can be used for reviewing participants learning on safe and risk behaviour. Alternatively, it can be used for re-enforcing safe behaviours.

Session 8.14
Making a Decision

Expected Outcomes
Participants will learn that timely decision-making can reduce and eliminate the risk of STIs and HIV / AIDS.

Stop Now

Objective Making decisions about stopping before it is too late.

Materials Cards with some actions that depict physical affection but stop short of penetrative sex, drawing of a stepladder or mountain peaks in ascending order, cello tape / gum stick.

Time 30 minutes.

Process Explain to the participants that they will be doing an exercise called "stopping before its too late".

This exercise will provide information types of physical affection and their impact on the recipient.

Unveil the drawing of the stepladder or mountain peaks. You can draw it quickly on a blackboard / white board or on flip charts on the wall. Make a large drawing so that all participants can participate in the exercise.
Place a box containing the action cards on a table or chair within easy reach of the participants.

Ask all the participants to come and stand near the drawing and empty out the box.

Ask them to read each card and place it an appropriate level, from the one that is least physical to the one that is most physical.

Encourage the group choose the placement of the card by consensus.

Once the group correctly places the cards on the "mountain" encourage them to have a discussion on the exercise.

You may like to facilitate the discussion by using these questions

- *Why is it hard to stop, as you get closer physically?*
- *Would it be easy to go back to a safer activity? Why or Why not?*
- *Where do you think the limit is?*
- *Who should decide where the limit is?*
- *When should the limit be decided?*

Note for the Facilitator

This exercise is simple and involves the participants in an activity that is non-threatening while at the same time thought provoking. It touches on important questions in decision-making, such as who, when, where and how.

List of physical actions that can be used for making the cards

Hugging
Caressing without the removal of clothes
Dry kissing
Holding hands
Touching the breasts under the clothes
Touching the genitals under the clothes
Deep wet kissing
Body massage without the clothes
Lying next to each other
Running the hands through the partner's hair
Touching the breasts and genitals over clothes
Lying on top of each other
Keeping your head in your partners lap
Sitting on the partner's thigh and putting your arms around his/her neck

Session 8.15
Learning to Use a Condom

Expected Outcomes

Participants will become familiar with a condom.
Participants will be aware of the myths / beliefs related with condom use.
Participants will understand how to correctly use a condom.

Touch Me!

Objective To provide a chance for participants to become familiar with a condom.
To increase awareness on the benefits of condom use.

Materials Condoms (select different types in terms of colour and texture), slips of paper with a statement, tape with music / songs, tape recorder

Time 1 hour

Process Ask all the participants to sit in a circle on the floor. Tell them about the exercise and its purpose.

Ask for a few volunteers. Ask the volunteers to blow up the condoms like balloons. Some condoms should have a slip of paper with a statement, in them. Prepare about 15 balloons; 7 to 8 should have statements in them.

Put the inflated condoms in one place.

Start the music (use something lively) and have the participants pass a condom balloon around the circle. The participants should hold the condom in their hands and feel it.

Stop the music. The participant who is holding the balloon at that moment must sit on the condom and try to burst it. If there is a statement in the burst condom he / she should read it out and state whether the statement is true or false. Ask the participant to giving reasons for his / her answer.

Open the discussion to the large group to solicit additional information and correct misunderstandings.

Introduce a new condom balloon and start the music again. Continue this exercise until you feel everyone has had a chance to express herself / himself on the subject of condoms.

If someone gets a condom balloon without a statement in it, ask them to ask a question about condoms or express his / her views on the subject.

Try to use as many condom balloons with statements as possible in order to coverer most issues in condom use.
You can use the following questions for a discussion:

- *How did you feel touching the condom? Why?*
- *Has anyone used a condom before? Would the person like to demonstrate its use or share how he/she felt?*
- *Why do some people resist the use of condoms?*
- *How can you persuade them to use a condom?*
- *Do you think you will be able to persuade your partners to use condoms?*

Notes for the Facilitator

If a person is unable to answer a question during the course of the exercise due to reasons of shyness or some other reason, open the discussion to the large group and encourage them to search for the answer together. If boys and girls feel shy or inhibited doing this exercise together, divide them into two groups. Make sure you have a co-facilitator who can lead the other group. If some participants have religious/cultural inhibitions, involve the group in answering the questions, and leave the choice of participating in the exercise to the concerned individuals.

Try and generate debate on whether women face more difficulties in persuading a partner to use a condom? You can make the exercise more interesting by asking the participants to develop some responses that would persuade a partner to use a condom. There may be some questions on whether women can use condoms. Provide information on female condoms. You can use some handouts with basic information on condom use and access for this exercise. You can also use a dildo to demonstrate how to use a condom correctly. Some facilitators use a banana for the demonstration but sometimes this is not culturally acceptable. There have been instances when people have assumed that putting a condom on a banana or dildo is what is expected. Be sure to tell the participants that condoms are to be used by the person who is having sex.

Some statements that may be used for this exercise:

Condoms reduce sexual pleasure.
Condoms can be lubricated by using ordinary creams and lotions.
Condoms are cumbersome and annoy the partner.
If I use a condom, my partner will think I have some disease.
If I go to a shop that sells condoms, people will think poorly of me.
I only need to use a condom when I have sex with many partners.
I don't have to use a condom if I go to a sex worker.
Condoms are expensive.
Sometimes condoms break.
Sometimes the condom stays in the vagina.
A girl/woman asks for a condom to be used only if she wants to avoid pregnancy or if she is unfaithful.

Helpline for the peer educator

This material can also be used for making handouts and posters.

Addressing barriers to condom use

1. Condoms reduce sexual pleasure

Sexual pleasure is a psychological experience of a physiological sensation. Thoughts, expectations and other emotions attached to sex are also factors. Pleasure depends on the relationship between the partners, their expectations, the novelty of the experience, the setting of the sexual activity, the degree and length of foreplay, and the level of fatigue or freshness. Even with the same partner, the same degree of pleasure may not be experienced every time.

Also, condoms currently available are so thin that they do not in any way decrease sexual arousal or pleasure. Condoms should rather be seen in the context of providing protection from STI / HIV, enabling a person to enjoy sexuality for a longer time, free from the fear of getting any infections.

2. Condoms break and are not reliable

The condoms currently available are good quality. If you handle them carefully and wear them correctly there should be no problem. Do not use more than one condom at a time, and use water based lubrication because this will greatly reduce the chances of the condom breaking. If the condom is good quality and it breaks, the problem is more than likely a one of usage. Properly expelling the air reduces the chance of it breaking.

3. Too shy to buy a condom

It can be a very difficult task to buy condoms. It is a public declaration of a private activity. We only overcome this shyness with practice. There are easier places to get condoms, however, you may find it easier to go to a shop where you are not known.

Some government clinics give them out for free, or your doctor may sell condoms. A local community group focusing on health may also distribute them

It may help you to be courageous if you think of why you are buying them. Condoms protect you from disease and pregnancy. Would it not be more embarrassing to get pregnant or get someone pregnant by accident?

Positive points about condoms

- Condoms are reliable methods of disease prevention and birth control.
- Condoms have none of the medical side effects of other methods.
- Condoms are only used when they are needed.
- Condoms don't interfere with the way a woman's body works.
- Condoms can be bought easily and do not require a prescription.
- Condoms help to prevent the spread of sexually transmitted disease including HIV.
- Condoms help to provide protection from cancer of the cervix.
- Condoms make sex a lot less messy. You don't have to argue about who sleeps on the wet patch, and the woman does not have to put up with the sticky, wet, drippy feeling after sex.
- Condoms can be checked after to see if they have been used properly.
- Men can take responsibility for disease prevention.

Session 8.16
Learning to Use a Condom continued

Expected Outcome
Participants will know the correct method of using a condom.

Wear Me!

Objective To be able to use a condom correctly.
To be able to speak with partners to convince them to use condoms.

Materials Condoms (different types of condoms in terms of colour, scent), dildo / bananas / any other object shaped like a penis, flip chart and markers.

Time 30 to 45 minutes.

Process Invite the participants to sit in a circle.

Explain that a condom is one of the most useful methods of preventing STIs, HIV / AIDS infection and unwanted pregnancies. It is important to know about its use and be able to convince our partners to use it. This exercise will enable the participants to learn how to use a condom and persuade their partner to use it.

Pass the container with the condoms and the container with the dildos / bananas around the circle so that every participant has a condom and a dildo or banana in their hands.

Ask for some volunteers who feel comfortable demonstrating the use of a condom. Ask them to stand in a place where everyone is able to see them and invite them to demonstrate the use of the condom.

Guide the volunteers in the correct method of using the condom.

If there are no volunteers, demonstrate the correct method of condom use yourself own.

Invite all of the participants to practice putting a condom on the dildo / banana (any object shaped like a penis).

Ask the volunteers to return to their seats.

Invite the participants to form pairs and convince each other to use a condom. Allow them to practice for some time.

Ask for volunteer pairs to demonstrate the messages / responses they used to persuade each other.

Facilitate a discussion on the exercise by using following questions:

- *Were all of you comfortable handling of a condom?*
- *What thoughts went through your mind while practicing how to use a condom correctly?*
- *How did you feel trying to persuade your partner to use a condom?*
- *Do you think in a real life situation you will be able to persuade your partner?*
- *What will happen if you cannot persuade your partner? Do you think you will be able to refuse to have sex?*
- *How can you start a conversation with a friend to explain the benefits of condom use?*

Note for the Facilitator

The facilitator should be sensitive to the cultural and religious sentiments of the participants. You should be prepared to deal with resistance and embarrassment and be able to provide encouragement. Ask the participants to encouraging the volunteers. Use the flip charts to record the responses of the participants. This will help you summarize the activity. Use transparencies / charts / drawings for to summarize effectively and reinforce the basic facts / benefits of condom use. The duration of the activity can be reduced or increased according to the group size and willingness.

The following statements may be used to generate responses during the "persuade your partner" part of the exercise:

- Come on darling don't waste time on this thing.
- Do you think I have a disease?
- I hate this thing; can't get any pleasure.
- You must be having an affair.
- You are using it so that I won't get pregnant, but I want a baby.
- You must have another partner and that is why you are using it.
- What a nuisance. I simply refuse.

Helpline for the peer educator

The following material can be used for the preparation of handouts, posters and presentations. Peer educators can also use this material for preparing themselves for the session.

What is a condom?

A condom is a thin sheath made of latex / rubber that fits on the penis to make sex safer.

What is it for?

It protects both partners during vaginal, anal or oral intercourse. It prevents pregnancy by preventing sperm from entering the vagina.

The latex condom protects against many sexually transmitted diseases including HIV / AIDS, by eliminating contact with the body fluids that may be infected.

How well it works?

- In relation to HIV prevention, condoms are presently the best solution and substantially reduce the risk of HIV transmission.
- Condoms are only effective when used consistently and correctly.
- Using a condom during intercourse is more than 10,000 times safer than not using a condom.
- Condoms are 98% effective in preventing pregnancy when used correctly and up to 99.9% effective in reducing the risk of STD transmission when combined with a spermicidal.
- In relation to pregnancies the first-year failure rates among typical condom users averages about 12% and includes pregnancies resulting from errors in condom use.
- Studies of hundreds of couples show that consistent condom use is possible when sexual partners have the skills and motivation.

How to use condoms?

- Handle condoms gently.
- Store them in cool, dry place (long exposure to air, heat and light makes the condoms more breakable).
- Do not stash them continually in a back pocket, wallet, on vehicle dashboard or glove compartment.
- Use lubricant inside and outside the condom. Lubrication helps prevent rips and tears and increases sensitivity.
- Use only water-based lubricants, such as KY Jelly with latex condoms.
- Oil-based lubricants like petroleum jelly, cold cream, and mobil oil damage the latex.
- Latex will become brittle from changes in temperature, rough handling or age. Don't use damaged, discoloured, brittle or sticky condoms.

Correct use of Condom

- Check the expiration date.
- Carefully open the condom package (teeth or fingernails can tear the condom).
- Use a new condom every time a person has sexual intercourse. Put the condom on after the penis is erect and before it touches any part of a partner's body. If a penis is uncircumcised, the person must pull back the foreskin before putting on the condom.
- Put the condom on by pinching the reservoir tip and unrolling it all the way down the shaft of the penis from head to base. If the condom does not have a reservoir tip, pinch it to leave a half-inch space at the head of the penis for semen to collect after ejaculation.
- Withdraw the penis immediately if the condom breaks during sexual intercourse, and put on a new condom before resuming intercourse. When a condom breaks, use spermicidal foam or jelly, and speak to a health-care provider about emergency contraception.
- Use only water-based lubrication. Do not use oil-based lubricants such as cooking/vegetable oil, baby oil, hand lotion or petroleum jelly. These will cause the condom to deteriorate and break.
- Withdraw the penis immediately after ejaculation, while the penis is still erect, grasp the rim of the condom between the fingers and slowly withdraw

the penis (with the condom still on) so that no semen is spilled.

War And Peace

Objective Warm up exercise to illustrate benefits of working together.

Materials A length of strong rope.

Time 20 minutes.

Process Ask the participants to stand up and divide into two teams. Clear the room of all hindrances or go outside in an open space.

Ask the two teams to hold the opposite ends of the rope. Mark a line between the two teams.

Say, "1, 2, 3 Go!" The teams should start pulling against each other. Let them go on until one team has crossed over the dividing line.

Ask everyone to sit in a circle on the floor. Now tie the same strong rope in a large circle.

Place it within the circle of the participants so that everyone is sitting around it.

Ask the participants to hold the rope in their hands and pull together on the rope so that they can all stand up.

Ask them what this illustrates to them.

The idea is to show how, instead of people pulling on opposite ends – a tug of war, where only one team wins, we can approach situations in a win-win way, so that everyone benefits and feels good about the result.

Note for the Facilitator

This exercise can be used as an energizer. It is useful in emphasizing the importance of cooperation and teamwork.

Session 8.17
Learning to Persuade

Expected Outcomes

Participants will know that persuasion skills can help them resolve potentially risky situations.
Participants will be able to use persuasive arguments and behaviours to protect themselves from risky situations and practices.

Open Sim Sim!

Objective To practice persuasion skills.

Materials None.

Time 30 minutes.

Process Ask the participants to form pairs.

Explain the following to participants, acting it out as you say it:
Our body language can influence other people's responses to us. For instance, if someone is acting aggressively with us, s/he may lean towards us or push us. When someone is feeling gentle they may touch us on our shoulder or hold our hand. We can use our body to convey many emotions and feelings. For example, we can contend with an aggressor by relaxing our body and looking them in the eye.

Since the participants have already formed pairs, tell them that first one person will act the persuader then the other. Both will get a chance to be the aggressor and the persuader.

First ask one person in each pair to be the aggressor. S/he must hold his/her hand up in a very tight fist and feel very angry. The persuader in each pair must try and persuade the aggressor to undo his/her fist.

The persuader should use all his/her skill to persuade the other person to calm down and open their fist. The persuader must not touch the aggressor physically. The aggressor can open his/her fist if they feel the persuader has done a good job.

Give the pair 5 minutes each way to try out their persuasion on each other.

Ask by a show of hands how many people managed to persuade their partners to open their fist.

Invite some pairs to demonstrate their persuasion skills to others.

Note for the Facilitator

This is an easy exercise and effective in emphasizing the important issues in "persuasion". The facilitator should point out the good practices / methods used by the persuaders - those who could convince their partners to opening the fist. You can ask the aggressors why some of them opened their fist while others did not. What did each of them feel as the aggressor and the persuader?

Session 8.18
Learning to Respond to Difficult Situations

Expected Outcomes

Participants will become aware of their strengths and weaknesses in dealing with difficult situations.
Participants will be able to respond better to difficult situations.

Objectives

To explore different responses to difficult situations.
To recognize our current tactics and skills in handling such situations, and to learn from the tactics and skills of others.
To find appropriate responses to situations that concerned us.
To anticipate difficulties and prepare responses.

Materials

Flip charts, markers.

Time

1 hour.

Process

Invite the participants to sit in a circle.

Ask them to take a few minutes and think about an incident or situation they faced recently, at home, at work or socially, that they feel they did not deal with effectively or as they would have liked to.

Divide the participants into groups of 4 or 6.

Ask each group to agree to work on one person's situation/incident. And they decide as a group. Together they should explore the following for their chosen case:
What could have been the most likely response?
What could have been the most provocative response?
What could have been the successful response (that is, the response which would have worked for that person, at that time but not necessarily for everyone)? The groups' decides on their role-play options among themselves. If the most likely response is similar to the most provocative response, there would be only two options left to role-play.

Either assemble as a whole group and watch some of the role-plays, or join groups together in twos to show their role-plays to one another.

When the groups rejoin into the larger group, the following questions could be used for a discussion:

- *What differences did different approaches make?*
- *What worked? Why?*
- *In what ways was it similar or familiar to their own life situations?*
- *How often is the likely response the provocative one or the successful one? Why/ why not?*
- *What skills or tactics, such as body language, do we use to achieve a successful response?*

Note for the Facilitator

The facilitator must observe the work in the different groups as it unfolds. You could have a co-facilitator to assist you in this session. Usually the most likely response will be a response, which is not successful, in terms of the result one expects. If the group feels that, in their example, the most likely response is actually the successful response, you could explore the factors that contributed to making it possible.

Session 8.19
Why We Make the Choices We Make

Expected Outcomes
Participants will know the reasons for the choices they make.
Participants will know one specific skill for making choices.

Comparing To Choose

Objective To learn to analyze why we chose certain activities / practices and reject others.

Materials Flash cards, markers, chalk.

Time 1 hour.

Process Invite the participants to sit in a circle on the floor. Leave lots of space at the centre for this exercise.

Invite two volunteers to the centre of the circle. Give them a stack of flash cards, markers and chalk.

Ask the participants to call out activities / practices that may be common in their peer group, for example, going to party, sports, or reading.

As they call out, ask the volunteers to write each suggestion on a flash card. Try and get a mix of negative and positive activities / practices. Try to stop at 10 to 15 activities / practices.

Ask the volunteers to arrange the flash cards on the floor in a vertical line.

Ask the participants to call out reasons for choosing an activity / practice. Ask the volunteers to note these on flash cards as well.

Try and limit the reasons to 8 to 10. If the participants agree, similar sounding reasons could be clubbed together.

Ask the volunteers to place these “reason” flash cards horizontally.

Ask the volunteers to draw a matrix using the vertical and horizontal placement of the cards. As a result, there should be a table with rows and columns on the floor.

Explain that each activity / practice will be analyzed according to the reasons mentioned by the participants.

Start with the first activity and analyze it against all the reasons mentioned. Then, move to the next and analyze it according to all the reasons mentioned. Complete all the rows, one after the other, in this fashion

As the participants to analyze each activity, they could give scores to show which reason is the most important for each one.

Once the matrix is complete, the participants will be able to see why they choose certain activities over others.

The quality of the discussion is dependent on the facilitator's ability to read the matrix and ask open-ended questions. For example,

So, the most important reason for going to a party is to be with friends, and I can see that the most important reason for drinking alcohol is also to be with friends. Why is that so?

I can see that the least important reason for drinking is having fun. Why is this so?

Note for the Facilitator

This exercise is very effective in promoting analytical skills among the participants. It enables maximum use of our senses, which ensures maximum learning. It is participatory and based on the knowledge and perceptions of the participants so no one feels forced. You could ask the participants to do a similar exercise in their free time to analyze their personal and intimate activities/practices according to the reasons for those activities/practices. They could share it with the larger group or with their friends, dependingon how they feel about it.

Session 8.20
Making decisions

Expected Outcomes
Participants will be able to identify their strengths and weaknesses in the area of decision-making.
Participants will understand the process for making decisions.

I Decide!

Objective To make the participants aware of their decision-making capabilities.
To explain the process of "decision- making".

Materials Pre-prepared situations, flip charts, markers, transparencies on decision making, over head projector.

Time 1 hour 30 minutes.

Process Explain that decision-making is a critical skill. It is important for our day-to-day lives and often determines the manner in which our lives will turn out. Inform the participants that they will be doing a small group exercise to understand how they make decisions, and then, they will learn about "decision-making".

Divide the participants into 4 groups.

Give one "situation" to each group and ask them to work on it. Allow 20 minutes for this exercise.

Explain that each group should try and come up with one response, but if there is disagreement within the group they should present the differing points of view during the presentations. Ensure them that there are no right or wrong answers.

Invite the groups to make their respective presentation.

For discussion, after the presentations, you can use the following questions:

- *What process did you use to arrive at the response you presented?*
- *How did you come to the decision?*
- *Can you identify the skills you needed for arriving at your decisions? What skills did you use?*

Note down their responses on a flip chart.

Summarize with the help of your transparencies. If you are unable to use transparencies, make charts and put them up on the wall.

Note for the Facilitator

This exercise allows participants to explore their decision-making skills. You can ask the participants to do a personal home task in addition to this exercise. That will enable them to reflect on the issue of decision-making – whether they followed a process in making a decision or simply reacted on the spur of the moment. Emphasize that decision-making is not reacting to situations; it is a well thought out process.

Situations that may be used for this exercise

Situation 1

You are invited to a party at your friends place this evening. You are really excited and looking forward to it. Your parents tell you that your cousins and their parents are coming to your home this evening. Your cousins are really keen to see you. They are coming from a long way, after a long time and would like to spend time with you.

- *What will you do?*

Situation 2

Your aunt is very fond of you. She works in the city and visits you sometimes. When she came to see you this time, she gave you some money.

- *How will you spend the money?*

Situation 3

You are very close to your friend. You share everything with her/him. Your sister/brother has a fight with your friend. Both of them start pressuring you to break off your relationship with the other.

- *What will you do?*

Situation 4

You work in a shop part-time so that you can go to school. One day you arrive at the shop and find the owner waiting for you. He begins accusing you of theft, as some things are missing from the shop. Others who work in the shop have accused you of the crime.

- *What will you do?*

Helpline for the peer educator

This material can also be used to make handouts and posters.

Four skills are particularly important for decision-making:

- A person must be able to identify and define the issue.
- A person must be able to generate a variety of alternative solutions to any given situation.
- A person must be able to identify and evaluate the possible consequences of each alternative.
- A person must be able to implement the solution.

One popular strategy for teaching decision-making / problem solution is called **FAST**. The purpose of FAST is to teach people to consider problems carefully before responding to them and to consider alternatives and their consequences.

F Freeze and think!
What is the problem?

A Alternatives
What are my possible solutions?

S Solution Evaluation
Choose the best alternative: Safe? Fair?

T Try it!
Slowly and carefully: Does it work?

Another way of looking at decision-making process is as follows:

Step 1 Identify the situation or problem.
Recognize that a problem or situation exists, and a decision has to be made.

Step 2 Collect information.
Collect all the relevant information. Use the six helpers – What? Why? When? Where? How? Who?

Step 3 Identify possible solutions.
Think carefully about all the possible alternatives that you could choose from.

Step 4 Examine each alternative?
Look at each of the possible solutions that you have listed, and think about the advantages and disadvantages of each. Also, consider how you feel about each of them. Discuss with people you think can help you. Think about the worst that can happen.

Step 5 Choose one alternative
Decide on one alternative from your list of alternatives. This choice will be based on your information, advantages, disadvantages, values and feelings.

Step 6 Implement the decision.
Work out the methodology and carry out your decision.

Step 7 Evaluate you decision.
Did it work? Why / Why not?

Session 8.21
Practicing the FAST Technique

Expected Outcomes
Participants will be able to make decisions.
Participants will be able to avoid risk situations and behaviour.

Making A Choice

Objective To learn and practice decision-making skills.

Materials flip charts, markers, flash cards, case scenarios

Time 1 hour and 30 minutes

Process Ask the participants to divide into small groups of 4 persons each.

Explain that they will receive one scenario each and work on it in their respective groups for 25 minutes.

Explain the FAST problem solving method, and ask them to follow this method in working on the scenario given to each group.

Each group should prepare a presentation based on the FAST method.

Explain that they can use flip charts, markers etc., for this purpose and that they can also use role-plays or both.

Invite each group to make its presentation. Ask the observers to hold their questions until all the groups have made their presentations.

Invite the participants to ask questions and share their observations. Give them the required feedback and summarize the exercise.

Note for the Facilitator
This exercise will allow the participants to practice the decision-making skill learnt in session VI.19. If the participants are unable to remember the FAST approach, help them remember it by going over the handouts and materials used in the earlier session.

Scenario 1
You are your parent's only child, and they have great expectations from you. They often tell you that they would like you to become a successful doctor. You have always tried to live up to their expectations, but now that the time has come to study for the entrance examination to a medical course, you want to tell them that you are really interested in becoming an actor. How will you communicate this to your parents?

Scenario 2
You have just joined a new college and are very eager to make friends. Your family has spent a lot of money and effort to allow you to attend this college. They live in a village. You are excited being in the city and want to explore your newly found freedom. You go to parties and try to fit in with the expectations of your friends. During one such party your friends offer you drugs and dare you to use them. What will you do?

Scenario 3
You live with your aunt and uncle and work in a department store. You work hard and long but are unable to afford a place of your own. Your girlfriend/boy friend is insisting that you should find a new job and house so that you can spend more time together. What will you do?

Scenario 4
You are deeply involved in a relationship, but one night in a reckless moment you have sex with another friend. You are afraid that the person may disrupt your relationship, and you are also worried about the consequences of the act regarding your own health. What will you do?

Scenario 5
You are 17 years old, but your parents think you are a child. They advise you on the clothes you should wear, the friends you should have and the college you should go to. You feel oppressed and want to make your own decisions. What will you do?

Scenario 6
You want to be rich and successful. You feel that life will only have meaning if you can achieve this as soon as possible. An acquaintance offers you the chance to earn a lot of money by working as a sex worker. He also promises you contacts and opportunities for long-term business partnerships. What will you do?

Scenario 7
You love your friend but s/he says that, unless you have sex with him/her, s/ he will not believe you. What will you do?

Note for the Facilitator
This exercise is very useful for practicing decision-making skills. These are suggestion; you may make new scenarios for the group depending on their age and socio-cultural background. Try to choose issues that may be the likely concerns of young people. The "FAST" approach to problem solving is easy to learn and practice; therefore, it has been suggested for this activity.

The following are more examples of problems/issues that young people face and can be used in this exercise:

- Your friend has some marijuana and offers you some.
- You see a syringe and some drugs in your sister's room.
- Your friends dare you to go to a sex worker and become a man.
- While you are driving, your friends are drinking alcohol and insist that you join them.
- You are studying for exams and some one offers you a pill to stay awake.

- You are new in the college and your classmates invite you for a picnic away from home.
- Your parents do not approve of your friendship with a person of the opposite sex and ask you to avoid social gatherings.
- You have a friend who takes drugs and you are concerned.
- Your sister is pregnant, but she is afraid to tell the parents.
- You want to study and get a job, but your family wants you to get married.

Session 8.22
Assessing the Decision

Expected Outcomes
Participants will learn to evaluate their decisions.
Participants will make better decisions and choices about their lives.

How Did I Decide

Objective To develop the skills necessary to assess a decision.

Materials Flip charts, markers.

Time 1 hour.

Process Ask the participants to divid e into 4 groups.

Explain that each of us has made some decision in our life, that, in retrospect, we might regret. It is possible to analyze the possible impact of our decision before we implement it.

Ways in which we can undertake this kind of analysis will be learnt through this exercise.

Ask each group to brainstorm on one decision that may have been made by any one member of the group.

Discuss the decision and whether the decision was ultimately correct, or not? Discuss why it was right or wrong.

After about 10 minutes, give the groups a handout and ask them to make a presentation about the decision they were discussing in the group.

This presentation should be based on the handout given.

Give the groups 20 minutes to make the presentation.

Invite each group to present.

After the presentations, use the following questions to facilitate a discussion:

- *What did you learn from this exercise?*
- *How did you find the format given for the analysis of a decision?*
- *Can you use this format in your decision making process? Why/ why not?*
- *What factors make a decision "good"? Why?*
- *What factors make a decision "bad"? Why?*
- *Can you change some factors in a "bad" decision and turn it into a "good" decision? How?*

Note for the Facilitator

This exercise is good practice for decision-making. You can alternatively ask the groups to demonstrate how certain factors can be changed to make a "bad" decision "good". Encourage the participants to reflect on and discuss the decisions they have made during the course of their lives. Facilitate the exercise so that nobody is ridiculed or harassed about their decisions. Create an environment of trust and confidentiality for this exercise. You may want to point out that, a decision that may be good for one person may not be good for another. This is because a decision is based on multiple factors, and these factors vary from person to person. Some of the factors that contribute to a decision are family, economic situation, ability, time, and social environment.

The following format may be given to the participants analyze decisions the make:

1. Statement of the decision made:
2. Out come of the decision:
3. Factors for analysis of the discussion:
4. Effects on me:
5. Effects on others:
6. Short-term effects:
7. Long-term effects:
8. Time taken:
9. Money and resources used:
10. Skills used:
11. Assistance needed:
12. Possible advantages:
13. Possible disadvantages:

Session 8.23
Cause and Effect

Expected Outcomes

Participants will become aware that every action has a cause and effect.
Participants will learn that, though effects can be controlled, causes may not be in one's control.
Participants will become more aware of their actions and behaviour, and therefore, able to protect themselves.

This Leads To That!

Objective To recognize that every actionhas a cause and effect.

Materials Chalk, action cards, paper, markers, flip charts.

Time 45 minutes.

Process Invite the participants to sit in a circle.

Pass around a container with chalk in it. Ask each participant to take one piece.

Ask them why they are holding a piece of chalk in their hand?

Possible response could be – you asked us to, to write, to draw.

Ask if they think this is the cause?

And, what is the effect?

Possible responses could be – I am holding it, I have kept it on the floor,I am drawing with it.

Explain that, similarly, all of our actions and behaviour have a cause and effect. Cause and effect are so natural that most of the time we are not even aware of their existence. However, between the cause and effect there is always an action. Many times the cause may not be in our hands, for example, a child being infected with HIV/AIDS by its mother. On the other hand, most of the time we can control the effect by choosing or not choosing, an action or behaviour.

Ask the participants to break into small groups of 6.

Give each group four action cards, and ask them to brainstorm the probable cause and effect of each action. Allow 20 minutes for this activity.

Ask them to come to the large group and facilitate a discussion:

- *What did you think of this exercise?*
- *How can the cause and effect analysis be applied to real-life situations?*
- *Would you like to share an incident or situation where you could have applied this skill and benefited?*
- *Are emotions a cause or an effect of an action/behaviour?*

Note for the Facilitator

Cause and effect analysis is an important decision-making skill. Most times we use it subconsciously. This exercise allows the participants to become aware of this skill. Awareness of this skill will also allow them to reflect on their actions and behaviours in life, prompting them to make changes. You could ask the participants to undertake individual cause and effect exercises. Ask them to take a sheet of paper and make a list of the actions/behaviours that they would like to change. Then, ask them to define the cause and effect of each of those actions/behaviours. They could share this in pairs, if so desired. You could also ask them to do a cause and affect analysis of actions/behaviour that they would like to improve.

Action cards for the exercise

Giving a compliment	Reading to a blind person	Drinking alcohol	Not using a condom during sexual intercourse
Giving flowers to your teacher	Injecting drugs	Masturbating	Helping mother in the house work
Dreaming	Playing guitar	Helping an old person cross the road	Skipping school/college
Sharing needles	Donating blood	Falling	Slapping your younger brother

*Actions/behaviour can have multiple causes and effects.

*Cause-action-and-effect is the circle of life.

Session 8.24
Examining Feelings

Expected Outcomes
Participants will become aware that some emotions are healthy, while others are not.
Participants will be able to deal with their emotions.

Handling Emotions

Objective To learn to distinguish between healthy and unhealthy expressions of feelings / emotions.

Materials List of emotions / feelings.

Time 45 minutes.

Process Ask the participants to divide into two teams, and sit on the floor facing each other.

One team should demonstrate unhealthy ways of showing feelings / emotions, and the other team should demonstrate healthy ways of showing feelings / emotions.

Each team will have 2 minutes to decide on their response, and display it.

The facilitator will read out the feelings / emotions.

The facilitator can use his / her own list or quickly make one with the help of the participants, using a flip chart and markers.

Switch teams after 10 minutes and follow the same process.

You can use the following questions for discussion:

- *How did you feel when you used unhealthy ways of showing feelings/emotions?*
- *How did you feel when you used healthy ways?*
- *Which is easier? More effective?*
- *When do you use healthy ways, and when do you use unhealthy ways of showing emotions/feelings? Why?*
- *Do you get the desired results from an unhealthy way of showing emotions/feelings?*
- *Do you see any advantages in using healthy ways of showing emotions/feelings?*

Note for the Facilitator

It is said that there is nothing healthy or unhealthy about feelings and emotions. This is true to some extent, but the ways in which they are expressed can be healthy or unhealthy. For example, beating your wife when you are feeling frustrated would be unhealthy. Unhealthy expressions of emotions and feelings can also take the form of suicide or self-injury. It is important that participants learn to distinguish between feeling/emotions and the way they are expressed.

List of emotions/feelings that may be used for this exercise:

Love	Gloomy
Sadness	Ashamed
Joy	Confused
Ecstasy	Excited
Anger	Mixed up
Frustration	Helpless
Jealousy	Brave
Revenge	Depressed
Loneliness	Hate
Fear	Embarrassed
Empathy	Patient

Session 8.25
How Feelings Help or Hinder Our Lives?

Expected Outcomes

Participants will understand that certain feelings hinder their progress in life, while certain feelings enhance their lives.
Participants will become conscious of their feelings, and therefore, be able to control them.

Does It Help?

Objective To learn about the feelings / emotions that hinder or help us.

Materials Emotion / feeling cards, flip charts, markers.

Time 45 minutes.

Process Ask the participants to sit in a circle on the floor.

Explain that they will do a card sorting exercise.

One group should have the cards with feeling / emotions that they think hinder their lives.

The second group should have the cards that they think help them lead happy lives.

If the group feels that there are emotions / feelings that both hinder and help, allow them to make a third group of cards.

Empty the container of cards in the centre of the circle, and allow the group to work for 20 to 25 minutes.

Observe the proceedings. If some people get left out of the exercise, encourage them to join in, and remind others to include them.

When the 2 to 3 groups of cards are ready and displayed on the floor. Ask for volunteers, from each group, to read out the cards.

You may want to use the following questions for a discussion:

- *Which is the largest group of cards? How, and why did this happen ?*
- *Which cards were easy to categorize? Why?*
- *Why do think certain feelings/emotions help, while some others hinder?*
- *What feelings/emotions do you normally enjoy experiencing? Why?*
- *Would you like to avoid having feelings/emotions that you do not like experiencing? How can it be achieved?*

Note for the Facilitator

Assure the participants that emotions/feelings are normal and experienced by everyone. It is the way we express those feelings that are important. For example, if we feel angry and bang our head against the wall, what will happen? Encourage the participants to reflect on their feelings and the expression of those feelings.

OR

Feelings

Objective To understand healthy and unhealthy expressions of feelings.
To become aware of the advantages and disadvantages of the way in which feelings are expressed.

Materials none.

Time 1 hour 30 minutes.

Process Invite the participants to sit in a circle.

Explain that feelings and emotions are common in a young persons' life. Many a times these emotions and feelings are expressed in ways that are not healthy or conducive to the well being of a person.

This exercise will allow the participants to explore the advantages and disadvantages of the various ways in which feelings/emotions are expressed.

As they discuss the most frequently experienced feelings/emotions, ask a volunteer to list the by the participants.

Allow 5 minutes for this, and then, ask them to choose the 4 most often experienced emotions/feelings.

Invite the participants to divide into 4 groups. Each group should take one emotion/feeling.

Ask each group to prepare role-plays to show a healthy and unhealthy expression of the chosen emotion/feeling. For example, if a group has chosen sadness as their feeling/emotion, they should be able to role-play its negative expression as well as a positive or balanced expression.

Give the groups 15 minutes to prepare. Invite them to discuss each other's presentation.

Gather in a circle and facilitate a discussion using the following questions:

- *What did you learn from this exercise?*
- *What are the consequences of the way in which you express your feelings and emotions? Why?*

- *How can young people learn to control the expression of their feelings and emotions to lead reasonably happy lives?*
- *Are some people more emotional than others? Why?*
- *Why is proper handling of emotions/feelings important for personal well-being?*
- *How can you help your friends in developing a balanced outlook towards life?*

Note for the Facilitator

This is a simple exercise that appreciates the fact that young people are prone to emotional fluctuations and outbursts. The ways in which emotions and feelings are expressed, often determines the consequences. Therefore, the expression of feelings and emotions is an issue worth exploring. Generally, the ways in which we chose to express ourselves are up to us, so this exercise should enable us to make good choices.

Session 8.26
Learning to Distinguish Behaviours

Expected Outcomes
Participants will be able to distinguish between negative and positive behaviour in others.
Participants will be able protect themselves from harm.

Distinguish!

Objective To learn to distinguish between positive and negative behaviour in interpersonal relationships.

Materials List of positive and negative behaviour, 2 charts – one with the "+" sign and one with "– " sign.

Time 30 to 40 minutes.

Process Ask the participants to put up the chart with the "+" sign on one wall and the chart with the "–" sign on a wall facing it.

Ask the participants if they understand the meaning of the signs.

Ask them to gather in the middle of the two charts.

Explain that you will read out some behaviour statements. They should move to the "–" sign, if they think it is a negative behaviour and to "+" sign, if they think the statement is a positive behaviour.

Quickly ask them to give reasons for their choice, and read out the next behaviour statement.

Continue as long as necessary.

You can use the following questions to generate discussion:

- *Is it easy to recognize whether behaviour is negative or positive?*
- *Can the awareness about negative and positive behaviour protect you from potentially dangerous situations?*
- *How will you deal with people who exhibit behaviour that you think can be harmful for you?*

Note for the Facilitator
This is a fun game. It is helps youngsters learn about positive and negative behaviour in others. It also works as an energizer and can be used by the facilitator as such. Assure the participants that there are no right and wrong answers. The purpose is to learn together and make corrections in our perceptions.

Statements that may be used for this exercise:

Smiles at you	Hits you	Invites you to a party	Talks about you to others	Helps you
Asks you to steal Dares you to do something	Talks to you Gives you a hug	Listens to you Shares things with you	Asks you to come for a movie Blames you	Invites you to join a game Offers to be your friend if you start smoking
Offers you an alcoholic drink	Tells you a funny story	Says its okay to have sex	Lies to you	Offers you drugs
Respects your feelings	Yells at you	Forces you to do something you do not want to do	Takes you out	Laughs with you

Session 8.27
Analyzing the Effect One has on Another

Expected Outcomes
Participants will understand that their personal choices and behaviour affect other people.
Participants will become sensitive to the affects of their choices and behaviour on those around them.

Why, Who, What, Where, When, How?

Objectives Participants will practice their analytical skills.
Participants will experience how their choices affect the people around him / her.

Materials Situations for role-play, flip charts, markers

Time 1 hour 30 minutes

Process Ask the participants to divide into 5 groups.

Explain that they will be doing role-plays based on the information that they will receive.

Allow 20 minutes to prepare the role-play.
Also inform them that they will get 7 to 8 minutes to present the role-plays.

Nest, they will reassemble and each group will present their role-play.

Encourage them to use their experience and knowledge to prepare the role-plays. They may use materials or props that are available in the learning environment.

While the groups prepare, the facilitator should arrange the flipcharts and seating area for the performance.

One by one, invite the groups to do their role-plays. The discussion should take place after everyone has presented their work.

The following questions may be used for the discussion:

- *How did it feel to role-play the situations given to you?*
- *Was it difficult to plan and execute the role-plays? Why/ Why not?*
- *What are your observations/views on the choices the characters made?*
- *What impact would their choices have on their own life and those of the people around them?*
- *What choices would you make, if placed in similar situations? Why?*

- *Have you ever wondered about the impact/affect of your personal choices on the people around you (family, friends and partners)*
- *While making a personal choice, should one be concerned about others? Why/Why not?*

Note for the Facilitator

Role-plays create a safe environment to discuss difficult subjects. While discussing characters, they get an opportunity to discuss their own problems and issues. However, role-plays are a difficult medium to control, and, at times, the facilitator may not be able to get the results s/he wanted. Therefore, the facilitator should be prepared to adapt to the situation and facilitate the discussion to maximize learning. Help the participants prepare realistic role-plays based on their experiences. Realistic role-plays enable more learning.

Situations that may be used for this exercise:

1. There is a festival/celebration. One of the relatives is very drunk. The family members are afraid that s/he will become violent or emotional and create a public scene. Each family member has different responses/reactions to the situation.

2. Some friends are hanging around in a lonely spot. One of them takes out his/her drug injecting equipment and invites others to try out some of the tablets s/he has. Each person has a different response/reaction to this situation and offer.

3. A young woman is sitting with her family at mealtime but refuses to eat anything. She is very thin and weak but insists on dieting. Each family member has a different response/reaction to her behaviour.

4. Some friends are living in the same room. They are drinking alcohol and listening to loud music. One of the friends is trying to sleep, as he/she has to go to work early. S/he/ asks the others to make less noise. Each person has a different reaction.

5. Many people are travelling on a bus. One person starts smoking a cigarette. Everyone has a different reaction/response to the situation.

Session 8.28
Appreciating Gender Differences

Expected Outcomes

Participants will understand the concept of gender.
Participants will become curious about the concept and begin to question their own biases and beliefs.

What Is Gender?

Objective To enable the participants to reflect on how they understand gender and sex and enable an understanding of social conditioning.
To increase awareness of gender and sex and increase participants' comfort level with theses issues.

Materials Flip charts, markers.

Time 1 hour.

Process Ask the participants to sit in a semicircle facing the flip charts / white board / black board.

Divide the flip-chart / blackboard into two, by drawing a line in the middle.

Write "Man" on one side and "Woman" on the other.

Ask the group to brainstorm a list of words that they associate with woman. List these under "Woman".

Ask them to do the same for man and list them under "Man".

Allow the participants to compare the two lists.

Ask the group to look at the list of words under the heading woman. Ask which of these are true only for women. Repeat the activity for "man". Cross out the words that can be true for both men and women. What is left?
Ask the group to brainstorm which of the words refer to gender and which refer to sex.

Explain the difference between sex and gender.

Facilitate a discussion using the following questions:

- *Why did you use different words for men and women?*
- *Can men and women perform similar tasks?*
- *How do we become man and woman from male and female?*

Note for the Facilitator

Keep the discussion general; avoid getting embroiled in pointless controversy. Remember that, basically, gender is about social roles of a male and female, while sex is either male, female or transsexual. Perceptions of gender and gender roles have a bearing on people with different sexual identities. Some gay men may identify with the female role and some gay women may identify with male roles. Gender has an important influence on vulnerability to STI/HIV infection. To understand how gender affects vulnerability, it is important to look at men and women's different roles in the economy, community and family. Ideal images of what men and women should be like may also contribute to vulnerability.

OR

Being A 'Man' And A 'Woman'

Objective Appreciating the difference and the similarities.
Learning to empathize.

Materials Flip charts, markers.

Time 1 hour.

Process Ask the participants to divide into 2 groups.

One group should be all male and one group should be all female.

Explain that they will be doing role-plays to learn about being male and female. Empathy is critical to appreciate and understand the differences and similarities between the sexes.

Ask the all male group to prepare a role-play entitled "I feel being a woman is ……"

Ask the all female group to prepare a role-play titled "I feel being a man is…"

Allow 20 minutes to prepare. Invite them to present their role-plays to each other.

After the presentations encourage discussion from observations on each presentation,

Invite the participants to sit in a circle and facilitate a discussion using the following questions:

- *How did you feel about the role-plays? Why?*
- *Are the things you depicted in your roles play true to life? Why/ why not?*
- *What are the advantages and disadvantages of being a man or a woman? Why?*
- *Have you ever thought about being the opposite sex?*

- *Does being a woman have more disadvantages than advantages? Why/why not?*
- *How can we learn to appreciate the similarities and differences between the sexes?*

Note for the Facilitator

This exercise helps to create an understanding of gender. It also allows young men and women the opportunity to explore their views, feelings, perceptions and assumptions about each other. You may feel that the topic given for the role-play is too open-ended and difficult to facilitate. If this is the case, make it a close-ended statement, for example, " I feel being a man is an advantage". Empathy is the ability to be in the others' shoes. That is why the males were asked to perform the female point of view and the females to perform the male point of view. This provides an interesting opportunity to explore the sexes' view and beliefs about each other, and the feedback indicates what is possibly true and not.

Helpline for the peer educator

This material can also be used for making handouts and posters.

The term ***Gender*** has undergone many changes over the years. At one time, it was a synonym for classifying nouns as male, female and neuter. It is now used to define socially defined sex roles (for men and women) and attitudes and values which societies consider as appropriate for one or the other.

Gender Roles are roles that are classified by sex, where this classification is social, not biological. For example, if cooking is classified as female role, it is a female gender role, not a female sex role since men or women can cook.

Sex Roles may, therefore, be contrasted with gender roles, since sex roles refer to an occupation or function for which a necessary qualification is to belong to a particular sex category. For example, pregnancy is a female sex role because only women have reproductive organs for child bearing.

Gender Roles Stereotyping is the constant portrayal, such as in the media, schoolbooks, books and general references, of women and men occupying social roles, according to the traditional division of labour in a particular society. This stereotyping works to support and reinforce the traditional gender division of labour by calling it "normal" and "natural".

Gender sensitivity is the ability to recognize gender issues, especially the ability to recognize women's different perceptions and interests arising from their different social location and roles. One could call gender sensitivity the beginning of gender awareness. However gender awareness is more analytical, more critical and questioning of gender disparities.

Gender Awareness means the ability to identify problems arising from gender inequality and discrimination, even if they are not evident and visible on the surface.

Gender Issues arise when an instance of gender inequality is recognized as undesirable, or unjust. For example, low wages paid to women for the same work as men.

Gender discrimination means to give differential treatment to individuals on the basis of their gender. In many societies, this involves systematic and structural discrimination against women in the distribution of income, access and control of resources and participation in decision-making. For example, women not having a share in the property of the father.

Unequal Gender Division of Labour refers to a gender division of labour where there is un-equal gender division of reward. Discrimination against women in this regard means that women often end up with the burden of labour (mostly unpaid labour), but men collect most of the income and rewards related to labour.

Gender Equality means that there is no discrimination on the grounds of a person's sex in the allocation of resources or benefits, or in access to services or on control of resources. The United Nations convention on the Elimination of All Forms of Discrimination against Women, is a plan to rectify inequalities. Many countries have constitutional provisions and laws that provide for equality for women.

Session 8.29
Roles Men and Women Play

Expected Outcomes

Participants will understand that men and women face different expectations from family and society.
Participants will know that various socio-cultural and religious factors shape the roles of men and women in society.
Women and men will be more appreciative of and sensitive to one another other.

I Am A Woman

Objective To develop an understanding of how religious, cultural, social and economic expectations shape the roles men and women are asked to play.

Materials flip charts, markers.

Time 1 hour.

Process Ask the participants to divide into two groups based on their sex – male and female.

Ask each group to make a list of expectations that they face – religious, cultural, social and economic.

Allow 30 minutes for this activity.

Invite the groups to share their lists.

You may use the following questions to facilitate a discussion:

- *Do these expectations affect your behaviour and choices in life? If yes, how? If not, why?*
- *Are you able to cope with these expectations? If yes, how? If not, why?*
- *Can you do something to deal with these expectations? If yes, what? If not, why?*
- *Are there different expectations from men and women? Why?*

Note for the Facilitator

This exercise helps participants reflect on the impact of various social, economic and cultural dynamics on their behaviour and life choices. If there are many participants, you may want to make more than 2 groups. You may want to explore the vulnerabilities linked with these expectations. Also remember to point out that women are more vulnerable to HIV/AIDS and STI infections. Women living with HIV/AIDS face more discrimination, marginalization and stigmatization. For statistics and details on how women are more affected you can consult Module III of this manual.

Session 8.30
Becoming Sensitive to the Needs of Vulnerable Groups

Expected Outcomes

Participants will know that some groups in society are more vulnerable to diseases (i.e., HIV / AIDS).
Participants will become sensitive to the needs of vulnerable groups.

This Is Also A Gender Issue

Objective

To explore attitudes towards the sexual activities of homosexual persons.
To create a better understanding of different sexual orientations.
To raise awareness of different responses and opinions about sexual orientation.

Materials

Adequate space in the room for people to move around

Time

1 hour

Process

Ask the participants to stand up, and if necessary, move chairs and other hindrances out of the way to make adequate space for them to walk around.

Explain that you are going to make a number of statements related to sex and sexuality.

One end of the room is for people who strongly agree with the statement, and the other end is for those who strongly disagree. If people are not sure about their response, they should stand in the middle of the room.

If it helps, invite the participants to put up appropriate signs to mark the areas corresponding to the responses. After each statement, the participants should move to the place that corresponds to their feelings about the statement.

Ask the participants to explain their positions (reasons) after each statement. If all of participants place themselves at one end of the room, ask them why there is no one at the other end.

Participants may also question each other about the positions they have taken.

They can change their position, if they change their minds during the discussion.

Try to ensure that, over the course of the exercise, everyone is asked to explain his or her position at least once.

Ask the participants to return to their seats and form a circle. Facilitate a brief discussion about sexual orientation and the feelings and beliefs attached to them. You can use the following questions to do so:

- *What were your thoughts when you saw that people œuld have so many different responses?*
- *What are some of the factors that influence how we perceive and understand different sexual orientations?*
- *Can our perceptions and understanding affect the lives of people with different sexual orientations? How?*
- *Is it possible that people who have different sexual orientations may be at higher risk of HIV/AIDS infection? Why/Why not?*
- *How can we contribute to an environment that supports and helps people of different sexual orientations lead healthy and dignified lives?*

Note for the Facilitator

What makes a person homosexual or heterosexual? While nature defines chromosomal sex and anatomical sex, it need not define sex at a psychological and social level. Sexual orientation is believed to be a mixture of both nature (b iology) and nurture (social conditioning).

Sexual behaviour and sexual identity depend much on the society one lives in. Sexual behaviour and sexual identity are choices. A man or woman with a homosexual orientation can chose not to have sex with other men or women. They can also choose to have sex with many or one partner. They can choose to be active or passive about their sexual preferences. In a society where same-sex relations are accepted, people are able to express their sexuality more freely. If the society is hostile towards same-sex relations people who have sex with same-sex people may do so in private and lead heterosexual lives in public. This obviously has repercussions on sexual health for those people and their partners.

Statements that may be used for this exercise are as follows:

Homosexuality is not natural.
Heterosexuality is normal.
Homosexuality is a result of how children are raised.
Heterosexuality is a result of how children are raised.
Heterosexuality is more pleasurable than homo sexuality.
In some societies, it is easier for married men and women to have sex with other men and women.
A person only knows his / her sexuality later in life.
Women who prefer to have sex with women should not get married.
Men who prefer to have sex with men should not get married.
Men who have sex with men do not need women in their lives.
Women who have sex with women do not need men in their lives.

Men are more likely to be homosexual then women.
Homosexual people cannot have normal family lives.
Homosexual people should be allowed to get married.

Helpline for the peer educator

This material can also be used for making handouts and posters.

1 What are the various kinds of safer sexual practices?

The various kinds of safer sex practices are:

- Kissing
- Fondling
- Talking, writing or reading about sex
- Watching sexy movies & live shows
- Individual or mutual masturbation
- Sex with underclothes on
- Sex with other parts of the body (thighs, breast etc.)
- Penetrative oral, vaginal and anal sex with condom.

2 What exactly is "normal" sexual behaviour? .

It is now recognized that there are many variations of sexual behaviour. Normal for one, might be abnormal for the other. Culture, tradition, society and our own emotions and experiences condition a person's thinking. We must learn to be non-judgemental with regard to alternative sexual behaviour whatever our beliefs or personal views may be.

Certain criteria to evaluate what is "normal" in a relationship could be:

- Consent between the two partners to enact what gives them mutual pleasure -oral sex, variations in coital positions or anal sex.
- Any sexual activity that does not cause physical or mental harm.
- It should be a private affair - not public.
- The activity should not be exclusive, for example, one partner insisting that only oral sex should be done.

3 What is oral sex?

Using the mouth in any way on portions of the body is defined as oral sex. "Fellatio" is when the female uses her mouth on the partner's genitals. "Cunnilingus" is when the male uses his mouth to stimulate the female's vagina.

4 What is masturbation and does it have any side effects?

Masturbation means stimulating one's own genitals to reach orgasm. Both males and females can do it. There are no side effects to masturbation. In fact, it can be considered a satisfactory and harmless ways to achieve sexual satisfaction. There are lots of myths and misconceptions surrounding masturbation and people feel anxious, uncomfortable or guilty about it.

5 Who are homosexuals, and is homosexuality natural?

Persons who choose to share their bodies sexually with persons of the same gender are called homosexuals. A male-male relationship is called gayism and a female-female relationship is called lesbianism. Bisexuals are persons who are sexually

attracted to both men and women. The accepted term now is Men who have Sex with Men (MSM) & Women who have Sex with Women (WSW)
Homosexuality is now accepted as alternative sexual behaviour and is considered by psychologists as normal.

Homosexual behaviour is dangerous only if penetrative anal sex occurs. Condom use can prevent transmission of HIV among men who have sex with men.

6 What is sexual health?
Sexual health is the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love.

It is the capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic. It is also the freedom from fear, shame, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships. It is also freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive functions.

In simple words, to obtain sexual health, a person must:

- Be able to say “yes” or ”no” to sexual encounters and respect their partner's wishes.
- Have proper information about sex.
- Be physically well and free from sexually transmitted diseases.

7 What are the barriers to sexual health?

- ***Myths, taboos and attitudes*** - These are responsible for much sexual inhibition and unhappiness. Taboos and attitudes are a barrier to talking about sex.
- ***The idea that sex is only for reproduction*** - It denies sexual acts as pleasure producing and a biological need. It also negates expressions of closeness and love between people through simple acts of intimacy.
- ***Sex roles (male and female) and sexuality***
- ***Denial of sexuality in childhood***

8 How can one talk about sensitive topics like sex?
One must first be comfortable with the topic (human anatomy, physiology and sexual behaviour). There is a need to appreciate the range and variety of sexual expression in human culture. One has to work at being able to deal candidly with one's own sexuality in relation to others and reflect on the related moral and ethical dilemmas. Then, bring up the issue in a non-threatening atmosphere, adding personal insights and humour. Always reinforce the point that sex is natural, and if not for sex, we would not be in this world!

Session 8.31
Why do Humans Have Sex?

Expected Outcomes
Participants will understand the facts of sexual intimacy.

All About Sex

Objective — To reiterate the importance of sexual intimacy.

Materials — flip charts, markers.

Time — 20 minutes.

Process — Ask the participants to sit in a circle.

Make sure everyone is able to see the flip chart you will write on.

Generate a discussion using the following questions and record the participant responses on the flip chart.

- *What do you like about sex?*
- *What is sex for?*
- *What is the* primary purpose of sex?

Note for the Facilitator

How often does the desire to have sex stem directly from the desire to have a child? Although one of the outcomes of sexual activity can be reproduction, the primary purpose of sex may actually be pleasure. If this were not the case, humans would be different. If sex were only meant for procreation, women might ovulate every time they have sex the way cats do. Human beings, however, ovulate on a regular schedule, which is unrelated to sexual activity. There are only a few days during a woman's monthly cycle when she can get pregnant, but most humans have a desire for sex and produce semen and vaginal fluids throughout the month. Even when a woman becomes pregnant, she will continue to feel the desire for sex and produce vaginal fluids to aid sexual activity. If sex were only meant for procreation, people would not feel the desire for sex after menopause. If sex were only meant for procreation, women would not have a clitoris. The clitoris has no function besides providing sexual pleasure and orgasm. If sex were only meant for procreation nobody would enjoy sex with others of the same gender. It is these facts plus the great creativity and love that humans are capable of bringing to sexual intimacy that make sex part of being human.

Session 8.32
Sexuality, Society and Me

Expected Outcomes

Participants will become aware of the role society plays in defining one's sexuality.
Participants will become aware of the fact that people who do not conform to the society's expectations can be marginalized, discriminated against and stigmatized.

My Sexuality

Objective To see how society defines the roles we take in relationships.
To look at sexuality from the vantage point of the relationships that shape our sexual expression and sexual identity.
To raise awareness about the power of gender.

Materials Flip charts, markers.

Time 1 hour.

Process Ask the participants to sit in a circle.

Start with a discussion about the various types of sexual relationships that occur in your culture. Invite the participants to discuss these relationships (living together, sex outside marriage, monogamous relationships, marriage).

You may want to use the following questions for the discussion:

- *How do people become recognized as a couple in your society?*
- *Do boys have a greater choice than girls about whom to marry, when to marry? Why?*
- *What are different reasons for getting married?*
- *What is considered a good relationship in your culture? What are some important factors in maintaining a good relationship?*
- *In what ways do children affect relationships?*
- *How do people feel about couples that cannot have children?*
- *Who is affected more when they cannot have children, men or women? Why?*
- *How can people choose when to have a family? What methods of contraception are available to people?*
- *What are some relationships beside marriage where people have sex or some kind of sexual intimacy?*
- *How do people feel about these relationships?*

OR

Have the participants draw the lifeline of two fictitious people – one male and one female. They could do this on the floor with chalk or on the flip charts with markers. Encourage the participants to describe the lives of these two characters. You may have to fix the period for

this lifeline activity. For example, ask them to draw their lives up to the 35 or 25.

- Compare the lifelines of the two characters. How do they differ, and why?
- Identify the opportunities and limitations for experiencing a full and active life for men and women in your community.
- How do the messages we receive about sex and sexuality differ depending on whether we are male or female?
- What effect does it have on the way we express our sexuality?
- If a man has sex, how does he share the experience with his friends? How about a woman?
- Do boys and girls feel pressure to have sex or to say they have had sex in your community? Why / Why not?

Note for the Facilitator

Either of the two exercises in session 8.32 can be used for sensitizing the participants to the factors that impact a person's expression of sexuality. Women face more stigmatization and restrictions related to sexuality. Certain groups, like men who have sex with men and women who have sex with women, face stigmatization and discrimination. This also has implications for their sexual health. They find it more difficult to access health facilities for treatment of STIs and HIV / AIDS. They are also more vulnerable to being infected with STIs and HIV / AIDS.

In certain socio-cultural settings it may be appropriate to avoid the use of these exercises, or separate men and women groups during these exercises. The peer educator should exercise his or her knowledge of the local situation to make the appropriate choice.

Session 8.33
Learning to Listen

Expected Outcomes
Participants will know that there is a difference between listening and hearing.
Participants will learn that different people have different perceptions and this influences their choices and behaviours.

Perceptions, Listening And Hearing!

Objective A fun game to illustrate different people's perceptions of what they hear.

Materials Flip charts, markers

Time 30 to 40 minutes

Process Invite the participants to sit in a circle.

Explain that they will be playing an interesting game to begin appreciating that people can have different perceptions of the same thing.

Ask 5 volunteers to leave the training area until they are called back.

Put up a flipchart, and invite the remaining participants to agree on one simple picture, and draw it on the flipchart. For example, they can draw a person, a house, a tree and some flowers or animals. Just ensure that the picture is not complicated.

When the picture is complete, ask the participants to hide it. Ask someone to call the five volunteers back to the room.

Show the hidden picture to one volunteer. Then, ask this volunteer to describe the picture in words to the second volunteer, who in turn describes it to the third volunteer and so on.

When the fifth volunteer has heard a description of the picture, s/he should be given a new flip chart and some markers to draw the picture. S/he should draw the picture based on the description heard from the fourth volunteer and must receive no help from the group.

When s/he has finished the picture, compare it with the original. You are sure to find some interesting differences.

Thank the volunteers and sum up the exercise. Point out that it is very unlikely that we will understand something in the same manner but often we think that we do.

Note for the Facilitator

This is a fun exercise that creates a feeling of ease and enthusiasm. It is also demonstrates that people hear what interests them and what they can easily associate with. People remember best when they can hear and see at the same time. The most effective combination is when people can hear, see and do something – this is the best way to remember something.

People's perceptions also influence the way they lead their lives, the choices they make and the behaviour they adopt. It is important to appreciate that people have different perceptions, but it is also important to pay attention to the process that leads to a perception formation. For example, in the case of this exercise, if the participants had heard, seen and done everything at the same time, they would not have made mistakes.

OR

Listen!

Objective To learn to listen to others.
To uncover the roles played by people in a discussion.

Materials A soft object that can be passed or thrown around, such as a pillow, a rolled up piece of cloth or a paper ball.

Time 45 minutes to 1 hour.

Process Invite the participants to sit in a circle on the floor.

Explain that they will be having a discussion on a topic of their choice.

They can speak, only if they are holding the pillow, otherwise, they should remain silent and listen to what is being said.

When an individual has finished speaking s/he can pass the pillow to someone who has raised his/her hand to speak, to someone who is requesting to speak or anyone they choose.

If some receives the pillow and does not wish to speak, they can pass the pillow on.

Alternatively, the pillow can be placed in the centre after a person finishes speaking, and the next person wishing to speak can pick it up.

Continue the exercise as long as there is an interest in the discussion.
You may want to use the following questions for a discussion after the exercise:

- *How did you feel about holding the object?*
- *How did you feel when the object was passed to you and you had nothing to say?*
- *How did you feel when you had to ask for the object so that you could speak?*

- *Did some people speak more often than some? Why?*
- *Who felt shy and uncomfortable when the object came to them? Why?*
- *Was it difficult to keep quiet and listen? Why/Why not?*

Note to the facilitator

The exercise encourages a "listening attitude" and it allows quieter members of the group an opportunity to speak. It also makes more dominant members conscious of the amount they speak, since they are holding the object while speaking. Listening is a very important part of a conversation, but most of us spend little time or effort on it. You may want to point out the body language of people as they spoke and listened; body language is also very important part of a conversation. For example, looking at the person who is speaking with interest or nodding in agreement or disagreement.

Active listening is an essential element of an effective communication process. Communication becomes ineffective when the following occur:

- People are so preoccupied with what they are going to say that they do not pay attention to what the other person is saying.
- People wait for an opportunity to focus on an issue being discussed by another person so that they can express their point of view.
- People listen selectively – they hear only what they want to hear.
- People interrupt and finish the other person's statement, changing it for their own purposes.

The following listening skills are essential to effective communication:

- Giving your physical attention to another person. Looking involved by adopting an open body position. Maintaining eye contact and showing facial expressions and other signs that you are interested in what the person is saying.
- Not interrupting and diverting the speaker. Using minimal encouragers – simple responses that encourage the speaker to tell their story. Asking relevant questions but not too many. Don't take on the role of an inquisitor; maintain attentive silence.
- Use reflective skills – tell the other person what you think they are feeling. For example "you are obviously happy", "sounds like you are angry" or "it seems to me that you are upset".
- Paraphrasing skills. For example "if I understand correctly", "so you were saying that", or "are you saying".
- Focusing skills (politely asking the person to focus on the main concern). For example "I know that these issues are important to you, but is there something in particular that we can do something about"? "of what you mentioned, what concerns you the most"?

Session 8.34
Working Together

Expected Outcomes
Participants will become aware of the importance of cooperation.

Web Of Life

Objective To remind everyone that we are all part of a group and dependent on one another.

Materials A big ball of string or wool.

Time 45 minutes.

Process Invite the participants to sit in a circle, preferably on the floor. You should also join the circle.

Take out the ball of string / wool, and hold the end of the string in your hand. Roll it towards someone sitting across from you, and call out the name of the person.

Ask the person who receives the ball to hold his / her end, and roll the ball on to someone else.

The ball should be rolled around until everyone is holding a bit of string, and in the end, it should come back to you, so that you are holding the two ends of the string.

Invite everyone to look at the web, and see how it connects with everyone in a crisscross pattern. Explain that we are all dependent on each other, and in order to keep the web taut and intact, we all have a role to play. If anyone were to leave, the thread the web would collapse.

Invite the participants to share their observations of the web in relation to the web of relationships in our real lives.

After a few minutes of sharing, ask the participants to gather the string in a loose pile, so that it can be untangled and rolled later on.

Note to the facilitator
This is an interesting exercise that demonstrates the importance of interdependence, and, the fact that, in real life we all have a role and responsibility, if the web of relationships is to be maintained and nurtured. You may want to use this exercise at the beginning of the session on care for people living with HIV / AIDS.

Session 8.35
Communication through non-verbal expression

Expected Outcomes

Participants will understand that non-verbal communication is an effective mode of communication.
Participants will be able to use non-verbal communication and read other non-verbal communication

Not A Sound!

Objective To sensitize participants to how non-verbal behaviour can indicate dominance, submissiveness and friendliness.

Materials None, but the participants can use the things available in the environment as props for improvisation.

Time 45 minutes

Process Invite the participants to divide into three groups.

Explain that group 1 will demonstrate as many non-verbal actions on dominance as they can think of, while group 2 and 3 observe them.

Then, group 2 will demonstrate as many non-verbal actions as they can on submissiveness, while group 1 and 3 observe them.

Then, group 3 will demonstrate as many non-verbal actions as they can on friendliness, while group 1 and 2 observe them.

Give 10 minutes to each group for their demonstration.

Explain that observers should not make comments when the demonstrations are in progress. Each observer should choose one action that they consider the "best".

After all of the groups have finished their demonstration, ask the participants to gather in the large group and stand in a circle.

Invite each participant to demonstrate their "best" action choice, and state why s/he thought it was the best.

You can use the following questions for a discussion in the large group after the exercise:

- *How did you feel observing the non-verbal actions? Why?*
- *Do you often use such non-verbal actions in your day-to-day life?*
- *Are you comfortable reading non-verbal messages? Why/ Why not?*
- *Do you feel non-verbal actions play a role in our conversations? How?*
- *Do you respect people's non-verbal communication? Why/Why not?*
- *Do people respect your non-verbal communication? Why/Why not?*

Notes for the Facilitator

This exercise is most effective when combined with a discussion on the importance of non-verbal behaviour. Often, people who speak less are very comfortable with this exercise. If you observe this in the group, you could ask them to share the reasons for their quietness and comfort with non-verbal communication. Research shows that in a normal person-to-person conversation, verbal components are responsible for less than 35% of the message, while non-verbal components make up more than 65%.

Non-verbal communication plays an important role in intimate behaviour and can be important for issues such as condom use, care of people living with HIV/AIDS and other sensitive situations. One can convey anger, love, disgust, disagreement, or aggression through non-verbal communication. Therefore, familiarity with non-verbal expression and an understanding of it will benefit young people in their relationships and interactions with other people.

Session 8.36
Learning to be Sensitive

Expected Outcomes
Participants will be able to recognize the importance of empathy and sensitivity.
Participants will take measures to display and develop sensitivity and empathy.

I Feel For You

Objectives To explore ones capacity for empathy and sensitivity.

Materials Some instruction cards for the volunteers, flip charts, markers.

Time 45 minutes.

Process Invite the participants to sit in a circle.

Explain that invariably, most of us expect others to be sensitive to our needs. We expect unconditional understanding and empathy from our friends and family. Some people are very sensitive and empathetic, but for most these two qualities require learning and practice.

This exercise will allow us to explore our capacities for being sensitive and empathetic.

Ask for 5 volunteers. Request them to step out of the training arena so that you can speak to them without being over heard.

Request each volunteer to undertake the following pantomime (communication through action and expression without the use of words):

- *Bidding farewell to a dear and trusted friend.*
- *Feeling very hurt and emotional because your partner forgot your birthday.*
- *Feeling happy to see your mother after a long time.*
- *Unable to show anger but still wanting your friend to know that you are angry.*
- *Feeling very ill but not wanting to ask for help because it will delay your friend from reaching office on time.*

One by one, invite each volunteer back into the room, and ask him / her to communicate the message through pantomime.

The observers should guess what the volunteers are trying to communicate.

Allow 5 minutes for each round.

Ask the volunteers to rejoin the group, and facilitate a discussion using the following questions:

- *Did anyone understand all of the messages given by the volunteers through the pantomime? If yes, how?*
- *Which messages were understood clearly? Why?*
- *Why did you not understand some of the messages?*
- *Are you able to understand your friends and family when they try to tell you something indirectly? Why/Why not?*
- *What qualities does one need to be able to respond to people who communicate in ways that are not used commonly?*
- *Have you ever known a person who understood your needs and feelings without having to be told?*
- *Why do you think some people are able to respond to your needs without your asking for it?*
- *How do you feel when someone is sensitive and empathetic to you? Why?*
- *How do you feel when you are able to understand someone you really care about?*
- *How can you become more sensitive and empathetic in your day-to-day dealings with people?*

Note for the Facilitator

Sensitivity and empathy are important elements in taking care of the people living with HIV/AIDS. These qualities are a key for healthy and fulfilling relationships. Sensitivity and empathy in action imply an ability to listen, think, care, attend and respond. Highlight these behavioural elements, and explain why these are very relevant to our interpersonal relationships.

Session 8.37
Setting Goals

Expected Outcomes
Participants will realize that one's aspirations must be based on reality.
Participants will be able to distinguish between achievable and unachievable goals.

Getting There

Objective To help participants understand the principles of realistic goal setting.

Materials Participants decide.

Time 1 hour.

Process Invite the participants to sit on the floor in a circle.

Explain that they will learn about goal setting in this exercise.

Inform the participants that they should follow them your instructions.

Allow them 30 seconds to do what you say.

Ask a volunteer to keep time, and call stop when the 30 seconds are up.

Ask the participants to work individually.

Use the following instructions:
- *Draw a circle*
- *Make a star*
- *Touch your nose*
- *Make a triangle*
- *Touch your neighbour*
- *Bring a stone*

Except the one where you ask the participants to bring a stone, most of these instructions can be followed within 30 seconds

Ask the volunteer to keep time until the last participant has been able to bring a stone (make sure that stones are available in the environment. If not, substitute the stone with something that can be easily found).

Ask the volunteer to tell the group the amount of time it took them to follow your last instruction.

Once all of the participants are in their place, ask them the following questions:

- *Of the six instructions given to you, how many did you achieve within the 30-second time limit? Why?*
- *Do you think the last instruction was realistic? Why?*
- *Who decided on the 30-second time limit?*
- *Who decided on the action to be done?*
- *If you had to decide the time limit and the list of actions what would you do? How would you decide?*
- *Have you faced similar situations in life – when someone else decides what you should do, when you should do it, and how you should do it?*
- *Are there things in your life that you decide to do for yourself? What?*
- *How do you plan for it?*

Note for the Facilitator

This exercise is simple, but the facilitation is complex. The questions you ask, and the responses you receive, have to be synthesized to achieve the principles of goal setting. The basic elements of realistic goal setting include answers to the following questions:

Why the reasons for the goal
When the time frame for achieving the goal
How the method of achieving the goal
What the goal; the things needed to achieve the goal
Who the people who can support you in achieving the goal
Where the physical context of the goal

Session 8.38
Learning to Differentiate Between Want and Need

Expected Outcomes

Participants will know that, sometimes, problems emerge from our inability to recognize the difference between need and want.
Participants will use their discretion in situations where they may be at risk.

I need or do I want

Objective To learn to recognize the difference between want and need.

Materials Flash cards, markers.

Time 1 hour.

Process Invite the participants to sit in a circle.

Explain that we often desire things for our loved ones and ourselves. We also need certain things for survival. Somewhere along the line, we forget what we really need and what we simply desire or want.

This loss of distinction becomes a reason that we make harmful choices in life.

Through this exercise the participants will learn to, once again, become conscious of this distinction.

Pass the container with the flash cards and markers around the circle. Ask each participant to pick up 2 flash cards and a marker.

Ask the participants to use the flashcards for writing their highest "want" on one card and the most essential "need" on another.

Place two cards on the floor within the circle – "want" and "need".

Ask the participants to place their cards under the two headings as they finish writing.

After everyone has placed their cards under the two headings, invite them to read them out. Invite them to look carefully, and see if the same cards appear under need and want.

Encourage the participants to discuss the cards appearing in the two lists.

- *Why are certain cards repeated under both categories?*
- *Why do some of the cards in the need category actually fit in the want category and vice a versa?*
- *Can one person's need be another person's want and vice a versa?*
- *Is it possible to limit our wants? Why/Why not?*
- *What problems can one face if one decides to pursue one's "wants" indiscriminately?*

Note for the Facilitator

This exercise encourages reflection and discussion. Let the discussion be open ended and free from judgments. Encourage the participants to use the why questions to discuss the placement of cards in the two categories. You could use the following questions for a discussion, if you feel the participants are not able to bring distinguish the difference between want and need:

- *What is the difference between a want and a need?*
- *What are the basic needs of all human beings?*
- *Have you ever confused a want with a need? What happened when you did this?*
- *Have you ever needed something badly but not been able to get it? How did you feel and what were the consequences?*
- *What happens when wants take precedence over needs? Why?*

Session 8.39
Learning to Be a Team

Expected Outcomes

Participants will realize that working as a team is important for finding solutions to problems.

Participants will seek out support and guidance from peers to solve problems that they may face during the course of their lives.

Working Together

Objective To develop skills for working as a team.
To create an atmosphere of cooperation.
To demonstrate that teamwork can help solve problems.

Materials 5 triangles cut into pieces, flip charts, markers.

Time 45 minutes.

Process Ask the participants to divide into small groups of 5 or 6.

Explain that each group will be given an envelope containing pieces of a triangle, and they must make a square out of those pieces.

Give 5 to 10 minutes to the groups to do this exercise.

If any group finishes the exercise during this time ask, them to demonstrate it to other groups.

If no one finishes the exercise during the allotted time, ask them if they would like to try for a few more minutes, and if still no one is able, demonstrate the solution yourself.

Invite the participants to gather in a circle for a discussion.

You may want to use the following questions to facilitate a discussion:

- *How easy or difficult was the exercise? Why?*
- *How did you go about the process of forming a square from the pieces of a triangle?*
- *Was anyone able to assemble the square within the allotted time? Why/Why not?*
- *How was the participation of the members within each group?*
- *Have you ever worked in a team before?*
- *How do you feel about working in a team? Explain.*
- *In your day-to-day, life what kinds of activities do you do with others?*
- *What are the ways in which we can include shy and withdrawn people in group activities?*

Note for the Facilitator

This is a fun exercise. It demonstrates the point that teamwork requires participation from all members of the group. Explain that those who lead, and those who follow are equally important in accomplishing a task. People who do not speak too much, or those who listen carefully, also serve a purpose within a group. Emphasize that team work is not only about achieving an end; it is also a process.

Session 8.40
Problem Resolution

Expected Outcomes
Participants will acquire skills to solve problems.
Participants will be able to solve problems that they may face.

Seeking Solutions

Objective To learn problem-resolving techniques.

Materials Cards with problem statements, flip charts, markers.

Time 1 hour 30 minutes.

Process Invite the participants to sit in a circle.

Explain that they will be discussing the problems they face in interpersonal relationships.

Ask them to make a list of problem situations in their interpersonal relationships that they have solved or failed to solve.

Allow 20 minutes to do this activity. Invite the participants to put the list up on the wall.

Ask the participants to divid e into small groups of 4 people each.

Explain that each group should choose one problem from the list on the wall.

They should brainstorm in their respective groups and come up with a role-play showing at least two ways in which the problem could be resolved or managed.

After a presentation of the role-plays, facilitate a discussion using the following questions:

- *Based on your own experiences, how did you feel preparing for role-plays? Why?*
- *What kinds of things, words or gestures cause a problem in a relationship? Why?*
- *Are there problems that recur in your relationships?*
- *Do you often feel that you run into problems in your relationships with others? Why do you think this happens?*
- *What can you do to reduce conflict in your relationships?*
- *When you encounter problems in your relationships, what do you do?*
- *Are you usually satisfied with the results you get? Why/Why not?*

Notes for the Facilitator

This exercise teaches problem-solution skills. The participants learn from each other's experience and through practice.

Helpline for the peer educator

Usually conflicts can be resolved through one or the other of the following methods:

Compromise: state your point of view, and allow the other person to state his/her point of view. Discuss and accept part of each other's point, idea or thought. Suggest alternatives that approximate what you and your friend desires.

Verbalization: choose words that accurately reflect your thoughts and feelings. Avoid blaming statements. Know the meaning of words and phrases you use. Ask if you are being understood, and do not use abusive or harsh language.

Attack the problem and not the person: state the problem, and look for solutions.

Allow time and space for communication and change: make your point and leave things for a while, observe, and if things do not show any signs of changing, discuss.

Change personal behaviour/try out different things: try out different options, change your behaviour and see if it helps.

Negotiation: calmly state your point of view. Listen to the other person. Offer a compromise that is mutually beneficial. Give reasons for your opinions and offers. Together, choose the best alternative and give positive feedback to one another.

Terminating: if things do not improve, even after trying different approaches, then, perhaps you should consider terminating the relationship. Sometimes this is the only option.

Help the participants explore these techniques in their resolution to their problems. People use many of these techniques without being aware of them. Point these out when the participants do their role-plays. Hold small discussions on each of the techniques in relation to the pros and cons of each.

Module 9
People Living with HIV/AIDS

FLOW CHART

Content Flow at A Glance
Module 9: People Living With HIV/AIDS

Subject/topic/activity	**Objective**	**Page No.**
Reading material for the peer educator.	To introduce the subject of people living with HIV / AIDS, care and support.	9-2 to 9-5
Case Study – Learning from Mr. X.	To become aware of the needs of a person living with HIV / AIDS.	9-6 to 9-8
Exercise – Of course it has effects!	To become aware of the consequences of HIV infection and to develop sensitivity to their situation.	9-9 to 9-10
Exercise – Aren't I human?	To become aware of discrimination faced by the people living with HIV / AIDS.	9-11 to 9-13
Exercise – I'd like to help.	To explore ways of removing discrimination.	9-14 to 9-15
Exercise – Who, Where, How	To explore ways of helping PLWHAs	9-16 to 9-17
Exercise – Do we understand?	To develop a common understanding of treatment and care for PLWHAs.	9-18 to 9-20
Exercise – What is the link?	To explore if there is a link between HIV / AIDS prevention and treatment.	9-21 to 9-23
Exercise – It is there but where?	To become aware of the issues of availability and accessibility of treatment and care.	9-24 to 9-26
Exercise – Web of relationships.	To realize that a number of people join hands to provide care, support and treatment to PLWHAs.	9-27 to 9-28
Exercise – Taking care is serious work.	To realize that providing care and support to PLWHAs requires both ability and capacity.	9-29 to 9-32

Module 9
People Living With HIV/AIDS

" Life may not be the party we hoped for, but while we are here we should dance"
Unknown

I Introduction

Globally, at the end of 2002, there were 42 million people living with HIV/AIDS (PLWHAs), 19 million of them women and more than 3 million of them children under 15 years of age. Currently, about 5 million people are acquiring HIV each year. Prevalence rates have risen sharply in virtually every region of the world in the past decade. Projections for 126 low and middle-income countries showed that an additional 45 million people would become infected between 2002 and 2010 in the absence of concerted and robust prevention efforts. Asia and the Pacific now accounts for one in every five new HIV infections worldwide. In all, over 8 million people were living with the virus in the region at the end of 2002; 2.6 million of who were young people aged 15 to 24.

II Living healthy and productive lives

People living with HIV/AIDS can live healthy and productive lives when they have access to information, treatment, care and support.

Information includes knowing what your rights are in terms of employment, welfare, education and family life, and having clear information about treatment and how to get treatment. It also means knowing about property rights, personal laws related to divorce, alimony and custody of children. Personal laws gain importance in the context of women, as they are likely to face more discrimination and harassment on being diagnosed with HIV/AIDS.
Support means acceptance, affection, respect and love from friends and family and from the community. It also means supportive laws to protect against discrimination and stigmatization.
Care includes moral support and access to necessary medical treatments, a healthy diet, clean water and accommodation.

Although key human rights, such as the right to information, the right to life and the right to health create entitlement to care and support, most young people (especially young women) living with HIV/AIDS do not have full access to these services. The situation is worse for young people belonging to marginalized groups, such as sex workers, homosexuals and injecting drug users.

The realization of human rights and other constitutional rights is not simply a matter of state action to develop laws and policies that protect against discrimination and stigma. Advocacy for public policies and legal action is also very important. However, this is not enough to transform the reality at the grassroots. When it comes

to improving the daily lives of people living with HIV / AIDS the community, family and friends have to play an important and dynamic role.

III Peers and PLWHAs

Assuming the responsibility to provide information, care and support to their peers living with HIV / AIDS is a task in which youth can make a very big difference. Offering friendship, providing access to information on care, setting up home visiting programmes for those who are sick and organizing support services are some of the possible actions they can take.
A good place to start showing your solidarity may be within your group or family or with colleagues and relatives.

Don't fear or falter!

- If you know that someone in your group has HIV or AIDS, make sure that friends who are already aware of his / her condition know that it is safe to touch, hug, share food and be together socially.
- If your HIV / AIDS infected friends want you to maintain confidentiality, respect their wishes.
- Don't forget to show your concern, affection and love.
- If the person is sick, help out with cooking, shopping, getting medication, cleaning or simply talking about his / her feelings.
- To address stigmatization and discrimination at the work place, create awareness about rights in the work place of people living with HIV / AIDS.
- Advocate for behaviour and conduct that are supportive of people living with HIV / AIDS.

A good starting point is to listen to experiences of people living with HIV / AIDS. Listen carefully and list the ways in which they think they could have been helped. Add any others that you can think of and discuss it together.

- Say hello
- Invite him / her to lunch or dinner, a movie or a walk
- Just listen
- Hold his / her hand
- Discuss the future
- Celebrate special days and anniversaries
- Ask how you can help
- Run errands and pick up medication
- Give a hug
- Clean the house
- Give a small token of affection and care
- Invite others to spend time together

IV Information

Some people call information the "cheapest form of therapy". Developing youth friendly HIV / AIDS information / resource services focused on the needs of people living with HIV / AIDS is not difficult. A simple information leaflet, a discussion in a peer group, a list of important phone numbers and people who can help can make a big difference.

People living with HIV / AIDS and those living with them or caring for them need up-to-date information on a range of issues. For example, caretakers need information to help them understand the progression of HIV and to know what advice to give; people with HIV need information to be able to seek early treatment for common illnesses.

Counselling can be very useful for anyone in a difficult and stressful situation. This includes anyone going for an HIV test, anyone diagnosed HIV positive and caregivers looking after someone who is ill.

If young people wish to work with PLWHAs they can get training in counselling skills and develop networks that provide support.

V Practical Tips for Care Givers

- Treat people living with HIV / AIDS with dignity and respect
- Listen
- Respect their need for confidentiality and privacy
- Let them know that it is okay to talk about their feelings or to show anger.
- Ask to visit or do things together, do not ignore them and stay away.
- Share your concerns and feelings; do not pretend that everything is normal.
- If a person is sick, offer to shop / cook / clean. Do not wait to be asked.
- Help them take their medication and seek treatment on time.
- Do not allow them to become isolated. Tell them about support groups and other services that may be available in the community.

VI Care and Support for People Living With HIV/AIDS (PLWHAs)

Care and support are based on an active concern for the well being of others and ourselves. People directly affected by HIV / AIDS need care. People with HIV / AIDS, families and communities are involved in care and support. They all need support to face the challenges of illness. The aim of HIV / AIDS care and support is to improve the quality of life of people living with HIV / AIDS, their families and communities. Care and support are also important because they assist efforts to prevent the spread of HIV / AIDS.

Comprehensive care meets the needs of the PLWHAs, their families and communities. This "holistic" care method requires a variety of information, resources and services to address a range of needs – not just medical needs.

Components of Comprehensive Care

- Diagnosis
- Treatment
- Referral and follow up
- Nursing care
- Counselling
- Support to meet psychological, spiritual, economic, social and legal needs.

Depending on the stage of illness and circumstances each person living with HIV / AIDS has different needs. For example, a person with HIV / AIDS who is not ill will have different needs and require different care and support than a person with HIV / AIDS who is very ill and bed ridden most of the time.

Comprehensive care for a person with HIV / AIDS should happen along a continuum of care. This means responding to the range of care and support needs in different places such as hospital, clinic, community and home. Over the course of the persons illness, responding to these needs also requires a coordinated response from people with a variety of complimentary skills for example, counsellors, nurses, doctors, community health workers, people with HIV / AIDS, pharmacists, family and friends. It is vital that people and places involved in care and support work together to have an efficient flow of information, resources and services between them to ensure a continuum of quality care and support.

Session 9.1
Needs of a Person Living with HIV/AIDS

Expected Outcomes

Participants will become aware of the special needs of a person living with HIV / AIDS.
Participants will be able to appropriately respond to the needs of a person living with HIV / AIDS.

Learning From Mr. X

Objective

To sensitize the participants to the needs of a person living with HIV / AIDS.
To enable participants to see that treatment, care and support can be provided through linkages with various agencies, individuals, resources and services.

Materials

Case study, flip charts, markers.

Time

1 hour 30 minutes.

Process

Ask the participants to divide into groups of 5 to 6.

Explain that people living with HIV / AIDS need care and support. This care and support comes from different people at different times. The exercise will enable the participants to understand this and think of ways in which they can support and care for their friends, family and relatives.

Hand out the case study to each group, and ask them to discuss it.

They should answer the questions at the end of the case study, and prepare a presentation.

Give them 30 minutes to do the exercise.

Invite the groups to make their presentations. Encourage the observers to ask questions and discuss.

Reassemble in the large group and facilitate a discussion using the following questions:

- *What did you learn from this exercise?*
- *The case study mentions some of the needs and solutions for a person living with HIV/AIDS, can you think of other needs/requirements of a person living with HIV/AIDS?*

In your opinion would the needs and requirements of a man and woman be similar? Why and why not?

- *List some of the needs/requirements that would be different for a man and woman.*
- *Can you think of ways in which you can help a person living with HIV/AIDS? How?*

Note for the Facilitator

This exercise is useful in encouraging the participants to think about the range of needs that PLWHAs may have. During the discussion in the large group, encourage the participants to think creatively while brainstorming on the needs and requirements of the PLWHAs given the socio-cultural, economic and gender dimensions of HIV / AIDS.

Case study that may be used for this exercise:

Mr. X lives in a town in Zambia. He went to a hospital for an HIV / AIDS test because he was loosing weight and coughing. Due to his cough the doctor also checked him for Tuberculosis (TB). The results of both tests were positive. The doctor started Mr. X on TB treatment while he was in the hospital, but when Mr. X was coughing less he was sent home and referred to the home-based care team of a local church. The team came to Mr. X's house to ensure that he took his medication. He shouted at them and told them not to come back. The team persuaded Mr. X to see the medical officer who listened carefully and realized that Mr. X was afraid that his neighbours would see the team visiting him. As a result, the people would realize that he has TB and reject him. So, the team helped Mr. X to talk to a trust worthy relative. The relative learnt to help Mr. X take his drugs every day and go for check ups at the hospital. Mr. X's TB was controlled and he started to feel much happier.

- *Where did Mr. X go for his HIV/AIDS test and TB treatment? What support did he receive from the hospital staff?*
- *Who did the doctor refer him to for home-based care?*
- *What support did Mr. X receive from the home-based care team?*
- *Why does Mr. X feel happy and healthy?*

At a skills building workshop in Zambia, participants came up with the following elements in a comprehensive care exercise:

- Personal and family hygiene
- Spiritual support
- Environmental hygiene
- Education on diet, food
- Income generating activities
- Employment
- Sharing experiences
- Transport
- Counselling
- Nursing care

- Clothing, blankets
- Relief of symptoms, treatment, medication
- School needs
- Singing

Afterwards, the facilitator led a group discussion about what had been learnt from the activity. For example, the participants agreed that effective care and support should involve responding to a variety of physical, spiritual, psychosocial and material needs.

Session 9.2
Consequences of Living with HIV/AIDS

Expected Outcomes

Participants will know the issues a person living with HIV / AIDS faces.
Participants will be able to identify the types of support needed by a person living with HIV / AIDS.
Participants will be able to provide a network of support services required by a person living with HIV / AIDS.

Of Course It Has Effects!

Objectives Understand the personal and social repercussions of infection faced by a person infected with HIV / AIDS.
Develop sensitivity towards persons infected with HIV / AIDS.
Identify the support systems needed for persons infected with HIV / AIDS.

Materials Paper, markers, flip charts.

Time 1 hour.

Process Ask the participants to break into four groups, and pick up some flip charts and markers for the group exercise.

Tell them to imagine that a person they know has tested positive for HIV / AIDS.

Ask them to work in their respective groups and draw up two lists of consequences they think would follow this news (one social and one personal).

Ask group 1 to discuss and make a list of the consequences for the individual who has tested positive – personal and social.

Ask group 2 to make a list of the consequences for the individual's partner – personal and social.

Ask group 3 to make a list of the consequences for the individual's school- aged child – personal and social.

Ask group 4 to make a list of the consequences for the individual's teenage sister and brother – personal and social.

Give the groups at least 20 minutes to do this exercise.

Invite the participants to display their flipcharts on the walls marked PERSONAL and SOCIAL (this can be done while the groups are working).

It is possible that the participants will create more categories such economic or cultural, so be prepared to include them in the presentation.

Once the groups have put up their lists, ask them to stand around the wall bearing PERSONAL charts. Encourage them to read it and facilitate a discussion on the emerging issues.

Next, turn to the SOCIAL wall and repeat the process of reading and encouraging discussion.

Use the following questions for discussion:

- *How did you feel when you were told that a person you know has tested positive?*
- *How did you feel when you were asked to discuss and list the consequences?*
- *Why did you feel the way you felt?*
- *Why do you think there are such wide spread consequences for the person who has tested positive and for those associated with him?*
- *Do you think some of the consequences discussed can be avoided? How?*

Note for the Facilitator

You can widen the scope of the discussion by relating the participants' responses to the responses that an HIV infected person might face in relation to the culture, norms, laws and rights within a particular country or society. Participants may bring up the issue of the rights of an HIV infected person, so be prepared to deal with this eventuality. Find out if there are any discriminatory laws in your country or society, such as laws barring an HIV infected person from seeking employment or getting married. Clarify any myths or misinformation that may arise during the course of the discussion. Allow the participants to discuss the issue of discrimination and stigmatization attached to HIV / AIDS. Do not force the participants to accept any one point of view, but encourage them to explore their personal responses and reactions.

Session 9.3
PLWHAs Face Discrimination

Expected Outcomes
Participants will become sensitive to the types of discrimination faced by PLWHAs.
Participants will take steps to reduce the discrimination faced by their peers who are living with HIV / AIDS.

Aren't I Human?

Objectives Become aware of discrimination against HIV infected individuals.
Understand the different ways in which discrimination towards a person infected with HIV / AIDS is expressed.
Decide whether the discrimination is appropriate or inappropriate.
Think of ways to reduce the discrimination.

Materials Chalk, previously prepared statements, flip charts, markers.

Time 1 hour.

Process Invite the participants to sit in a circle on the floor.

Ask them to pick up one piece of chalk each. Explain that this exercise will enable them to explore "discrimination" through their responses to the statements you will read.

Invite the participants to devise signs for "agree" and "disagree".

Each participant should use chalk to make their signs and put them on the floor. Observe the signs made by the participants and after each statement, encourage them to discuss the reasons for their responses. Clarify any myths and misinformation.

The participants may want to know the meaning of the term "discrimination". Explain the term with examples before starting the exercise.

You may want to use the following questions to generate discussion:

- *Why do people discriminate against some people?*
- *How can you reduce discrimination?*
- *What can you do to reduce or stop discrimination?*
- *Have you ever felt discriminated against? Would you like to share the experience?*
- *What would you do if you discovered that a person infected with HIV had been asked to leave his/her job in your community?*

Note for the Facilitator

Discrimination is a sensitive issue and requires gentle handling. It is usually related to long held beliefs and practices. People need time to deal it. Help participants explore their feelings and understand their reasons and responses to the statements you read.

The statements that you might like to use for this exercise are as follows (next to each is a note you can use for discussion):

Rekha's parents died because of AIDS. Her school authorities found out and asked her to leave the school.	This is discriminatory because the child, whose parents have HIV / AIDS, has the same right to be educated as anyone else. Additionally HIV / AIDS can only be transmitted through sexual contact, transfer of blood and blood products and from mother to child.
The village council decided to bar any person infected with HIV / AIDS from living in the village. Li is infected with HIV. His employer has asked him to stop coming for work.	People infected with HIV have the right to a normal life. A ban of this type is no protection against HIV / AIDS. The council would have to spend large amounts on enforcing such a ban. HIV / AIDS cannot be transmitted through the air, by sharing of clothes or by living next to the infected persons. People infected with HIV / AIDS have the right to work and gainful employment. Perhaps the employer is afraid that if the clients find out about Li they will stop coming to his firm.
Karim's test results have just come in. He doesn't want his parents to know that he has tested positive for HIV, but the clinic staff has sent a letter to his parents.	The right to confidentiality has been violated. The doctor-patient relationship is based on trust and integrity. Karim has a right to inform, or not inform, his parents in his own time and space.
John is an employee in a transport company. The new rules of the company state that every employee will be tested for HIV / AIDS and that in future, no person will be employed without a test for HIV / AIDS.	This is discriminatory because it bars people with HIV / AIDS from access to equal opportunities. The test will have to be repeated over and over again, as the person being tested may be in the "window" period. To be tested, or not, is a personal decision and cannot be forced. It requires personal preparedness and counselling.
Sheela went for a medical test because she was suffering from TB. The hospital did a test for HIV without her knowledge and then refused to treat her.	Testing without the consent and knowledge of the person is a violation of the person's rights and trust. Refusal to treat a person with HIV is also discriminatory. In many countries hospitals and health care personnel have been sued for such violations of a persons right to treatment and care.
The waiter in the hotel refuses to serve Pari	This is discriminatory. HIV cannot be transmitted through touch or proximity or through sharing of

because she is HIV positive.	utensils.
Huan has been admitted to a care centre even though he is healthy and capable of living a normal life.	This is discriminatory. A person with HIV / AIDS has the right to a healthy and normal life. He has a right to work and be happy. People with HIV / AIDS need love and care and can be looked after at home or in their community.

In the context of HIV/AIDS, discrimination seems to be caused mainly by:

- A presumption that those who are infected lack morality.
- Racism, homophobia, class differences and sexism.
- Laws and social norms that reflect prejudice, fears and biases.
- Misguided fears of catching the virus through social contact.

Session 9.4
Removing discrimination against people living with HIV/AIDS

Expected Outcomes

Participants will be familiar with specific methods that minimize discrimination against PLWHAs.

Participants will develop appropriate behaviour for dealing with peers who are living with HIV/AIDS.

I'd Like To Help

Objectives Learn specific ways to minimize discrimination against persons infected with HIV/AIDS.

Learn specific ways to promote a positive attitude within the family and community towards PLWHAs.

Materials Flip charts, markers, paper, scissors, tape, coloured markers.

Time 1 hour.

Process Ask the participants to divide into four groups.

Explain that they will be doing some exercises pertaining to the objectives specified above in the small group.

Ask group 1 to prepare a small role-play showing how they would take care of a friend who has been infected with HIV.

Ask group 2 to prepare an article for the local newspaper emphasizing the need to stop discrimination against people living with HIV/AIDS.

Ask group 3 and 4 to prepare posters with positive messages for raising awareness about the needs and requirements of people living with HIV/AIDS. They may prepare posters for the community, peer groups or government.

Give the groups 30 minutes to do these exercises. Then ask them to convene in the training room.

Invite group 3 and 4 to display their posters in the room. Invite group 2 to share their article. Group 1 should be invited towards the end to stage their role-play.

Discuss the issues raised in the exercises after the of each group presents

Encourage the participants to ask questions and discuss the subject. If the participants have any misconceptions about HIV / AIDS please address them.

Take the opportunity to emphasize the right to equality and the charter of human rights.

Close the session with a recap of the major learnings from the exercise. These can be summed up in the following three broad headings – dealing with discrimination, care for people living with HIV / AIDS and communication about the needs of PLWHAs.

Note for the facilitator

This is an interesting mix of exercises that allows the participants to be creative and learn from one another. As a facilitator, you should be prepared with some interesting posters and articles to share with the participants. Also, it may be useful to make a small presentation on Human Rights and HIV / AIDS (this charter is given in Module III). Alternatively, you could give a home task to the participants, for example, a rapid survey among their peer group on prevalent attitudes about PLWHAs. They could also do this survey in their community or with their family members.

Helpline for the peer educator

This material can also be used for making handouts.

To start a public awareness campaign in your community you could begin by exploring the following:

- Are there beliefs, norms and behaviours in your community that generate and promote negative attitudes towards specific groups of people; thus increasing their vulnerability to HIV / AIDS?
- What are people's beliefs and knowledge about HIV / AIDS?

Tips for a public awareness campaign

- Present positive images; people living with HIV / AIDS have the right to live a healthy and normal life.
- Involve the target groups (those who will receive the messages) in preparing and planning the campaign.
- Involve the people living with HIV / AIDS to help in the design and planning and delivery of the campaign.
- Make the messages short, direct and appropriate to the life style of the target audience.
- Aim to motivate, not advise or lecture.
- Test the images and messages by showing them to a group of target audiences and asking their reactions. For example, you could ask them what they feel about the pictures and words used in the posters?
- Refrain form annoying people; your aim is to educate and inform.
- Do not use words that reinforce negative attitudes and behaviours.

Session 9.5
Helping PLWHAs

Expected Outcomes
Participants will know some ways to help PLWHAs.
Participants will help and support PLWHAs.

Who, Where, How?

Objective Think of concrete and practical ways to help Person Living with HIV/AIDS.

Materials Blackboard, chalk, scenarios (given at the end of the exercise).

Time 45 minutes

Process Ask the participants to divide into 4 groups.

Explain that you will be handing out a sheet with a scenario written on it.

Each group will receive a different scenario and will have to come up with at least two of ways of helping the people in the scenario.

They must think of things that they themselves can do.

Give the groups 20 minutes to do this exercise and then invite them to give presentations.

Encourage the participants to discuss the pros and cons of each presentation and whether the ways suggested by the presenters are practical, or not. How can the participants improve on the suggestions?

Note for the Facilitator

To be a caregiver for someone who has HIV/AIDS means giving extra amounts of warmth and gentleness. Most people with HIV/AIDS are young adults who are alert, full of energy and excited about life. For many, life has become full of fear, anger and fatigue. Many have lost hope, support from their community, friends, and family, and they need others to care for them. A caregiver may need to be nurse, cook, messenger, cleaner or listener. Overall care giving is about being a friend and companion. Every small gesture contributes in making the person feel wanted and cared for. You could also invite a person living with HIV/AIDS to come and share his/her experience with the participants or show a video on the life of a person living with HIV/AIDS (it is useful to choose a film that is based in a socio-cultural environment similar to that of the participants).

The following scenarios can be used for this exercise:

Scenario 1
Radha is 23 years old and she has HIV / AIDS. She is pregnant and fears that the baby may also have HIV / AIDS. Radha's husband died of HIV / AIDS. Her in-laws live nearby but do not talk to her. They blame her for giving the virus to their son. Her parents do not see her. They feel that their responsibilities ended when she got married. Moreover, they are poor and do not have the time and resources to help her. Her neighbours do not talk to her. They fear that they may also get HIV / AIDS. Radha is not educated and has no skills. People in the village do not allow her to work because of the fear that they may get HIV / AIDS. Radha was all right at first, but now she is tired, can't work and has very little money to buy food. She stays at home, simply waiting to die.

Scenario 2
Ibrahim is 19 years old. He works in a factory in a city. Last year, Ibrahim went in for a blood test, as he suspected that he might be infected with HIV. The result came out positive and his worst fears came true. His employers discovered his HIV positive status and terminated his contract. Ibrahim is unable to find another job and scared of returning to his family in the village. He wants to share his problem with his friends but is unable to do so due to the fear of loosing their support. He is depressed, lonely, afraid and worried about the future. He would very much like to have a friend to talk to.

Scenario 3
Sue is 16 years old. She is studying in a college and loves to party. She has many friends and a boy friend. She went for an HIV test because she has been feeling unwell, and the doctor advised her to take the test. Her result was positive and she was devastated. She is unable to accept the result and is scared of its impact on her life. Her parents are unable to understand her withdrawn and dull behaviour. Sue is contemplating suicide.

Scenario 4
Y is 20 years old. He is working in a bank and planning to get married. Y has led a life of excitement and experimentation (partying, girlfriends and drugs). He knew about the possibilities of HIV / AIDS but never believed it could happen to him. He has plans for the future and wants to achieve great success in his career. His girlfriend is also working as a secretary in a multi-national company. Y was advised to take an HIV test because he was suffering from a STI. The test results were positive. He has been going for counselling but is unable to come to terms with the result. He is scared but unable to share the trauma with his girlfriend or friends. He is loosing control and has once again resumed taking drugs.

Note: These scenarios are just suggestions, you may want to change them to suit the socio-cultural realities of the group with whom you conduct the session. You can write more scenarios based on newspaper items, case studies and experience.

Session 9.6
Understanding Care and Treatment for PLWHAs

Expected Outcomes

Participants will develop a common understanding on what is meant by treatment for PLWHAs.
Participants will be able to identify sources of care and support for PLWHAs.

Do We Understand?

Objective To develop a common understanding of what is meant by treatment/care for PLWHAs

Materials Flip charts, markers, scenario sheets, transparencies or charts showing the definition of "treatment."

Time 2 hours.

Process Invite the participants to sit in a circle. Explain that they will be doing an exercise to gain an understanding of the needs of people living with HIV/AIDS. Explain that these needs determine treatment and care possibilities for PLWHAs.

Ask the participants to divide into 6 groups.

Give each group a scenario of a person living with HIV/AIDS and ask them to work out answers to the questions given at the end of the scenario.

Ask the groups to read the scenarios, brainstorm and prepare their presentations. Allow 20 to 25 minutes for the exercise.

Starting with group 1 invite each group to put up their presentation on the wall. Encourage discussion and questions at the end of each presentation.

Invite the participants to return to the circle, and facilitate a discussion using the following questions:

- *What did you learn from this exercise?*
- *Who is responsible for the care and support of people living with HIV/AIDS? Why?*
- *Do women living with HIV/AIDS require different types of care and support? Why and why not?*
- *What is the difference between the needs/requirements of women and men living with HIV/AIDS?*
- *Can you think of ways in which you can help people living with HIV/AIDS? How can you help?*

Note for the facilitator

This is a comprehensive exercise for sensitizing participants to the varied needs of people living with HIV/AIDS. Focus on the multiple issues of care and support through this exercise and encourage the participants to think about the socio-economic, cultural, gender, religious, medical, psychological dimensions of the subject. Participants may come up with general solutions, but ask them to be specific and detailed. As a peer educator, be prepared with a list of contact numbers and addresses of people and places that provide care for PLWHAs and give it to the participants.

Helpline for the peer educator

This material can also be used for making handouts.

Treatment is a key element of care and support for PLWHAs. Any action that improves a person's quality and length of life is a form of treatment. Treatment can happen without medication. For example, personal and social or psychosocial support is also a treatment because it can provide relief and improve a person's well being.

For medication to be effective, other forms of treatment must support it. For example, if people feel cared for in their family or community and have food and clean water they are likely to make better use of their medication.

Treatment/care needs are varied depending on the stage of illness, the socio-economic status, cultural and religious environment and gender.

Treatment/care can happen in different places and requires different resources depending on the stage of illness.

The needs of PLWHAs should be central in deciding where and what kind of treatment and care is provided.

PLWHAs need treatment and care to be accessible in different locations at different times. Sometimes it can start in one place (such as a hospital) and continue in another (such as a person's home). When treatment and care are being given in different locations, it is important to have effective coordination of information, resources and services between the different locations.

Scenarios that may be used for this exercise:

Scenario for group 1

X is 22 years old. He is living with his parents and siblings in a small town. He is HIV positive, but healthy. His family is supportive of him, but he wants to work. He has applied for many jobs, but nobody is willing to employ him. He is feeling very depressed and lonely.

What kind of help does X need?
Where and how can he get help and support?

Scenario for group 2
H is 19 years old. She is not educated and has been living in the slum of a large metropolitan city. She works as a waitress in one of the bars. She is HIV po sitive and prone to frequent illnesses. She is very sacred and alone. Her friends are unable to help her, as they do not have the time and the resources. She goes to the local health care centre for treatment but she is unable to buy the medication they prescribe.

What kind of help does H need?
Where and how can she get help and support?

Scenario for group 3
G is 16 years old. He lives on the street, as he has no family. He is a drug user and a sex worker. He is very ill and the doctors have told him that he has TB. His friends take care of him but they cannot ensure regular treatment and care. G is very ill and unable to do anything for himself.

What kind of help does G need?
Where and how can he get help and support?

Scenario of group 4
S is in the hospital. She has been in the hospital for the last month but she wants to go home. Her family members think that she should stay in the hospital as they do not have the time and do not know how to take care of her. S is becoming depressed and restless.

What kind of help does S need?
Where and how can she get help and support?

Scenario for group 5
M is 24 years old. She is widowed and has one child who is also HIV positive. She lives alone with her child and works as a clerk in a bank. She is very worried about the future of her child. She is frequently depressed with the prospect of her own death and the effect it will have on her child. Her husband's family refuse to help her and have denied her all rights to her husband's insurance money. Of late, M has been falling sick, but she refuses to take her medication.

What kind of help does M need?
Where and how can she get help and support?

Scenario for group 6
O is 21 years old. He is working in an advertising agency and has many friends. They support him and take care of him when he is sick. His partner is also very loving and supportive, but O is obsessed with the idea of death. He is loosing weight and ignoring his doctor's instructions. He is slowly loosing interest in his work and refusing his friends' offers of help. He lies in bed for days on end and refuses to respond to anyone.

What kind of help does O need?
Where and how can he get help and support?

Session 9.6
Is there a Link between HIV/AIDS Prevention and Treatment/Care?

Expected Outcomes

Participants will be able to identify the links between HIV/AIDS prevention and treatment/care.

Participants will be able to address treatment and care issues in their prevention work.

What Is The Link?

Objective To enable participants to make the link between HIV/AIDS prevention and HIV/AIDS treatment and care.
To demonstrate that HIV/AIDS prevention and treatment/care support each other in many ways.

Materials Flash cards, markers.

Time 1 hour.

Process Invite the participants to sit in a circle on the floor.

Explain that the exercise will focus on brainstorming and drawing links between HIV/AIDS care/treatment and HIV/AIDS prevention.

Ask two volunteers to help in the facilitation of the exercise. Give them the flash cards and markers. Let them sit in the centre of the group.

Ask the participants to brainstorm on the subject and create a diagram showing the links between HIV/AIDS care/treatment and HIV/AIDS prevention. For example HIV/AIDS prevention messages, when designed and disseminated in an effective manner, can lead to testing and counselling for HIV/AIDS. In turn, this will lead to early treatment for those who may be infected.

Allow 30 minutes for this activity.

Participants may be unable to draw any links. In this instance, help them by giving examples.

When the exercise is complete facilitate a discussion using the following questions:

- How easy or difficult was the exercise? Why?
- *Can people living with HIV/AIDS play a role in prevention of HIV/AIDS? How?*
- *How can you help the people living with HIV/AIDS in their efforts towards prevention of HIV/AIDS?*

Note for the Facilitator
People living with HIV/AIDS can help in the prevention of HIV/AIDS. Youth can also make significant contributions. This exercise generates ways in which they can contribute.

HIV/AIDS prevention aims to prevent the transmission of HIV. HIV/AIDS treatment and care aims to improve the quality of life of people living with HIV/AIDS. HIV/AIDS prevention and treatment support each other in many ways:

Well designed HIV prevention activities can lead to increased voluntary counselling and testing, which in turn can lead to broader and quicker access to treatment for people with HIV/AIDS.

Well-designed HIV prevention activities can reduce fear and stigmatization around HIV/AIDS. This improves the quality of life for PLWHAs, as they become more accepted and better understood by their families and communities.

Through Voluntary Counselling and Testing (VCT) people can learn about HIV/AIDS prevention, and if they are HIV positive, they can be given information on how to live safely with the virus and plan for the future. VCT also helps people gain assistance early on and learn about possible treatments for health problems that may occur. For example, VCT can be helpful in preventing tuberculosis and STIs.

Prevention programs and VCT allow women with HIV/AIDS to access services that will reduce the chance of them passing HIV to their unborn or newborn children. If they become pregnant, women and men might also choose to increase contraceptive use.

Access to care and support increases condom use and other preventive behaviour amongst people with HIV/AIDS. These positive changes can be reinforced when care and treatment programs deliberately promote and distribute condoms.

Increased availability of care and increased visibility and acceptance of PLWHAs makes the broader population more aware of HIV/AIDS and increases safer behaviour.

Examples
In Cambodia, homecare teams from local organisations support a large number of families affected by HIV/AIDS. Most of the people with HIV/AIDS found that there over all well being improved due to the visits from the home care teams. Families spent less money on medication and had to make fewer visits to hospitals. In addition, neighbours, friends and family members learned more about HIV/AIDS. They also became less afraid of the virus, and there was less of a stigma around HIV/AIDS in the community, making it easier to provide education on HIV/AIDS prevention.

In a workshop in Africa participants made the following diagram to show these links:

Epidemic begins The availability of treatment gives messages of hope.
As there is hope, more people get tested.

	People accessing treatment feel good about planning for the future. People with HIV / AIDS become more visible and speak out about positive living. There is more acceptance of people with HIV / AIDS. PLWHAs feel empowered. Empowerment and quality of life encourage people working in prevention.
Epidemic slows	More people become involved in prevention.

Session 9.7
Availability and Access to Treatment and Care

Expected Outcomes

Participants will become aware of issues regarding the access and availability of treatment and care for PLWHAs.
Participants will be able to design treatment and care interventions that consider availability and access as important issues

It Is There, But Where?

Objective To enable participants to think about the availability and access of HIV / AIDS treatment and care options.

Materials Chalk, flash cards, markers.

Time 1 hour and 30 minutes.

Process Divide the participants into groups based on their community / geographical similarities. For example, if the participants come from a single locality and town they can be asked to form one group. If the participants belong to the same peer group, they can be formed into one group.

Explain that they will draw maps of their locality showing their houses (if possible) and services available within the community. The groups may draw maps of their village, town etc.

Once the map is ready they should think of a person living with HIV / AIDS within that community / locality and focus on the places and services that can be accessed and used by the person.

Ask the participants to use the chalk, markers, flip charts to draw the map. It is good idea to use chalk for the drawing, as it enables one to make changes.

After the exercise is complete, review the map. Ask the participants about the facilities available in a particular place, the distance to be travelled and the resources that may be required.

Focus on the needs / requirements of the person living with HIV / AIDS and whether they would be able to access those services. It is one thing for a service to be available, but access is the key issue. Encourage the group to think of ways in which services can be made accessible and the ways in which they can help to do so.

Note for the facilitator

Mapping in its simplest form identifies the comparative location and importance of different resources / services within an area. The key components of a map are spatial analysis of a wide range of different issues and identification of key elements

important to different groups of people. Maps are also useful in providing a framework for discussion, highlighting resources / services of importance to different groups, analyzing the present status and location of resources / services, stimulating discussion over the importance of specific resources / services and enabling location of different services / resources and places.

For people to use medical treatment, care and support it must be available – meaning that it can be found anywhere that is appropriate. For example, a medical treatment is available if the materials needed to treat a health problem can be found in that community (basic drugs). Care and support is available if the person living with HIV / AIDS has a family and friends and support networks.

Helpline for the peer educator

This material can also be used to make handouts.

Some reasons why an HIV related treatment, care and support might not be available include the following;

- The drug is new and access is restricted by law.
- The drug is not imported into the country for commercial reasons.
- The public health system does not allocate funds to purchase the drug.
- Only specialists are allowed to prescribe the drugs.
- Families are scared of contracting HIV / AIDS because they do not have information on how to protect themselves or how the infection is transmitted.
- Friends have little awareness and limited resources.
- There are socio-cultural taboos that increase the isolation of PLWHAs.
- There are religious and legal sanctions that prevent people from supporting and caring for PLWHAs.

For people to benefit from treatment, care and support they must be available. More importantly though, they must also be accessible. Treatment, care and support should be found in appropriate places and should be easy to obtain and use. Sometimes treatment, care and support are available but ***not accessible because of a variety of reasons, such as:***

- People cannot afford the right drug.
- The treatment provider discriminates against people with HIV / AIDS and refuses to give them the drug.
- The treatment provider does not have the right skills to administer the drug.
- It is too difficult for people with HIV / AIDS to get to the drug.
- The caregiver does not have the right knowledge and skills.
- The caregiver does not live with the PLWHA.
- The support networks and services are too far away (usually found only in towns and cities).

A barrier to access treatment, support and care is anything that prevents a person from getting the treatment, care and support that they need. ***There can be many barriers for PLWHAs. These may be related to:***

A. Service: cost, staff attitudes, skills or facilities offered. For example, a clinic might only be open during the day when many PLWHAs are working.

The Context: political, economic and cultural situation in which treatment is provided. For example, women may not be able to access treatment for STIs because sex is a taboo subject or because of the stigma of being seen at an STI clinic.

Attitudes: knowledge and beliefs of the community members. For example, local people might believe that HIV counselling is only for the members of high-risk group, such as sex workers.

There are many different types of barriers to accessing HI/AIDS related treatment/care. These include:
Financial barriers – the cost of drugs and the need to prioritise other general supplies such as food.
Organizational barriers – the poor administration of treatment services and lack of skilled staff.
Physical barriers – treatment facilities in distant locations and transport not being available.
Social barriers – the stigma associated with a treatment and people being concerned about confidentiality.

At a workshop participants came up with the following barriers to effective medical treatment

Organizational	Physical	Social	Financial
Negative attitudes of health care workers	Distance to health facilities	Traditional beliefs	Poverty
Lack of materials needed for treatment	Lack of transport	Stigma	Cost of drugs
Delays in treatment / health care workers not available		Ignorance	Expense of user fee in hospitals
Corruption in health care facilities		Denial	Cost of transport to health care facilities
		Myths and misinformation about HIV / AIDS	Lack of medical insurance schemes

Session 9.8
Relationships that Enable People to Live Productive Lives

Expected Outcomes

Participants will learn that a web of relationships exists in everyone's life.
Participants will become aware that these relationships can be tapped and supported to create a web of support and care for people living with HIV / AIDS.

Web Of Relationships

Objective To enable the participants to explore their relationships with different people in their lives.
To enable understanding of the fact that we all have a network of relationships that allows us to lead useful and comfortable lives.

Materials Flip charts, markers, chalk.

Time 1 hour.

Process Divide the participants into small groups of 4 to 5.

Explain that they will be drawing a web of the relationships in their lives. Everyone has a web of relationships that sustains and supports them. The friends we have have relationships with other friends, with our family and with many other people known and unknown to us. The web will enable us to understand their relationship to us and others and how the combinations help us in our lives.

Ask each group to draw a web of relationships. They can choose one person in their group and draw a web of their relationships or they could draw a common group web.

If the task is difficult to understand, give an example by showing a web diagram on the board or a flipchart. You may want to use the example given at the end of this exercise.

Give the groups 30 minutes to do the exercise. Ask them to put up their outputs on the wall. If they have used chalk and the floor to do the exercise, the groups could visit each other's web.

Encourage the participants to ask questions and discuss why and how the web of relationships is helpful. Also encourage discussion on how relationships can be nurtured and improved to enhance the quality of our lives.

You may want to use the following questions to facilitate a discussion in the large group:

- *In the web of relationships are there some relationships that help you more than the others? Which ones, and why?*
- *How do different relationships help you and each other?*
- *Can a similar web of relationships exist in a community? Why, and how?*
- *Can you draw a web of relationships that may be useful in improving the lives of people living with HIV/AIDS? Ask the participants to draw the web.*
- *How can you become a part of this web and support a person living with HIV/AIDS?*

Note for the facilitator

Drawing a diagram of relationships allows the participants to examine the role of different relationships in their lives and the way in which these relationships interact with each other. The drawing enables a visual context to the discussion and enables focused discussion. Men and women may have differences in their webs and it would be interesting to examine the reasons for this.

Helpline for the peer educator

This material can also be used to make handouts and posters.

Helping-relationships aim to improve the quality of peoples' lives. They are at the core of providing effective treatment and care for PLWHAs. ***Helping-relationships are important because:***

- They bring together someone who needs treatment and care and someone who can respond to those needs in a supportive and effective manner.
- They are based on identifying the needs of the person seeking treatment and care and helping them to lead a better and longer life.
- They are two-way and both parties need to be open, cooperative and informed.
- They are based on trust and confidentiality and grow over time.

Session 9.9
Attitudes, Behaviour, Knowledge and Skills Needed for Care and Support Work

Expected Outcomes

Participants will understand what attitudes, behaviour, knowledge and skills are required to become an effective caregiver for PLWHAs.

Participants will make an attempt to develop the attitudes, behaviours, knowledge and skills required for taking care of PLWHAs.

Taking Care Is Serious Work

Objective

To enable participants to understand that the knowledge, skills and attitudes of a person combine to provide care and support for a person living with HIV / AIDS.

To allow discussion that will lead to the discovery of the knowledge, skills and attitudes required to care and support a person living with HIV / AIDS.

Materials

Flip charts, markers.

Time

1 hour.

Process

Ask the participants to divide into 3 groups.

Explain that, in order to care for a person living with HIV / AIDS, certain knowledge, skills and attitudes and behaviours are mandatory. A combination of these three can lead to an improved quality of life for the person.

Ask the groups to do the following tasks and prepare a presentation:

Group 1: Make a list of the knowledge one would need to be able to take care and provide support for a person living with HIV / AIDS.
How can you gain this knowledge and help others access this knowledge?

Group 2: Make a list of the skills one would require to take care and provide support for a person living with HIV / AIDS.
How can you acquire the skills needed and help others to acquire them?

Group 3: Make a list of the attitudes and behaviours one needs to develop in order to take care of and provide support for a person living with HIV / AIDS.
How can you develop these attitudes and behaviour and promo te them among others within the community?

Allow 30 minutes for this exercise.

Ask each group to make their presentation.

Encourage and facilitate discussion after each presentation. Elicit the socio-cultural, religious, economic and gender dimensions present within each.

Note for the Facilitator

This exercise is useful in creating awareness about the various knowledge, skills and attitudes/behaviours required to take care of and provide support to people with HIV/AIDS. Alternatively, you could use this exercise to create awareness about the roles of medical personnel, family and friends in the lives of people with HIV/AIDS. You could ask group 1 to work on the knowledge, skills and attitudes/behaviours of medical personnel, group 2 to work on the family and group 3 to work on friends. You could also use role-plays. Use your own judgment to decide which method is most appropriate for the make up of the participants.

Helpline for the peer educator

This material can also be used for making handouts.

Knowledge, skills, attitudes and behaviours are all important for establishing helping relationships and providing effective care and treatment to people living with HIV/AIDS.

Knowledge - an understanding of information and ideas. It is important for HIV/AIDS related care and treatment because it allows the caregivers to understand what is going on. They can reassure the person seeking help and suggest the most appropriate plan of action. It is important that knowledge is kept up to date so that it can be the basis for providing the best possible care and treatment.

Skills - knowing how to do something. They might relate to technical work (such as how to prescribe medication) or "people" work (such as how to support a person with HIV/AIDS to communicate their care and treatment needs). Some of the most essential skills for providing effective treatment and care include listening, planning and taking action.

Attitudes - the way in which individuals view issues and other people. Appropriate attitudes are vital for people involved in HIV/AIDS related care and treatment work. For example, if a person is open and genuine rather than condemning or pitying of people living with HIV/AIDS, it will help the PLWHAs to come forward for help and take care of themselves. It is also important for people involved in care and treatment to be respectful and accepting of socially marginalized groups, such as sex workers, prisoners, men who have sex with men or injecting drug users.

Behaviours Mean the actions and expressions used by people to demonstrate their feelings, concerns and views. These are often a combination of knowledge, skill and attitudes.

Some examples of the knowledge, skills, attitudes and behaviours needed for effective HIV/AIDS care and treatment:

Knowledge	Skills	Attitudes	Behaviours
Basic of HIV / AIDS	Communication related to asking	Compassion	Listening
Nutrition	questions, listening and confirming	Respect	Giving a hug
Health education	Planning / managing	Sensitive	Discussing feelings and concerns
Positive living	in consultation with the PLWHA	Non - judgmental	Helping in chores and running errands
HIV / AIDS related treatment related to symptoms and causes, common problems, drugs and new treatments	Follow up and referral	Honesty	Picking up medication and giving medication
	Training	Common sense	Giving an injection or administering an IV drip
Human rights issues	Counselling	Equality	Writing and distributing information
Psychosocial issues	Building trust	Positive and encouraging	Attending support meetings
Vocational possibilities	Moving at the PLWHAs pace		
	Sharing information		

Good information is vital for care and treatment work, as it enables the PLWHAs and the caregivers to make joint decisions about what will be appropriate and effective. The relevant information needs to be:

Objective Meaning that it is "neutral", not affected by discriminatory attitudes, and free of bias.

Accurate Meaning that it is up to date and gives people a clear idea about their situation and possibilities.

Simple Meaning that it is communicated in a way understood by the persons involved.

No one person or organization can address all of the care and treatment needs of a person living with HIV/AIDS. Working with others can help to improve access to treatments, care and other resources that may be required. It can also improve the quality of care and treatment and help to reach more people who may be in need of similar help and support.

- Community and solidarity groups / peer groups can provide personal support for PLWHAs and keep others in touch with their needs.
- NGOs / CBOs can provide training, information, ideas, material support and skills such as counselling, finances and treatment.
- Government systems can provide policies, leadership, human resources and material support such as skilled health workers and medication for treatment.

- Businesses provide financial or "in kind" sponsorship for treatment and care and encourage public support for PLWHAs.
- Professional associations and academic institutions can contribute to knowledge, guidance, information, research and generating new knowledge that may be helpful in improving care and treatment.
- Donors can provide funds for care and treatment and facilitate learning from the experiences of other countries.
- Religious organisations can provide volunteers for care and treatment and mobilize community support and help to reduce stigma and discrimination.
- Media can provide accurate information about care and treatment issues and help to raise awareness and reduce stigmatization.

The following table indicates people and places that can be helpful to PLWHAs:

Home/family	**Community/peer group**	**Health care facilities**
Universal precautions to prevent transmission of HIV. Safer sex practices including family planning. Personal and environmental hygiene practices. Emotional support for PLWHAs. Nutrition and safety of food and water supply. Using medicine and traditional remedies correctly and adhering to treatment regimes. Sharing information about where to access more support.	Social support and counselling. Access to volunteers and testing. Support groups for sharing work and, information. Accompanying people for treatment. Nutritional / food needs. Providing condoms, bleach and clean syringes. Access to family planning services. Advocacy. Assistance to vulnerable groups such as orphans or young people living alone. Financial support. Legal support. Management of drug supplies. Bereavement and funeral support. Sports and recreational activities. Emotional support.	Voluntary testing. Access to safe blood and blood products. Clinical management of pain, malaise, fever and opportunistic infections. Treatment of STIs. Preventive treatments. Nutritional assessment and counselling. Ant1retroviral therapies. Clinical and laboratory monitoring of progression of illness. Access to breast milk substitutes.

Module 10
Action Planning

FLOW CHART

Content Flow at A Glance
Module 10: Action Planning

Subject/topic/activity	Objective	Page No.
Exercise - Is change possible?	To realize that change is possible.	10-3 to 10-4
Exercise – Theme for a dream.	To develop a vision for the future.	10-5 to 10-6
Exercise – How real is it?	To check if a dream is achievable.	10-7
Exercise – Getting there.	To set goals.	10-8
Exercise – Setting objectives. Exercise – What to do?	To develop achievable objectives. To make an activity chart.	10-9 10-10
Exercise – How to do It?	To develop a resource chart.	10-11
Exercise – How to do it? - continued.	To develop a table of who can do what?	10-12 to 10-13
Exercise – Making a commitment.	To ensure participant commitment.	10-14
Exercise – Expectations!	To understand that different groups have different roles to play in the fight against HIV / AIDS.	10-15 to 10-16
Exercise – Making requests.	To learn the art of requesting another for help and support.	10-17 to 10-18
Exercise – Timeline	Preparing a timeline for future work.	10-19

Module 10
Action Planning

"The woods are lovely, dark and deep,
But I have promises to keep,
And miles to go before I sleep,
And miles to go before I sleep".

Robert Frost

Introduction

Having a vision for one's future, and charting a course to achieve it, is called planning. Studies have consistently shown that vision, planning and goal setting can positively influence personal and organizational performance. Planning can force future thinking, highlight new opportunities and threats and refocus a person's mission. It's a tool for taking control of a wandering life style. Productive planning focuses on the most critical problems, choices and opportunities. Planning is also effective in modelling behaviour and norms that one would like to follow in one's life.

Planning requires time and a process. If used effectively, it is a powerful tool for self-management and goal based achievement.

The aim of this module is to help participants develop basic planning skills. This will lead to effective action planning and allow the charting of a course for the achievement of a vision.

Session 10.1
Is Change Possible?

Expected Outcomes

Participants will be able to decide whether behaviour and attitude change is possible and required.
Participants will spend time in introspection and start thinking about their lives.

To Change Or Not To Change

Objective To know that change is possible.
To focus on what can and cannot be changed.

Materials Flash cards, markers.

Time 1 hour.

Process Invite the participants to sit in a circle on the floor.

Explain that change is a part of life and that some changes are possible while others are not. Change usually requires effort and practice. This exercise will enable participants to explore whether or not they want to change something about themselves or their lives. How can these changes be achieved?

Pass out flash cards and ask each participant to pick 2.

Ask them to write something on one card that s/he would like to change about himself/herself and one card to write something s/he would not like to change.

Allow the participants 10 minutes for this activity.

Invite them to place the cards in two vertical lines on the floor – ”would like to change” and "would not like to change”.

Ask the participants to read the cards and group them. The cards should be sorted and grouped under both the categories.

Once this is done, invite the participants to sit in a circle around the cards.

Go through both lines of cards and examine the reasons why certain changes are possible and others are not. Also, examine the reasons for not wanting to change certain things.

Now ask the participants to make a list of the ways/methods in which the listed changes can be brought about.

Put all the three lists up on the wall. Facilitate a discussion using the following questions:

- *Is change possible? Why/Why not?*
- *Have you ever tried to change something about yourself? How easy or difficult was it? Why?*
- *Does one need support and guidance in their attempts at change? What and why?*
- *What can you do to change your own and your friends behaviour so that you do not contract HIV/AIDS?*

Note for the Facilitator

This is an interesting exercise to start the session on future planning and directions. Behaviour change is an important and critical element in the struggle against HIV / AIDS. It is also the most difficult. Therefore, a discussion on change and its multiple dimensions, possibilities and impossibilities is a good starting point for future planning. This exercise is open ended, but you may feel the need to make it simpler and more focused. To this end, you can ask the participants to focus on behaviour that they want to change and those they do not.

Session 10.2
Vision for the Future

Expected Outcome
Participants will think about and develop a vision for the future.

Theme For A Dream

Objective To dream a dream.

Materials Flip charts, markers / crayons.

Time 1 hour.

Process Invite the participants to sit in a circle.

Explain that planning is an important element of this training and of life. In order to plan, one must have a dream. One must have a vision of where one wants to be. This vision may be of an individual for himself / herself, or it may be the vision of a group for the group.

Ask the participants to work individually and arrive at a vision for themselves.

Explain that they should each draw a picture of, or create in words, a dream that they would like to realize for themselves. Something that represents the life they want to have for themselves.

Allow the participants 20 minutes for this exercise.

Invite them to share their vision with each other through a presentation.

Ask them to put their "vision" up on a wall so that everyone can see it.

After everyone has heard and seen all of the visions, facilitate a short discussion using the following questions:

- *How did it feel to dream and share the dream? Why?*
- *Can dreams come true? Why/Why not?*
- *How can you make your dream come true?*

Note for the facilitator

This is a simple exercise used to encourage dreaming and setting a vision for oneself. This can be altered to suit the needs of the participants. For example, if you are doing a training for young people to work as peer educators, you could ask them to dream about the kind of peer educator they would like to be. This can also be used for a group, community or organizational dream. Just remember that it is essentially about dreaming, and therefore, allows space for imagination. Do not decide what can and cannot be dreamt.

Session 10.3
Reality Check

Expected Outcomes
Participants will learn that unrealistic dreams can be more harmful than good.
Participants will be able to set a realistic vision for the future.

How Real Is It?

Objective Reality check.

Materials Outputs from the dreaming exercise, markers, flash cards.

Time 45 minutes.

Process Invite the participants to stand next to their dream / vision output with some flash cards and markers.

Explain that you will be giving them some instructions. They should listen to the instruction, and write the answer on the flash card.

After writing their answer, they should tape it next to their dream / vision in the sequence in which instructions are given.

The instructions should be given in the order that follows:

- *How long will it take you to achieve your dream/vision?*
- *How can you achieve your dream/vision?*
- *Invite the participants to share their responses to these questions. Point out that time and methodology are extremely important for achieving a vision or a dream.*

Note for the facilitator

A dream, or a vision, is usually a distant goal that one strives for. It is, therefore, more an aspiration than a reality. However, the dream can be further broken down into achievable and time-bound objectives. Encourage and commend the participants on their dream. Their responses to the two questions should be enough to indicate whether the dream is achievable, or not. Take this opportunity to explain the difference between a dream / vision and an achievable goal and objective.

Session 10.4
Goal Setting

Expected Outcomes
Participants will learn to set achievable goals for themselves.
Participants will be able to apply this method in their day-to-day lives.

Getting There

Objective Setting a goal.

Materials Flip charts, markers.

Time 45 minutes.

Process Invite the participants to sit in a circle on the floor.

Explain that everyone tries to set goals for himself / herself in life, but goals must be realistic. For example, the goal of this training programme is to change at least one unsafe behaviour of young people in order to reduce their chances of contracting HIV / AIDS.

Similarly, the participants must set some goals for themselves, goals that take the goal of this training further.

Encourage the participants to ask questions and clarify their doubts.

Give the participants 30 minutes to discuss and individually set their goals.

Remind them that goals should be realistic and time-bound.

Invite the participants to present their goals.

Ask the participants to read each other's goals and see if they have shared goals.

Invite the participants to discuss whether they can help each other to achieve their goals.

Note for the Facilitator
Depending on the objective of the exercise, it may be done in the large group with all of the participants or individually. If you expect the participants to set at least one individual goal for themselves, to be reviewed over a period of time, then you should ask them to do this exercise individually. On the other hand, if you want them to have common goals (as a group or as an organization) this exercise can be done in the large group. Since the training primarily focuses on behaviour change, individual goal setting may be more useful. In either case it is up to the facilitator to decide.

Session 10.5
Learning to Set Objectives

Expected Outcomes
Participants will be able to set achievable targets for themselves.
Peer educators will be able to use these objectives for monitoring the progress of the participants.

Getting There - Continued

Objective Setting objectives.

Materials Flip charts, markers.

Time 45 minutes.

Process Invite the participants to place their goals before them and think about SMART objectives. Explain that objectives need to be:

S Specific
M Measurable
A Achievable
R Relevant
T Time-bound

The goals that they had set for themselves earlier can be further broken down. For example, a goal of giving up cigarette smoking can have multiple objectives, such as reducing the number of cigarettes to five a day within the next week. Further reducing the number of cigarettes to three a day in the next one-week and so on.

Give the participants 25 minutes to set their objectives. These can either be common or individual; the facilitator decides.

Invite the participants to share the objectives.

Note for the facilitator
Objectives are important for follow up and monitoring an activity. Therefore, these need to be very specific, time-bound and, if possible, measurable. You may want to start the planning cycle from this point onwards, and ignore the dream and goal setting exercises. As mentioned earlier, these exercises are to be used at your discretion. If you feel that the participants only need to plan for a short period, then it is advisable to start with the objective exercise. If the participants are expected to plan for a behaviour change, then it may be useful to start with the dreaming exercise.

Session 10.6
Breaking down the Objectives into Activities

Expected Outcomes

Participants will list specific activities that they will undertake for each objective.
Peer educators will be able to use these activities for follow up.

What To Do

Objective Making the activity chart.

Material Flip charts, markers.

Time 1 hour.

Process Invite the participants to place their objectives before them.

If the objective setting was done collectively, this exercise should also be done collectively. However, if the objective setting was done individually, or in small groups, this exercise should be done accordingly.

Ask the participants to draw up a list of activities that would have to be done to achieve each objective.

Give the group 30 minutes to do this exercise. Facilitate the activity, and encourage the participants to make a detailed chart specifying all large and small activities required to achieve their objective.

Invite them to present their activity list if it is a common list, or ask them to put it up on a wall. Ask them to visit each other's list.

Note for the Facilitator

Activity lists should include all of the activities required to achieve a particular objective. These may be activities that the participants will do alone or will seek support for doing. They may need to ask someone to do it for them. Whether you make this an individual exercise, a small group exercise or a collective exercise is your choice.

Session 10.7
Making a Resource Chart

Expected Outcomes

Participants will know what support and resources they require to accomplishing their activities.
Peer educators will be able to plan for the support, resources and time needed to achieve the activities.

How To Do It

Objective Setting the time, responsibility and resources for the activities.

Materials Flip charts, markers.

Time 45 minutes.

Process Invite the participants to convert their activities list into a table with columns and rows.

The table should have four columns and rows corresponding to the number of activities (an example is provided below):

Activities	Time (when will it be undertaken)	Responsibility (who will do it)	Resources (what will be required to do it)

This table may be done collectively, in small groups or individually, depending on the process followed in the goal, objective and activity setting exercises.

If it is an individual or small group exercise, ask the participants to display the outcomes on the wall to share. However, if it is a collective exercise, do it on the floor with chalk in a participatory manner.

Note for the facilitator

This exercise is useful for personal, group and organizational planning. It is simple and can be done individually or in a participatory manner. It is your responsibility to ensure that the columns are filled in specifically i.e., in the time column specific dates / weeks / months should be filled in. Keep in mind holidays, weather constraints, availability of other people and places. Similarly, the responsibility column should be specific in stating the name of the person, or organization or group that has been assigned the responsibility. The resources column should include finance, material and human resources. If you think it would be useful, you could sub- divide the fourth column into 3 columns.

Session 10.8
Resources and Support Table

Expected Outcomes

Participants will be able to identify things they can do on their own and things they require support for.
Peer educators will be able to use this exercise for planning his/her schedule of support and future activities.

How To Do It - Continued

Objective Making the match.

Materials Flip charts, markers.

Time 1 hour.

Process Invite the participants to examine their time, responsibility and resource chart (outputs of session 10.7). Explain that on the basis of this chart they should make another chart in order to access the resources required for each activity. This could be done using a matrix similar to the one shown below:

Resources needed	Can do it myself/ourselves	Need support from family/peers	Need professional support

*The resources needed column will be taken from the previous exercise. Give the participants 30 minutes to complete this exercise.

If it is an individual or small group exercise, allow them to share the outputs.

If it is a collective exercise, facilitate a participatory matrix using chalk and the floor (flash cards are an option)

Note to the facilitator

The planning exercises can be brought to a close with this final matrix. However, in order to complete the spectrum of activities undertaken in a planning phase budgeting, spatial concerns and reconciliation steps also be considered.

Budgeting may be undertaken, if required, on an approximation basis for each planned activity. This may be done with the help of secondary information gathered from the market, newspapers and previous proposals. One could invite a resources person for this exercise. The resource person could be a commerce graduate with some experience in making budget statements, or it could be a colleague within your organization responsible for financial management. It could be a participant with similar experience.

Spatial concerns Include the physical place and location of the activities. It also pertains to arrangements, such as places to stay, resource staff and others involved in the planned activity.

Reconciliation Deals with a review of the compatibility of the goals, objectives and activities. This will confirm whether or not the final plan will enable the dream / vision to be achieved.

It Is Easy!

Planning seems like a complicated issue but it isn't. All of us plan all of the time. Even effortless daily activities are an example of planning. Good planning is essential for a life well lived, and it is essential for an activity, programme or project. Here is how you can do it:

Why do you want to do what you want to do?
Who will benefit from it, who will support it and who will oppose it?
Where will you start the activity, project or programme, determine the physical place / space?
When will you start and when will you finish, and in between when will you do what?
What will you do? (the activities)
How will you do it, monitor it and evaluate it? (the methodology)

Session 10.9
Making a Commitment

Expected Outcomes
Participants will realize that commitment is essential for achieving goals.
Participants will need to keep to their plans and promises.

I Commit

Objective To elicit participants' commitment.

Material None

Time 45 minutes

Process Invite the participants to stand in a circle.

Explain that the personal commitment of everyone is of great value in the collective fight against HIV/AIDS. Throughout this exercise, the participants will be able to pledge their commitment and support to the struggle.

Start at one end of the circle, and ask the participants to complete this sentence "I will…"

Put up a flip chart and record the participants' responses.

After the exercise , this information should be typed and distributed.

Alternatively, put up a list of the participants' and record each one's commitment beside their name.

If you plan to monitor the progress of the commitment, ask the participants to specify the time within which they hope to fulfil their commitment.

Note to the Facilitator
This is a simple exercise and its seriousness depends on how it is facilitated. It is also possible to use this activity as a session closing exercise. However, if you wish to follow up on the commitments, make sure that these are documented beside every participant's name and have a definite time frame.

Session 10.10
Who Should do What?

Expected Outcomes

Participants will realize that multiple stakeholders have a role to play in the fight against HIV / AIDS.
Participants will be able to state their expectations from the various stakeholders.
Participants can sum up the statements and use them as advocacy tools or send them to the respective stakeholders as suggestions.

Expectations

Objective To explore the participants' expectations of self and others in the fight against HIV / AIDS.

Materials Flash cards, markers.

Time 1 hour and 30 minutes.

Process Invite the participants to sit in a circle on the floor.

Explain that many people, organizations, groups and governments have a role to play in the fight against HIV / AIDS. This exercise is designed to explore the expectations that participants have of themselves and others in this fight.

Ask each participant to pick up four flash cards and a marker

Explain that they should use one flash card to write one thing that they expect to do themselves to contribute to the fight against HIV / AIDS. The other three cards should be used to write their expectations of the community, government and medical professionals.

Allow 20 minutes for this activity.

While the participants are busy writing their cards set the headings; expectations of self, expectations of the community, expectations of the government, expectations of the medical professionals. Ask the participants to place their cards in a vertical line on the floor under the headings.

Ask them to examine each vertical line, and group the similar cards. Invite the participants to sit in a circle around the final sorted card lines, and facilitate a discussion using the following questions:

- *How do you feel about your expectations of self and others? Why?*
- *Do you think these expectations can be met? Why/Why not?*

- *How can we ensure that the expectations discussed in this group are actually met?*
- *What possible steps can be taken to make these expectations a reality?*
- *How much time should be allotted to fulfil these expectations?*

Note to the Facilitator

This is a useful exercise to undertake if time for planning a future activity is short and you need to draw up a tentative plan for future areas of work. You can also use the outcomes of this exercise as recommendations for concerned groups. You can increase or decrease the groups of people from whom support is expected. For example, you could include religious leaders and teachers as possible groups from whom support is sought.

Session 10.11
Making Requests

Expected Outcomes
Participants will get support in their fight against HIV / AIDS.
Participants will learn to communicate and negotiate for something they want.

Request

Objective For participants to think and decide upon one special request concerning their own lives and HIV / AIDS that they would like their peer group to accept.

Materials Flip charts, markers.

Time 1 hour.

Process Ask the participants to divide into 4 groups.

Explain that they should brainstorm in their respective groups and come up with one request that they would like the other 3 groups to accept.

The request should pertain to HIV / AIDS and their lives. For example, a group may want to request the other three groups to help them perform a play in their community to show the ways in which HIV / AIDS can and cannot be transmitted. Another example may be, one group asking the other group to start using condoms while having sex with their partners. Encourage the groups to discuss issues that are most important in their peer group concerning HIV / AIDS.

Give them 10 minutes to brainstorm. Invite the four groups to sit in the four corners of the room.

Start with one corner and ask them to state their request to the other three groups.

Facilitate a discussion to achieve consensus on the request. It is possible that the request will be accepted by all three groups without any counter argument, or it may be that one group accepts and two ask for certain modifications. The final outcome must be based on consensus.

Allow each group 2 to 3 minutes to state its request and 10 minutes to reach a consensus.

After each group has stated its request and consensus has been reached, facilitate a discussion using the following questions:

- *How easy or difficult was it to get your request accepted by the other groups? Why?*
- *Will you be able to present these requests to the community or your peer groups? If yes, how? If not, why?*
- *Can the final requests be implemented? If yes, how? If not, why?*

Note for the facilitator

This is an interesting way to explore the issues the participants would like to work regarding their lives and HIV / AIDS. It also looks at the issue of support from others and reasons why the support may or may not be given by the others. It allows the participants an opportunity to hone their debating skills while defending and presenting their request for acceptance by others. You can also use this exercise in the community to reach consensus on sensitive issues linked with HIV / AIDS, such as condom use, inclusion of women in the property share or sex with multiple partners.

Session 10.12
Charting the Course

Expected Outcomes

Each participant will have a timeline of the things s/he wants to do in the future. Peer educators will be able to use these timelines to decide his/her work schedule and future plan of action.

Timeline

Objective Preparing a time-line for future work.

Material flipcharts, markers.

Time 1 hour.

Process Invite the participants to each take one flip chart and markers.

Explain that they will make a timeline to show how they would use the learnings from the training just received.

Each participant should draw a timeline showing his or her action plan for the next six months (the time can be reduced or increased depending on the peer educator's objective for this session).

Allow the participants to work individually for 30 minutes.

Invite them to display their timelines on the wall.

Examine the timelines with the participants, and encourage them to discuss each other's timeline.

Ask the participants to gather in a circle and facilitate a short discussion using the following questions:

- *Ho do you feel about your respective timelines?*
- *Will all of you be able to accomplish the tasks shown in your timeline?*
- *How will you accomplish what you have depicted on the timeline?*
- *Do you have any suggestions on how we can monitor the progress on these timelines?*

Note for the Facilitator

Timelines are useful participatory tools for historical analysis as well as future planning. In this case, the participants are using the timeline in the individual context to plan a future course of action. The timeline can be drawn using a daily weekly or monthly chart, or at random, depending on the convenience of the participants. It is important that each timeline have a stated objective, date and place of preparation. It should also have the name of the participant and the facilitator. This will enable the participants to use this as a monitoring tool. You could make a copy of the timelines for yourself for monitoring progress. It may be useful for you to make a timeline for yourself and to share it with the participants.

ANNEX:

TRAINING NEEDS ASSESSMENT FOR PEER EDUCATORS: A SIMPLE MODEL

I. What is training?

Generally, training involves the development or strengthening of three main aspects: knowledge, skills and attitudes. Usually these three aspects have to be taken together. All of them need to be addressed, if a person is to develop himself/herself to contribute effectively to a group or organization to which s/he belongs. So training is about enabling people to gain knowledge, to practise their skills and to shape their attitudes.

II. What is training needs assessment (TNA)?

A need is not a want or a desire. It is a gap between "what is" and "what ought to be".

Needs assessment is used for identifying gaps and to provide information for a decision on whether the gaps could be addressed through training. The assessment is part of a planning process focusing on identifying and solving performance problems. These performance problems may be related to knowledge, skills and attitudes.

Training needs assessment (TNA) is usually related to organizational and individual performance. A needs assessment means that the individual assessed has a defined job performance or that an organization has defined objectives and goals.

Similar concepts (with some modification) apply in the case of peer educators in the fields of HIV/AIDS and substance use prevention and reproductive health.

For example, in this instance, we are focusing on the training needs assessment of individuals to gauge their knowledge, skills and attitudes for the task of peer education in the fields of HIV/AIDS and substance use prevention. This implies that both "what ought to be," i.e., the knowledge, skills and attitudes expected of the peer educators and "what is," i.e., the current level of knowledge, skills and attitudes of the individuals who are to be trained, must be included in the assessment.

III. Why should we conduct a training needs assessment?

The primary purpose of the training needs assessment is to ensure that there is a need for training and to identify the nature of what a training programme should contain.

A training needs assessment provides the information needed for developing a training plan that is based on the learning needs of the participants. It increases the relevance of the training and the commitment of the learners, as they are involved in the preparation of the training design that reflects their expressed needs. Thus, it helps to foster a rapport between the facilitators and the participants. The facilitators can acquire basic knowledge of the strengths and limitations of the participants and the learners can become partners in analyzing their own learning needs.

IV. How should we carry out a training needs assessment?

There are many tools and methods for undertaking training needs assessment. These tools and techniques range from questionnaire-based surveys to participatory learning and action (PLA) tools.

Below are some tools used for training needs assessment:

Questionnaire/Survey Questionnaires: This tool involves the preparation of questionnaires that are often lengthy and therefore time-consuming.

Participants have to spend time to complete the questionnaires. The facilitators also have to spend time in analyzing the responses.

There are several weaknesses of the questionnaire method. Critical weaknesses of this method are that it is not participatory and often poses problems of excess information and differences in understanding between those who develop the questionnaires and the questionnaire respondents. Most importantly, a questionnaire is non-transparent about the end-use of its outcome. This can become a serious problem when dealing with sensitive issues such as HIV/AIDS, substance use and sexual behaviour.

Interviews: Individual interviews that rely on questionnaires, as is often the case, suffer from the same limitations as survey questionnaires. However, interviews are more participatory than questionnaires.

Focus group discussions: This method is more participatory than the questionnaire method and less time consuming than the individual interview method. However, this method also requires an open-ended questionnaire and careful facilitation and analysis for relevant results.

Tests: This tool indicates the involvement of "experts" and is considered costly. Participants often feel disadvantaged when such a tool is used and at times could become uncooperative.

Participatory Tools: These tools, such as card sorting, empowering lines, matrices and games, encourage the involvement of participants and facilitators. A rapport is established between the two and they become partners in determining the content and design of a training course. It is sometimes said that participatory tools are "unscientific" or that their use is dependent on the facilitation skills of the facilitator. However, these tools are less time consuming and more appropriate for participant involvement. These are also easy to learn and could be used with participants with low levels of, or no, reading and writing skills. Most important of all, these tools empower the learner. On balance, in training needs assessment for peer education, participatory tools may be considered the most appropriate.

V. Participatory Tools in TNA

Some of the participatory tools that may be used by peer educators for TNA are described below:

a. Empowering lines

Time needed: 1 hour

Invite the participants to sit in a circle on the floor. Or, if they are seated on chairs, place a table in the centre of the circle.

Explain that horizontal lines will be used for undertaking the training needs assessment of the group.

Determine the subject on which you would like to do the training needs assessment. For example, you may want to undertake the assessment on HIV/AIDS.

Determine the main components of HIV/AIDS. For example, the main components may be:

- Means of transmission;
- Was of protecting oneself and others from the virus;
- Testing for HIV;

- Treatment for HIV / AIDS;
- High-risk behaviour;
- Care of and support for people living with HIV / AIDS.

Take a large sheet of paper and draw as many horizontal lines as there are components. Draw the line at a considerable distance from each other. You may want to draw only two lines on one sheet of paper. You may even use old newspapers instead of fresh sheets of paper.

Label each line with the heading of the components.

Label one end of each line as low and one end as high.

Distribute small stickers to the participants. Or, they may use marker pens. If stickers are used, each participant should have as many stickers as the number of components in the topic being assessed.

Ask the participants to individually place their stickers on the line of each component starting from the low end and progressing towards the high end.

On completion of the exercise, each component line will have clusters of stickers or dots at varying intervals.

The placement of clusters will help the facilitator to determine:

- The components that need detailed discussion and inputs.
- The components that need limited focus and can be managed through mutual learning sessions, such as group discussion and games.
- The components that do not require focused attention at all as they can be covered through the distribution of reading material to the participants.

Interpretation of the clusters

The clusters need to be interpreted. Some clues for interpretation are given below:

- Clusters at the low end indicate that the participants have no knowledge of the subject.
- Clusters at the halfway point between the two ends indicate that the participants have some knowledge and beliefs about the subject.
- Clusters near the high end indicate complete or considerable knowledge of the subject.

Table a (i) An Example of TNA Using Empowering Lines

Topic of training needs assessment: **Knowledge about HIV/AIDS**

1. ***Means of HIV/AIDS transmission.***

Low High

2. Method of Protection from HIV/AIDS.

Low High

3. Testing for HIV/AIDS.

Low High

Table a (ii)

Topic of training needs assessment: **Skills for protection against HIV infection.**

1. Ability to say 'No' while under pressure from peers and friends.

Low High

2. Skill in using a condom correctly.

Low High

3. Ability to deal with emotions and feelings.

Low High

Advantages of using empowering lines

Some advantages experienced in the application of the tool are as follows:

- The completed line can be used to evaluate the training.
- The participants develop a rapport with each other and the facilitator.
- The facilitator gains the understanding needed to design training inputs according to the needs of the participants.
- Assessment can be done immediately before the training session begins, instead of being done well in advance.

b. Assessment Matrix

(i) Process
Time needed: 1 hour

Make a list of the knowledge, skills and attitudes that are necessary for a peer educator to be able to train other peers on the subject of HIV / AIDS and substance use. For ease, do this exercise for one subject at a time. For example, we may do the exercise for knowledge, skills and attitudes concerning HIV / AIDS training first, followed by the exercise concerning substance use.

Take each kno wledge component and write it separately on a card (or paper).

Place the cards on the floor in a vertical line.

Draw a matrix around the cards so placed. This matrix should have three columns, including the vertical line of cards and as many rows as there are cards plus one.

Label the column with the cards as “knowledge needed for peer education”.

Label the second column as “have”.

Label the third column as “need”.

Place a bowl of stickers (or small stones or seeds) next to the matrix.

Ask each pa rticipant to come forward one by one and place a sticker (or small stone or seed) in the columns and rows, depending on what they have and what they need.

After the matrix has been completed, ask a volunteer to copy it on a chart so that it can be displayed on the wall. This can then be used later for evaluation of the training.

Repeat the matrix for skills and for attitudes in the same manner.

(ii) Example

Table b (i) Assessment Matrix for Assessing the Knowledge Needed by Peer Educators to be Able to Train Peers on Substance Use:

Knowledge that a peer educator must have to undertake a training session on substance use	**Have the knowledge**	**Require the knowledge**	**Ranking based on intensity of need for knowledge**
Definition of the term "drug".	**	********	4
Types of substances used by young people.	*******	****	5
Reasons for substance use by young people.	***	**********	1
The effects that substance use has on the lives and bodies of young people.	******	**********	3
Treatment possibilities for young people who use substances.	***	**********	2
Symptoms of substance use.	********	***	6
Country's policy and laws on substance use and drug trafficking.	**	**********	2

- A score denoted by * indicates the number of respondents that have, or those that do not have, the knowledge on a given topic. The higher the score, the larger the number of people. The lower the score, the smaller the number of people.
- Ranking indicates the intensity of the need for knowledge on any given topic.

c. Scoring.
Time needed: 1 hour

Invite the participants to sit in a circle.

Explain that a free scoring exercise will be undertaken to assess the attitudes that are most important for protection against the spread of HIV/AIDS, sexually transmitted infections (STIs) and substance use.

Ask the participants to make a list of the attitudes required for protection against HIV/AIDS, STIs and substance use.

One flash card or one half sheet of A-4 sized paper may be used for writing one attitude.

Invite the participants to arrange the cards on the floor in a vertical line.

Ask the participants to discuss and score each attitude according to its importance for protection against HIV/AIDS, STIs and substance use. Since this is a free scoring exercise, the participants may use sand or stones to indicate the importance that they attach to each attitude.

Allow time for discussion, as the scores can only be assigned by consensus among the participants. Free scoring is different from voting and is based on consensus.

Table c (i) Scoring for Attitudes Needed by Peer Educators to be Able to Train Peers on the Subject of Protection from HIV/AIDS, STIs and Substance Use

Attitudes needed for protection from HIV/AIDS, STIs and substance use	Free scoring to indicate the importance attached to the attitude/behaviour for protection against HIV/AIDS, STIs and substance use	Ranking based on the intensity of the attitude and behaviour present in the peer educator
The belief that I am as vulnerable as everyone else.	********** **********	2
I could become dependant on drugs, even if I use them only once.	******* *******	3
The safety of my partner is as important as my own.	********** **********	1
People who have HIV/AIDS or who use drugs can help in the prevention of the same.	*** ****	4

- Free scoring indicates that there is no limit on the scores assigned. The participants use grains or sand or stones to indicate the importance that they attach to a stated attitude/behaviour.
- A high score indicates that the attitude/behaviour is present to a high degree and a low score indicates that the attitude/behaviour is present to a low degree.
- The ranking indicates the intensity.

VI. Using the outcomes of the TNA for designing a training course

Let us take a look at the outcomes in table a (i). The scores on the "empowering line" indicate that most participants have some knowledge on the transmission of HIV/AIDS and protection against HIV/AIDS, but very few participants have knowledge on testing for HIV/AIDS. Therefore, the

training session should focus on *session 5.4 Facts and Myths about HIV/AIDS dealing with testing for HIV/AIDS*. Handouts should be prepared from the material given under the title *Helpline for the Peer Educator*. All the information indicated is available in *Module 5 of the training guide.*

If we look at table b (i), the outcomes indicate that the participants need knowledge on the following subjects:

- Reasons for substance use by young people.
- Treatment possibilities for young people who use substances.
- Country's policy on substance use and drug trafficking.
- Effects of substance use on the lives and bodies of young people.
- Definition of the term "drug".

If a training course were developed to meet these needs using *Module 6* of the training guide, the following design would emerge:

TNA Outcome	**Session Number**	**Reading material**
Reasons for drug use by young people.	6.5	Module 6 on "Drugs and Substance Use", see Session 6.5: "Why Do Young People Use Drugs?" --- "Helpline for the peer educator"
Treatment possibilities for young people who use substances.	There is no session for this, as this needs to be based on the treatment possibilities available in the country or locality where the training is being held. A staff member of the local treatment facility could address the session through a lecture. Or, the facilitator could prepare a presentation based on the information that can be locally gathered.	Module 6 on "Drugs and Substance Use", see Section III: Critical Concepts, subsections e), f) and k).
Country's policy on drug use and drug trafficking.	This session also needs to be addressed through a lecture or presentation. Prior information on the subject	N / a

	needs to be collected by the peer educator.	
Effects of substance use on the lives and bodies of young people.	6.4 6.6	Module 6 on "Drugs and Substance Use", see Section III: Critical Concepts, subsection d).
Definition of the term "drug".	6.1	Module 6 on "Drugs and Substance Use", see Section III: Critical Concepts, subsection a).

VII. Linkage between training needs and the modules in the training guide.

The training guide has 11 modules. Each module caters to a certain set of training needs. The following table indicates the modules and the corresponding training needs fulfilled by it:

Module number	**Module name**	**Training needs addressed**
0	Introduction to Training and Learning	Knowledge about the basics of a training course, learning theory and games and exercises on introductions and the basic needs of the learners.
I	Peer Education	Knowledge of the concept of peer education. Games and exercises to understand the importance and relevance of peer education and to identify the basic qualities needed for becoming a peer educator.
II	Communication	Knowledge of the concept of communication, its elements and its importance in training. Games and exercises on gaining skills for better communication and the application of communication skills in creating and spreading messages on HIV / AIDS prevention.
III	Basics of Growing Up –	Knowledge about the changes that take place in the human body during adolescence, beliefs and

	Understanding Adolescence	myths related to these changes and critical issues, such as teenage pregnancy, appropriate nutrition and health hazards. Games and exercises for imparting this knowledge to learners.
IV	Teenage Pregnancy, Sexually Transmitted Infections (STIs) and HIV / AIDS	Knowledge about teenage pregnancy and sexually transmitted infections. Skills to deal with situations that could lead to teenage pregnancy and STIs. Games and exercise to impart this knowledge and skills.
V	Basics of HIV / AIDS	Knowledge about HIV / AIDS – transmission, protection and treatment. Skills to deal with situations that could lead to HIV / AIDS infection. Games and exercise to impart the knowledge, skills and attitudes required for protection against HIV / AIDS.
VI	Drugs and substance use	Knowledge about drugs, their linkage with HIV / AIDS and the skills needed for avoiding situations that could lead to substance use. Games and exercises to impart the knowledge, skills and attitudes needed for prevention of substance use.
VII	Life Skills	Knowledge about the concept of life skills and the basic life skills needed for prevention of HIV / AIDS, STIS and substance use.
VIII	Learning and Practising Core Life Skills	Exercises and games to enhance the competencies required for protection against HIV / AIDS, STIs and substance use.
IX	People Living with HIV / AIDS	Knowledge about the components of care and support required by people living with HIV / AIDS.

		Practical suggestions for peer educators on care giving. Games and exercises to understand the needs of people living with HIV / AIDS.
X	Action Planning	Knowledge about the need for and relevance of planning. Skills for making a plan. Games and exercises for imparting knowledge and skills for planning.

SAMPLE QUESTIONNAIRE

Survey Questionnaire for Training Needs Assessment

This questionnaire is designed to facilitate the gathering of information on the thoughts, opinions, feelings and knowledge that young people have about HIV/AIDS. It also aims to determine whether the target audience feels able to deal with situations that may lead to HIV infection.

Instructions

Do not put your name on this form.

Please take your time to answer carefully

Please answer the following questions:

Sex:_____

Date of Birth:_____

Do you live with your parents?_____

What languages do you speak?_____

What is your education qualification?_____

What work do you do?_____

Do you get paid for the work you do? _____

For each of the following questions, circle the correct answer.

1. The term HIV stands for human immunodeficiency virus.

(i) True

(ii) False

(iii) Don't know

2. The term AIDS stands for acquired immunodeficiency syndrome.

(i) True

(ii) False

(iii) Don't know

3. There is no cure for AIDS.

(i) True

(ii) False

(iii) Don't know

4. If one has HIV, a blood test will reveal the results.

(i) True

(ii) False

(iii) Don't know

5. Only people who look sick can have HIV.

(i) True

(ii) False

(iii) Don't know

6. People who are immoral spread HIV/AIDS.

(i) True

(ii) False

(iii) Don't know

7. One can only get HIV/AIDS through sexual intercourse with a person who already has the virus.

(i) True

(ii) False

(iii) Don't know

8. A mother can transmit HIV to her child through her breast milk.

(i) True

(ii) False

(iii) Don't know

9. Condoms reduce the risk of getting HIV/AIDS.

(i) True

(ii) False

(iii) Don't know

10. A person can get HIV/AIDS by touching or hugging someone with AIDS.

(i) True

(ii) False

(iii) Don't know

11. You can get HIV/AIDS by having anal sex without a condom.

(i) True

(ii) False

(iii) Don't know

12. You can get HIV/AIDS by being bitten by a mosquito that has bitten someone with HIV/AIDS.

(i) True

(ii) False

(iii) Don't know

13. Only people who have sexual intercourse with gay (homosexual) people get HIV/AIDS.

(i) True

(ii) False

(iii) Don't know

14. You can get HIV/AIDS from kissing someone who has HIV/AIDS.

i). True

ii). False

iii). Don't know

15. You can become infected with HIV/AIDS by having sex with someone who injects drugs using needles and syringes shared with others.

(i) True

(ii) False

(iii) Don't know

16. Birth control pills can protect women from getting HIV/AIDS.

(i) True

(ii) False

(iii) Don't know

17. Could you talk to your friends about someone you would like to have as a girl friend or boy friend?

(i) Definitely

(ii) Probably

(iii) Probably not

(iv) Definitely not

18. Could you talk about sex with your friends?

(i) Definitely

(ii) Probably

(iii) Probably not

(iv) Definitely not

19. Could you talk with your friends about diseases that you can get from having unprotected sex?

(i) Definitely

(ii) Probably

(iii) Probably not

(iv) Definitely not

20. Could you start a conversation about condoms with your friends?

(i) Definitely

(ii) Probably

(iii) Probably not

(iv) Definitely not

21. Could you talk about HIV/AIDS with your friends?

(i) Definitely

(ii) Probably

(iii) Probably not

(iv) Definitely not

22. Could you say "No" to your friends if they challenged you to have sex with your girlfriend or boyfriend?

(i) Definitely

(ii) Probably

(iii) Probably not

(iv) Definitely not

23. Could you tell your boy friend or girlfriend that you do not want to have sex with her /him?

(i) Definitely

(ii) Probably

(iii) Probably not

(iv) Definitely not

24. Could you tell your boyfriend or girlfriend to stop touching you sexually?

(i) Definitely

(ii) Probably

(iii) Probably not

25. Have you ever talked with your parents or any adult about sex?

(i) Yes

(ii) No

26. Have you ever discussed HIV/AIDS with your parents or any other older person that you are close to?

(i) Yes

(ii) No

27. Have you ever discussed pregnancy with your parents or any other older person that you are close to?

(i) Yes

(ii) No

28. Have you ever discussed the use of condoms or contraceptives with your parents (or any other older person that you are close to)?

(i) Yes

(ii) No

29. How would you feel about discussing sex with your parents?

(i) Comfortable

(ii) Uncomfortable

30. How would you feel about discussing HIV/AIDS with your parents (or any other older person that you are close to)?

(i) Comfortable

(ii) Uncomfortable

31. How would you feel about discussing pregnancy with your parents or any adult?

(i) Comfortable

(ii) Uncomfortable

32. How would you feel about discussing the use of condoms with your parents (or any other older person that you are close to)?

(i) Comfortable

(ii) Uncomfortable

33. How worried are you that you might become pregnant?

(i) Not at all worried

(ii) Somewhat worried

(iii) Very worried

34. How worried are you that you may become infected with HIV?

(i) Not at all worried

(ii) Very worried

(iii) Somewhat worried

35. Do you think using a condom is too much trouble?

(i) Yes

(ii) No

36. Have you ever used a condom while having sex?

(i) Yes

(ii) No

37. Having sexual intercourse is a "cool" thing to do. What is your view on this?

(i) Agree

(ii) Disagree

38. Having sexual intercourse makes a young man popular among his friends. What is your view on this?

(i) Agree

(ii) Disagree

39. Young girls should have sexual intercourse with their boyfriends because it shows that they love their boyfriends. What is your view on this?

(i) Agree

(ii) Disagree

40. I am worried about getting HIV/AIDS, so I will always make sure that I use a condom when I have sex.

(i) Definitely would

(ii) Probably would

(iii) I probably would not

(iv) I definitely would not

41. I would use a condom even if I were drunk or high on drugs.

(i) Definitely would

(ii) Probably would

(iii) I probably would not

(iv) I definitely would not

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