Sexual and Reproductive Health and Life-skills

Running groups for teens (14-19 years)

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& Marnie Vujovic

Anova Health Institute 2012
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All efforts have been made to acknowledge sources used in the preparation of the manual. If there are any omissions, please accept our apologies and inform us – they will be corrected in subsequent versions.

If you have any other comments that could help us improve the manual we would appreciate hearing from you.

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Support groups for middle adolescence
# Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>ARV</td>
<td>antiretroviral</td>
</tr>
<tr>
<td>ART</td>
<td>antiretroviral treatment</td>
</tr>
<tr>
<td>ASH</td>
<td>adolescent sexual health</td>
</tr>
<tr>
<td>ECP</td>
<td>emergency contraceptive pills</td>
</tr>
<tr>
<td>HAART</td>
<td>highly active antiretroviral therapy</td>
</tr>
<tr>
<td>IG</td>
<td>intergenerational</td>
</tr>
<tr>
<td>LGBT</td>
<td>lesbian, gay, bisexual and transgendered</td>
</tr>
<tr>
<td>MCP</td>
<td>multiple and concurrent partnerships</td>
</tr>
<tr>
<td>MSM</td>
<td>men who have sex with men</td>
</tr>
<tr>
<td>PID</td>
<td>pelvic inflammatory disease</td>
</tr>
<tr>
<td>PMTCT</td>
<td>prevention of mother-to-child transmission of HIV</td>
</tr>
<tr>
<td>SIV</td>
<td>simian immunodeficiency virus</td>
</tr>
<tr>
<td>SRH</td>
<td>sexual and reproductive health</td>
</tr>
<tr>
<td>STI</td>
<td>sexually transmitted infection</td>
</tr>
<tr>
<td>TOP</td>
<td>termination of pregnancy</td>
</tr>
<tr>
<td>TS</td>
<td>transactional sex</td>
</tr>
<tr>
<td>VYA</td>
<td>very young adolescent</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>
Adolescents are expected to negotiate increasingly difficult situations as they mature. This includes discovering and expressing their sexuality. Without the correct advice and care these young adults may take decisions that put their sexual health at risk. In the South African context, where HIV prevalence is exceptionally high, effective counselling for teenagers is especially important.

Despite this urgent need, many people working with adolescents are not equipped to provide the guidance that could help adolescents to properly negotiate these challenges and effectively manage their sexual health. Without training or reliable resources, imparting life skills and sharing information in a sensitive and age-appropriate manner can be extremely challenging.

This manual offers a solution and is an essential resource for all people working with adolescents. It provides trainers and facilitators with the necessary insight to work effectively with young adults. Using participatory learning methodology, the manual serves as a tool for facilitators, helping them to set up clubs where adolescents can explore their sexuality in a judgement-free space. The manual includes various other training methodologies like role-playing, case studies and small group work, which encourage maximum participation from the adolescent club members.

Discussion of traditionally “controversial” issues is encouraged in the sessions. Adolescents can share their thoughts without fear of moral judgement from facilitators or peers and are empowered to explore a range of decisions and their behavioural outcomes.

The manual is designed to be of particular relevance to the South African setting. Drawing on in-depth research with South African adolescents (between the ages of 14 and 19 years), it provides a nuanced and sensitive understanding of the issues facing local adolescents, including living with HIV. The findings from this research serve as the building blocks for the material in the manual, enabling informed behavioural change to take place over a period of time.

I am confident that this manual will significantly contribute to trainers’ and facilitators’ capacity to work with young adults. Through more effective guidance the manual also puts adolescents in a better position to make informed decisions regarding their sexuality and reproductive health. Importantly, this manual includes HIV-positive adolescents and gives them a space to discuss their concerns and aspirations, allowing them to develop resilience and a sense of hope.

Helen Struthers
Anova Health Institute
Endorsements

“The Sexual and Reproductive Health & Life Skills manual for healthcare providers running groups dealing with teenagers and the challenges they face in this important area is long overdue. There is a dearth of practical training tools that can be used today to deal with one of the most challenging of problems of our times, the sexual and reproductive health of our youth. This manual and the workshops that are run along the lines set out by this innovative approach will go a long way in dealing with these issues. It will empower both the recipients of this knowledge as much as it will the providers, the healthcare personnel who use these tools. I feel this should form part of every adolescent service and perhaps in time be incorporated into the school curriculum.”

Ashraf Coovadia
Adjunct Professor
Head of Empilweni Services and Research Unit (ESRU)
Department of Paediatrics and Child Health
Rahima Moosa Mother and Child Hospital (Previously Coronation)
University of The Witwatersrand (Wits)
This training manual is an important and critical resource for developing in adolescents the knowledge and skills necessary to manage their own sexual and reproductive health. I believe the training methodology is especially strong in its use of participatory learning, which transforms participants from passive learners to active co-creators of meaning regarding their sexuality. The manual avoids taking a moralistic stand on a range of controversial issues, instead inviting participants to explore answers to a range of questions about the outcomes of various behavioural choices.

The manual takes cognizance of the South African context, which makes it a particularly powerful tool for behavioural change in this country. It also takes into account research conducted among South African adolescents, a feature rare in most currently available training materials.

The first part of the manual commendably describes the context of training and the attitudes and behaviours of an effective facilitator, which will enable more effective selection of facilitators with the appropriate interpersonal skills.

A particular strong aspect of the manual is its use of various training methodologies, including dramatisation of common dilemmas through role-playing, case-studies and working in small groups, all of which are more effective methodologies than didactic teaching.

I believe that the manual is an important contribution to empowering adolescents to make healthier life choices, and especially to enabling HIV-positive teenagers to develop resilience and a sense of hope.

Rob Hamilton
Clinical psychologist, HIV/AIDS trainer and materials developer
Aim

To equip people working with adolescents (between the ages of 14 and 19 years) with the relevant knowledge and materials to conduct structured support group sessions, in order to provide such adolescents with the sexual and reproductive health information and life-skills they need to make healthy choices.
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1.1 Introduction

This manual was informed by an in-depth investigation of the sexual behaviours and HIV risks of older adolescents and young adults (aged 14-19 years), and has been developed to assist young adolescents to make informed choices about their sexual and reproductive health.

1.2 About the study

A review of the literature concerned with the sexual and reproductive health of young people in South Africa suggested challenges in a number of areas. These include age-disparate relationships, multiple and concurrent partnerships, the early age of sexual debut, high rates of teenage pregnancy, and widespread sexual coercion and violence.

Considered to be one of the main drivers of HIV infection amongst young women (UNICEF, 2011), age-disparate sexual relationships are common in South Africa, with girls tending to become involved with men at least five years older than themselves. Whilst there are a number of factors that contribute to increased risk, reduced condom usage in such relationships remains a challenge.

Young women face difficulties in negotiating the use of condoms with an older partner, but such difficulties have also been linked to the transactional aspects of these relationships, which make it harder for young women to refuse to engage in sex without a condom.

Multiple and concurrent partnerships have long been recognised as a contributor to HIV risk. In addition, there is an emphasis on delaying sexual debut as an important area of focus in HIV prevention. In South Africa factors that have been found to increase risk of earlier sexual debut include coming from deprived socio-economic circumstances, not attending school, being an orphan, perceived risk, and low self-esteem and self-efficacy (Thurman et al., 2006; Mathews et al., 2008; Pettifor et al., 2009).

Pregnancy is of course a strong predictor of HIV infection amongst adolescents, with girls reporting early sexual intercourse having higher rates of teen pregnancy and child bearing (Shisana, Rehle et al., 2009). Many young women have unmet contraceptive needs and require access to services that can help them to manage their reproductive health.
All of these challenges suggest that there is plenty of scope for psychosocial interventions that can satisfactorily address a range of concerns, for example by building self-esteem, strengthening problem-solving skills, addressing gender inequity, and providing knowledge and information about sexually transmitted infections.

However listening to the voices of young people has remained a priority in shaping our response. Accordingly, this manual responds not only to the sexual and reproductive health issues that research has clearly identified as central, but is also guided by the views and perceptions of over 300 young people.

Between May and August 2012, young men and women were interviewed to establish knowledge and access to contraception; their experience of sexual and reproductive health services; sexual partnerships, including the number of partners, age of partners, sexual practices, and circumstances around the initiation and timing of sexual intercourse; pregnancy; HIV testing experiences; knowledge and experience of sexually transmitted infections; gender norms; and sexual communication and mental health.

The results of this survey have contributed much to understanding the sexual and reproductive health needs of older adolescents and young adults in South Africa. As such the survey has formed an important basis for the development of this manual.

1.3 What is the life-skills approach?

The challenges facing young people today have changed significantly from those affecting previous generations. Some simply did not exist before, and others have intensified or become more complex – for example, HIV/AIDS and other sexually transmitted diseases, alcohol, tobacco and other drug use, war and political instability, and also unemployment, sexual and other forms of exploitation, and discrimination in its many forms.

The causes of these problems are complex and multifaceted, and so they are unlikely to be solved quickly or simply. As part of a comprehensive, multi-strategy approach, a life-skills approach may help to contribute to a reduction in the harm associated with these issues, and to maintaining and promoting healthy lifestyles.

The life-skills approach refers to the interactive process of teaching and learning which focuses on acquiring knowledge, attitudes and skills which support behaviours that enable us to take greater responsibility for our own lives; by making healthy life choices, gaining greater resistance to negative pressures, and minimising harmful behaviours.

1.4 Understanding middle adolescent development

Adolescence is a time of change. In the transition from childhood, adolescents experience not just physical growth and change but also emotional, psychological, social and mental change.
<table>
<thead>
<tr>
<th>Stage</th>
<th>Cognitive development</th>
<th>Social-emotional development</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early adolescence</td>
<td>Growing capacity for abstract thought</td>
<td>Struggle with sense of identity</td>
</tr>
<tr>
<td>Approximately 11-13 years</td>
<td>Mostly interested in the present with limited</td>
<td>Feel awkward about self and body; worry about</td>
</tr>
<tr>
<td>of age</td>
<td>thoughts of the future</td>
<td>being normal</td>
</tr>
<tr>
<td></td>
<td>Intellectual interests expand and become</td>
<td>Realise that parents / caregivers are not perfect;</td>
</tr>
<tr>
<td></td>
<td>more important</td>
<td>increased conflict with parents / caregivers</td>
</tr>
<tr>
<td></td>
<td>Deeper moral thinking</td>
<td>Increased influence of peer group</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tendency to return to “childish” behaviour,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>particularly when stressed</td>
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<tr>
<td></td>
<td></td>
<td>Moodiness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rule and limit-testing</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Greater interest in privacy</td>
</tr>
<tr>
<td>Middle adolescence</td>
<td>Continued growth of capacity for abstract thought</td>
<td>Intense self-involvement, changing between high</td>
</tr>
<tr>
<td>Approximately 14-18 years</td>
<td>Greater capacity for setting goals</td>
<td>expectations and poor self-concept</td>
</tr>
<tr>
<td>of age</td>
<td>Interest in moral reasoning</td>
<td>Continued adjustment to changing body, worries about</td>
</tr>
<tr>
<td></td>
<td>Thinking about the meaning of life</td>
<td>being normal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Tendency to distance selves from parents /</td>
</tr>
<tr>
<td></td>
<td></td>
<td>caregivers, continued drive for independence</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Driven to make friends and greater reliance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>on them, popularity can be an important issue</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Feelings of love and passion</td>
</tr>
<tr>
<td>Late adolescence</td>
<td>Ability to think things through</td>
<td>Firmer sense of identity</td>
</tr>
<tr>
<td>Approximately 19-21 years</td>
<td>Able to delay gratification</td>
<td>Increased emotional stability</td>
</tr>
<tr>
<td>of age</td>
<td>Examination of inner experience</td>
<td>Increased concern for others</td>
</tr>
<tr>
<td></td>
<td>Increased concern for the future</td>
<td>Increased independence and self-reliance</td>
</tr>
<tr>
<td></td>
<td>Continued interest in moral reasoning</td>
<td>Peer relationships remain important</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social and cultural traditions regain some of their</td>
</tr>
<tr>
<td></td>
<td></td>
<td>importance</td>
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* Adapted from the American Academy of Child and Adolescent’s Facts for Families© All rights reserved

The following suggestions will help to encourage positive and healthy cognitive development in the adolescent:

- Include adolescents in discussions about a variety of topics, issues, and current events.
- Encourage adolescents to share ideas and thoughts with you.
- Encourage adolescents to think independently and develop their own ideas.
- Assist adolescents in setting their own goals.
- Stimulate adolescents to think about possibilities for the future.
- Compliment and praise adolescents for well thought-out decisions.
- Assist adolescents in re-evaluating poorly made decisions for themselves.
Some tips for supporting adolescents through early, middle and late adolescence

Early adolescence (12-14 years old)
- Support a critical perspective on media images of beauty and adulthood
- Promote healthy body image and self-esteem
- Affirm and support youth’s many physical, emotional and cognitive changes
- Be flexible and responsive
- Model respect
- Provide opportunities for complex thinking and the pondering of big questions
- Listen first
- Recognize that challenging authority provides an outlet for new cognitive skills
- Afford autonomy within limits of safety
- Engage in honest, supportive talk about sexuality
- Provide information and resources about healthy sexuality that affirm a range of sexualities and gender identities
- Provide outlets for questioning faith, religion and creed
- Have a sense of humour.

Middle adolescence (15-18 years old)
- Affirm that sexuality is a healthy part of human development
- Provide information about safe sex and contraception
- Be available for conversation; be a sounding board
- Offer fair and grounded support around risk taking; provide safety limits
- Enjoy the youth’s ability to think critically, hypothetically, and conceptually
- Encourage practices that celebrate youth’s mindfulness (such as journaling)
- Understand that new thinking skills may result in new criticisms
- Encourage involvement in multiple realms of activity or achievement (e.g. music, faith, community groups, sports)
- Learn and support youths’ realities and struggles
- Engage openly with youth about moral reasoning.

Late adolescence (18-22 years old)
- Continue providing information about safe sex and contraception
- Provide for self-care, including stress management
- Respect the privacy and intellect of the young adult
- Provide complex problems and complex questions to ponder
- Tie activities to broader concepts or issues (i.e. philosophical, existential, social activist lenses)
- Understand that intimacy and identity development are tied together and respect the young adult’s attention to this aspect of life
Cognitive development

The early stage of adolescence is a time of great cognitive development. At the beginning of adolescence, cognitive abilities are dominated by concrete thinking, egocentrism, and impulsive behaviour. The ability to engage in abstract reasoning is not highly developed in most young teens, limiting their capacity to comprehend nutrition and health relationships. Young adolescents also lack the skills necessary to problem solve in an effort to overcome barriers to behaviour change and the ability to appreciate how current behaviours can affect future health status.

Middle adolescence is characterised by growth in emotional autonomy and increasing detachment from family. The bulk of physical growth and development is completed during this stage. However, body image concerns may continue to be a source of trepidation, especially among males who are late to mature and females who have experienced great changes in body composition and size.

Conflicts over personal choice, including food choices, become increasingly common during this stage of adolescence. Peer groups become more important than family and their influence with regard to making food choices peaks. Coinciding with the increased importance of peer acceptance, the initiation of health-compromising behaviours such as smoking, alcohol consumption, using street drugs, and engaging in unsafe sexual activities often occurs during middle adolescence. Teens may consider themselves invincible and often still display impulsive behaviours.

What cognitive developmental changes occur during adolescence?

During adolescence (between 12 and 18 years of age), the developing teenager acquires the ability to think systematically about all logical relationships within a problem. The transition from concrete thinking to formal logical operations occurs over time. Each adolescent progresses at varying rates in developing his/her ability to think in more complex ways. Each adolescent develops his/her own view of the world. Some adolescents may be able to apply logical operations to school work long before they are able to apply them to personal dilemmas. When emotional issues arise, they often interfere with an adolescent’s ability to think in more complex ways. The ability to consider possibilities, as well as facts, may influence decision making, in either positive or negative ways.

Piaget’s cognitive development model

A form of thinking following the stage of concrete operations and representing the final, most mature state of thinking usually occurs after age 11 and is characterized by true logical thought, capability for deductive reasoning, abstract thinking, formulation and testing of hypotheses, appreciation for multiple perspectives on an issue, and the manipulation of ideas and concepts.

Some common indicators indicating a progression from more simple to more complex cognitive development include the following:
Early adolescence

During early adolescence, the use of more complex thinking is focused on personal decision making in school and home environments, including the following:

The early adolescent:

- begins to demonstrate use of formal logical operations in schoolwork
- begins to question authority and society standards, and
- begins to form and verbalize his/her own thoughts and views on a variety of topics, usually more related to his/her own life, such as:
  - which sports are better to play
  - which groups are better to be included in
  - what personal appearances are desirable or attractive, and
  - what parental rules should be changed.

Middle adolescence

With some experience in using more complex thinking processes, the focus of middle adolescence often expands to include more philosophical and futuristic concerns, including the following:

The middle adolescent:

- often questions more extensively
- often analyses more extensively
- thinks about and begins to form his/her own code of ethics (i.e. what do I think is right?)
- thinks about different possibilities and begins to develop own identity (i.e. who am I?)
- thinks about and begins to systematically consider possible future goals (i.e. what do I want?)
- thinks about and begins to make his/her own plans
- begins to think long term, and
- his or her use of systematic thinking begins to influence relationships with others.

Late adolescence

During late adolescence, complex thinking processes are used to focus on less self-centred concepts as well as personal decision making, including the following:

The late adolescent:

- has increased thoughts about more global concepts such as justice, history, politics, and patriotism
- often develops idealistic views on specific topics or concerns
- may debate and develop intolerance of opposing views
- begins to focus thinking on making career decisions, and
- begins to focus thinking on emerging role in adult society.

Development in middle adolescence

Adolescents experience dramatic biological changes related to puberty; these biological changes can significantly affect psychosocial development.

An increased awareness of sexuality and a heightened preoccupation with body image are fundamental psychosocial tasks during adolescence. Dramatic changes in body shape and size can cause a great deal of ambivalence among adolescents, especially among females, leading to the development of poor body
image and eating disturbances or disorders if not addressed by family or health care professionals. Similarly, a perceived delay in sexual maturation and biological development, especially among males, may lead to the development of poor body image and lowered self-esteem.

**Peer influence** is a dominant psychosocial issue during adolescence, especially during the early stages. Young teens are highly cognisant of their physical appearance and social behaviours, seeking acceptance within a peer group. The desire to conform can influence food intake among teens.

The broad chronological age range during which biological growth and development begins and advances can become a significant source of personal dissatisfaction for many adolescents as they struggle to conform to their peers.

Males who enter puberty at a later age may consider themselves to be late bloomers, and may feel physically inferior to their peers who mature earlier. This sense of dissatisfaction may lead to the use of anabolic steroids and other supplements in an effort to increase growth and muscle development and to gain weight. Such dissatisfaction can also lead to markedly reduced self-esteem.

For females, however, it is often early maturation that is associated with poor body image, poor self-esteem, frequent dieting, and, possibly, disturbed or disordered eating behaviours. Early maturing female teens are also at increased risk for engaging in other unhealthy behaviours such as smoking, alcohol consumption, and early sexual intercourse.

It is very important that young and middle adolescents be educated on normal variations in initiation and progression of biological growth and development in an effort to facilitate the development of a positive self-image and body image, and to reduce the likelihood of early initiation of health-compromising behaviours.

Abstract reasoning skills begin to emerge among most teens during middle adolescence. However, these skills may not be highly developed. Adolescents will often regress to concrete thinking skills when faced with overwhelming emotions or stressful situations. Teens start to comprehend the relationship between existing health behaviours and future health status but their desire to fit in with peers may make it difficult to make health-related choices based upon knowledge rather than peer pressure.

The late stage of adolescence is characterized by the development of a strong personal identity. Biological growth and development has concluded among most teens and body image issues are less common. Older adolescents are able to manage increasingly sophisticated social situations, are able to suppress impulsive behaviours, and are less affected by peer pressure. Economic and emotional dependence upon family is markedly decreased and conflict over personal issues, such as food choices, also decreases. Relationships with a single individual become more influential than those with a group of peers as a stronger sense of personal identity emerges.

The expansion of abstract reasoning skills continues to occur during late adolescence, which assists teens in developing an ability to comprehend how current health behaviours affect long-term health status. This is an especially important skill for adolescent females who plan to have children or who become pregnant during late adolescence. Older teens are now capable of learning problem solving skills that can assist them in overcoming barriers to behaviour change.
1.5 Working with belief systems in the context of sexual and reproductive health

South Africa is a culturally diverse nation, and the subject of traditional belief is complex and sensitive. To a greater or lesser extent, traditional Africa co-exists with modern Africa, with many people upholding Christian or even eastern doctrines alongside their traditional beliefs, maintaining a compound rather than a single-belief system.

Many teens in the 21st century are struggling to find a balance between values that have been instilled into them by parents and communities, and the extensive and often contradictory media-provided messages. Facilitators need to acknowledge the influence (and often central role) of traditional African beliefs. They need to recognise, understand and be sensitive to ethnic and lifestyle differences. Across the many different tribes and groups taboos and attitudes towards courtship customs tend to differ. There might also be different perceptions about illness and wellness within a group, as well as healing beliefs and practices. There is often a reluctance to talk about sexuality, death and illness, and ways of expressing feelings might also differ.

It is important that facilitators are open minded and tolerant about cultures that are different from their own or from the dominant culture in the group, particularly in the case of HIV-positive adolescents. They should have no expectations that group members with different beliefs should adapt to theirs. This does not mean, however, that cultural beliefs and traditions, for example virginity testing, cannot be explored and discussed in the context of sexual and reproductive health.

1.6 Adolescents and sexual and reproductive health rights

What the law says: Every child has the right to have access to information on health promotion and the prevention and treatment of ill-health and disease; sexuality and reproduction; have access to information regarding his or her health status; confidentiality regarding his or her health status and the health status of a parent, caregiver or family member, except where maintaining such confidentiality is not in the best interests of the child.

Information provided to children in terms of this subsection must be relevant and must be in a form accessible to children, giving due consideration to the needs of disabled children.

Every young person has the right to be healthy, to have access to services and to have control in decision-making. When the sexual and reproductive health rights of adolescents are recognised, for example, by giving age-appropriate information about sexual and reproductive health issues and by helping young people to deal with the practice and outcomes of sex in a responsible, respectful and safe way, it becomes possible for them to have satisfying relationships that are characterised by respect and concern for the other.

The United Nations Committee on the Rights of the Child says that adolescents have a right to health services
that can meet their particular needs, including the right to information on sexual and reproductive health, family planning, contraception, risks associated with early pregnancy, and the prevention and treatment of sexually transmitted diseases.

Various laws and policies exist to protect the rights of children in South Africa. In addition South Africa is a signatory to the UN Convention on the Rights of the Child and The African Charter on the Rights and Welfare of the Child. Both treaties recognise access to health-related education and information, including sexual and reproductive health, as an important health right.
2.1 Introduction

In the general absence of an environment where young people can comfortably talk (amongst other things) about:

- peer pressure
- self-esteem
- depression
- sexuality
- contraception
- gender norms
- reproductive health services
- sexual partnerships (including: number of partners, age of partners, sexual practices, transactional sex, coercive sex, and circumstances around the initiation and timing of sexual intercourse)
- pregnancy
- HIV (and testing) and STIs, and
- concerns about entering into sexual relationships,

a support group or club can provide a supportive environment where trust can be built, difficult issues can be discussed, confusing messages can be consistently countered, and fears and worries safely addressed.

Studies have shown that groups are an important source of psychological support and information, and can play a significant role in helping to build resilience in HIV-positive adolescents. As a therapeutic tool, group work can facilitate problem solving, reduce anxiety related to compromised communication, and promote a sense of belonging that is needed in the adolescent stages of development (Sweetland et al., 2005).

Generally, as with all young people, HIV-positive adolescents have lots of hope and big dreams. It is important to support a positive attitude and help them realise their full potential for life.

Because each member of a group is inevitably at a different point on the coping continuum and grows at a different rate, watching others cope with and overcome similar problems successfully instils hope and inspiration. New members or those in despair may be particularly encouraged by others’ positive outcomes.
and the group members' support of each other. Facilitators should promote and encourage mutual support at all times.

A common feeling among group members, especially when a group is just starting, is that of being isolated, unique, and apart from others. Many adolescents who enter a group have great difficulty sustaining interpersonal relationships, and feel unlikable and unlovable. Group support can provide a powerful antidote to these feelings. For many, it may be the first time they feel understood and similar to others. Enormous relief often accompanies the recognition that they are not alone; this is a special benefit of a support group.

Rather than using the term “support group” we suggest use of the word “club”. A club has a particular greeting and its own member-driven rules and structure. It is something that belongs to its members and to which its members belong. This enhances a sense of belonging and ownership.

**In the case of an HIV-positive group:**

Being HIV positive does not mean that a young person cannot express his or her sexuality. It simply means that adolescents need to have access to services that can help them to live positively and to look after their sexual and reproductive health. All this makes it important to give them the knowledge and skills that can help them to reduce risks should they choose to become sexually active.

HIV-positive adolescents need to know about their sexuality, come to terms with the identity of being HIV infected, live positively, avoid negative outcomes such as STIs and pregnancy, make informed choices, deal with status disclosure, and find a balance between responsible behaviour and sexual desire (Burungi, 2008).

### 2.2 Selecting club facilitators

It is recommended that the person or persons selected to take on the task of facilitating support group sessions should meet the following criteria:

- He/she should have experience in facilitating small groups for the purpose of learning new skills.
- He/she should have a background in a field related to psychosocial functioning such as psychology, social work or recognised counselling training and experience.
- He/she should be entirely comfortable talking about matters related to sex.
- He/she should have a high degree of self-awareness and high levels of observation.
- He/she should have experience in adapting information to meet a learner’s specific needs and level of education.
- He/she should be sufficiently creative to adapt the approach and make use of drawing, music, sculpting, singing, storytelling or drama, as appropriate.
- He/she should have the ability to maintain a consistent approach – same starting time, order of starting, not allowing ground rules to be broken (without being punitive), etc.
- He/she should have the ability to recognise when the content of a particular session needs to be split into two or more sessions.
- He/she should have the ability to update the relevant facts / statistics when necessary.
- He/she should be familiar with the content and rationale behind antiretroviral adherence.
- He/she should have a strong knowledge base with regards to HIV/AIDS, its progression, treatment and other related issues.
- He/she should have basic knowledge about the legal issues regarding rape, abuse and children’s rights.
- As a preparation for these clubs he/she should have carefully read and understood Part A of this manual.
Knowledge of the law as it pertains to children is important (see Legal issues highlighting aspects of the Children’s Act 38 of 2005, as amended by the Children’s Amendment Act 41 of 2007). Note should be taken of legal requirements regarding physical or sexual abuse or maltreatment that may come to light in the course of group work. This needs sensitive and careful handling on the part of the facilitator, who must ensure that there is a health-care professional available to see the child, either immediately or following the session, depending on which response will be most appropriate. The law requires that offences of this nature be reported to the police, with or without the consent of the child.

In addition facilitators should be familiar with community-based resources and support systems in order to make necessary referrals. A new resource, The Children’s Directory, is available via the Department of Social Development (contact email is mosesr@dsd.gov.za).

In reality some facilitators will not meet all of these requirements.

It is at the discretion of the site to ensure that basic counselling and communication skills be revisited and some knowledge on developmental stages of children and adolescents are instilled in potential facilitators.

In the case of HIV-positive groups, thorough knowledge of HIV/AIDS and treatment facts is essential.
2.3 Co-facilitating: Two or more facilitators working with one club

Both facilitators should always plan the sessions together and have a discussion pre- and post-session. This also aids referrals.

Co-facilitators should work towards creating and maintaining an effective working relationship and ensure that their respective content is similar and they are using similar approaches.

In the interest of maintaining trust and consistency:

- If one of the facilitators knows in advance that s/he will not be at the next session, the group should be told in advance.
- If the co-facilitator is absent, this should be noted and an explanation provided.
- If it is unavoidable that a new facilitator has to be introduced, explore reactions with the group in advance.

NOTE: In the case of two facilitators working in tandem with gender-split groups, they should work together to prepare the sessions in advance and debrief post-session. Facilitators must maintain a consistent approach as this helps to support the sense of safety that is crucially necessary in the group.

2.4 Setting up a club

One of the first steps in setting up a support club is to enrol members. Ideally there should be a gathering of eight to ten adolescents (boys and girls) who will mostly meet in clubs run by a male or female facilitator.

It is important to remember that the cognitive, emotional and social capacities of different adolescents develop at different rates.

In the case of HIV-positive groups, remember that vertical HIV infection may mean developmental delays.

The sensitive nature of topics may cause some young people to feel shy or embarrassed. For this reason it is important for adolescent members to know in advance what they should expect and to understand that membership and participation is entirely voluntary.

Assessment may be necessary to help decide whether or not a young person will feel comfortable in the group and able to interact with others.

It is also recommended that consent be obtained from each teenager.

Suggested steps for enrolling members:

- Talk to the young person alone.
- Spend some time discussing the club and answering any questions (see list below).
- Give him or her time to think about involvement.
- Don’t pressurise him or her.
- Complete the above steps at least two weeks or longer before the club starts.
- Obtain consent to participate.
What potential participants need to know:

- The advantages of belonging to the club/group
- What belonging to the club/group will involve for the young person
- Confidentiality (It is difficult to ensure confidentiality in a group context and it is important that the young person knows that other members will know their status and they will know the status of others. This knowledge should be respected.)
- When and where the club will meet and how long the sessions will be
- Objectives of the club/group
- Role of the club/group, and
- That there will an opportunity to ask questions.

Regarding their expectations of the club/group, ask the young person to think about the following points:

- What sort of information do they believe they will obtain if they join the club/group?
- Will the meeting place be accessible? (Can they get there easily?)
- Do they need help with transportation?
- Can they afford the cost of transport if this is available?
- What do they think the advantages of joining the club/group might be?
- Will they be comfortable talking about fears and feelings to do with sexual and reproductive health?
- Does the time when the club is held suit them?

Young people who are well-informed about what to expect from the club are likely to:

- Feel more comfortable about being part of the group
- Understand what a club is about
- Have more realistic expectations, and
- Make a clear commitment to attending.

Motivation card for members

**MY CLUB**

A friend is a present you give yourself.

A group is about friendships.

It is about giving yourself the gift of a group of good listeners who understand and will not judge you.

You may feel scared or angry or confused.

It’s brave to join with a group of people who are having the same or similar experiences to you.

Joining a support group means that you have made a decision not to be alone.
2.5 Getting going with the club

Meeting and seating:

1. The physical seating positive is important. A circle encourages participants to see each other with ease. It also gives the impression of equality between the facilitator and members of the group. “Own” the training space. Be sure to move around a great deal within the circle—approaching various participants, acting things out, and using different tones of voice. Such confidence from the facilitators makes it easier for participants to feel comfortable as they perform role plays or play games.

2. Create a climate of friendliness. It is a first meeting let each one introduce himself/herself. If new people are present, welcome them into the group. Develop a club greeting.

3. Initiate action by discussing the topic. Make sure that everyone understands what is being discussed.

4. Try to see that people speak to the whole group and not just the facilitator.

5. If a question is asked, give it back to the group, e.g. “What does the group think?” or “Would anyone like to answer this question?”

6. Make sure only one person speaks at a time.

7. Gently curb the talkative people: “Thank you. Some of the others might now like to say what they think.”

8. Encourage the silent ones by asking questions, for example, “Could what X has said be true for you?”

9. Encourage and respect everyone present. Every contribution is important.

10. Usually there is a time limit to group. Try to see that the group adheres to this.

11. Have the *Bridge Over the River Model* poster/flip chart posted on the wall at every session. Refer to it constantly.

Duration

Each session should take 120-150 minutes to complete.

Frequency of meetings

How frequently a group meets depends on its purpose and the needs of its members. Some groups are designed to run for a few months, others last for many years.

*In the case of support groups of HIV-positive adolescents, it is suggested that the group runs for a year, using the sessions provided, and then continues as needed. The previous manual provides the HIV facts in depth and should be used prior to these sessions as a base.*
Meeting place

Support groups can meet anywhere. Some clinics offer special areas for the groups, but they can also meet in homes, churches, libraries or other community buildings. Some support groups are run under trees if there is no covered space available.

What size is best?

The number of people in the group can vary, depending on the purpose of the group and the needs of its members. In the case of groups for HIV-positive adolescents the best size would be 8-10 members, but depending on the demand, larger or smaller groups can work as well.

Gender of facilitator for sexual and reproductive health groups

In the case of segregated groups, it is recommended that the group facilitator is the same gender as the group, but this may not always be possible. Discuss this with the group to establish any strong feelings in this regard.

General functions of the support group facilitator

- Organise and set up the club
- Plan appropriately
- Prepare materials
- Start the club
- Be prepared.

2.6 Creating trust within the club

- Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and group rules.
- Be sure to maintain consistency:
  - By starting and finishing at the same time
  - Using the same facilitators
  - Using the same order of starting
  - Maintaining the group rules
  - Gently ensuring consequences for breaking rules (get the group to devise a mild “punishment” if rules are broken, like having to sing a song if late). Consistency creates trust.
- Establish norms.
- Encourage participation of all.
- Facilitate understanding.
- Keep to time.
- Keep discipline.
- Keep the group focused.
- Be a role-model.
### 2.7 Managing the group process

- Deal with conflicts.
- Notice when energy levels are low (use an energiser).
- Keep the group moving forward at a good pace.
- Draw as much out of the group as possible.
- Encourage self-assessment.
- If appropriate encourage self-disclosure.
- Encourage feedback (within the group, and between group and facilitator).
- Talk about feelings.
- Remember that the club member brings with them the role they play in their outside world (e.g. a child-headed family).
- Be flexible and non-judgemental.
- Deal with unfinished business.
- Allow time for endings and evaluations.
- Address issues about ending so that members can name and process feelings evoked by endings.
- Start warning the club in advance of ending approaching, and remind the club by means of a chart/checklist how many sessions still remain.
- Be aware of the dynamic of the different ages and look at a possible need to protect the younger ones.
- After every activity, the facilitator should ask: “How did you feel when we were doing that activity, and how do you feel now?”

### 2.8 Tips for facilitators

- “Own” the training space. Be sure to move around a great deal within the circle—approaching various participants, acting things out, and using different tones of voice. Such confidence from the facilitators makes it easier for participants to feel comfortable as they perform role-plays or play games.
- Be conscious of the gender division of your facilitators. Having an equal number of men and women facilitating the programme can be much more powerful than merely talking about gender equality. It also helps by introducing a variety of perspectives on the topics and by demonstrating the crucial life skill of interacting well with the opposite sex.
- Be respectful when working with co-facilitators. Avoid correcting or interrupting your partner when he or she is facilitating, and be conscious of your body language and facial expressions while other trainers are facilitating. You are always on stage. Also, when one facilitator is guiding the group, other trainers should sit down – too many trainers at the front of the room can be distracting.
- For sensitive topics, it may be best to separate into single-sex groups to encourage better participation from both girls and boys. It is important, however, for them to come back together and present their ideas to each other. This sharing of information between sexes and attempting to work together comfortably is essential to the programme.
- Keep your participants involved by eliciting answers from them rather than lecturing to the group.
• Recommended companion materials:
  “Tell me about the changes in my body”.
  “Tell me about teenage pregnancy”. Contact M Slabbert or S Meyersfeld.

• Summarize the points on a flip chart or blackboard, if possible.
• If working with flip charts, hang the pages you have finished around the room so participants can refer back to them throughout the day or session.
• Have the Bridge Over the River Model posted on the wall during every session. You will find that you constantly refer to it.
• Pay attention to the scheduling of your sessions. Sessions near the end of the day or after meals should be lively to keep people awake. One session should move logically into another session.
• Start sessions with warm-ups or energisers.
• Monitor how your group is feeling. Have an alternative way to teach the same subject, and change styles as needed.
• Collect resources on the day’s subject and create a resource table at the back of the room for participants to peruse during breaks. Invite participants to make a list of ways in which they can serve as a resource for each other.

In the case of HIV-positive groups, make sure that the members have had their HIV status disclosed to them.

Include HIV Activity 13: Sexual and Reproductive ‘Health for young HIV-positive adolescents’
3 How to use the training manual

The terms “facilitator” and “trainer” are used interchangeably.

This section of suggested activities is aimed at assisting the facilitator to impart the required information and help the participants develop the necessary skills in order for them to make correct choices regarding their sexual and reproductive health. There are 18 activities that are offered for use in the club sessions.

Some of these might require two sessions. Activities have information handouts for participants’ use. Some of the illustrations can be used to make posters. These follow each activity.

Activity 2 introduces the Behaviour Change Model upon which these sessions are based. Facilitators should pin up a poster or drawing of the model at each subsequent session and after the session identify which of the “Planks” (Life-skills) has been “learnt”. There may be more than one skill focused upon within a session. This will reinforce the linked learning process.

Some activities have an HIV-specific component marked with this icon.

Each session is described in the following format:

- Session number
- Time (duration) gives an estimate of how long the session / activity would take to carry out
- Title of the activity, e.g. pregnancy and HIV
- Activity specifies the type of activity, e.g. a role-play, a small group discussion, a game, etc.
- Outcomes specify the outcomes of the session
- Suggested method gives step-by-step suggestions for how to conduct the activity
- Materials provides information as to what the trainer needs for the session, e.g. flipchart, markers, crayons
- Trainer’s notes are tips that may be helpful for the trainer to know, refer to or keep in mind
- Background Information
- Handouts numbered and linked to activities.
The structure, content and activities are presented as a guide to use in a way that best suits the participants, the trainer and the setting. The trainer can select the session topics that are more appropriate and useful to his or her particular group of adolescents.

Some of the activities may be more appropriate for younger or older group members. There are very big developmental differences between the ages in middle adolescence. The facilitator must ensure that the activity is age/development appropriate.

The facilitators are free to use any activities, such as story-telling, drawing, songs or a drama-based approach, if they feel this might be better suited to the age or developmental level of the group they are working with. They may alter the chronology after session 5 if appropriate.

Approximately 120 to 150 minutes per session is envisaged as an ideal length of time to complete the designated activities, but different settings may be influenced by constraints such as transport for the participants, the amount of time available, and the level of comprehension and skill of the participants. Trainers should adapt the vocabulary and tone used accordingly as well. Where possible, the local language should be used.

The illustrations are representational, presented in cartoon format to elicit amusement and minimise discomfort.
Structured activities for club sessions

SESSION 1

Activity 1a: Introductions

1. Ask participants to sign the registration forms.

2. The facilitators should introduce themselves, and thank everyone for attending. They should then provide the group with some information about their background and what their roles will be in the training sessions.

3. Ask the group to make a commitment to coming to every session, as new issues will be discussed in each session, which will build on what has been discussed before.

4. Start by asking each participant to think of:
   - Something they like about themselves
   - What they want from the group sessions.

5. Explain that as the bowl of sweets is passed around, each person should take one and then:
   a. Say their name
   b. Say something about themselves
   c. Say: “I want …… from the group meeting” (complete the statement for themselves)
   d. Pass the sweet bowl on to the next person.

6. Begin the game by demonstrating what to do. Take one sweet and say, for example:
   e. I am Grace
   f. I like dancing
   g. I want to learn more about drugs and alcohol.

7. Pass around the bowl of sweets.

8. Go around the group in a round robin. Allow each participant a few minutes to introduce themselves, say something they like about themselves and what they want/hope for from the group, and take a sweet.
**Trainer’s notes:**

- Do not make any comments about participants’ wants/hopes as you go round the circle, but record them on the flip chart.
- Once everybody has stated his or her wants you should then comment. If any hopes or wants are beyond the scope of the various sessions, this should be explained now.
- Ask the group if they have any fears and address them.
- NB: In the case of an HIV-positive group it is essential that all members of the group have been disclosed to.
- Tell the group that there might be members who are HIV positive. Tell them that there is a future session that deals with confidentiality and respect.
- Encourage participants to talk about how they came to attend this group. This should help you achieve an idea of the various attitudes regarding attending.
- Introduce the group as being more like a club for teens.
- Highlight the diversity in the group and stress the benefits of learning from each other’s experiences.
Session 1

Activity 1b: Ground-rules

Suggested method:

1. The facilitators should ask the group what ground-rules or agreements they think would make the sessions easier to run. (Some initial examples can be given.) Write these up on a flipchart.

2. Make sure the following ground-rules are included:
   - Confidentiality.
   - Attend all sessions if possible.
   - Be punctual, so sessions can start on time.
   - Try and take responsibility for your own learning.
   - Give yourself permission to risk, to “not know”, and to experiment with new ways of being.
   - Get as much as you can out of the sessions. Ask questions, and make requests and suggestions.
   - Use direct communication. Say what you feel.
   - Speak for yourself and not on behalf of others.
   - Do not interrupt others whilst they are speaking.
   - Be respectful of others.
   - Be aware of the differences between group members.
   - Say only as much or as little about yourself as you feel comfortable with.
   - Know that you are free to tell the facilitator if you are feeling uncomfortable with what is happening.
   - Turn off cell-phones.
   - The sessions usually use English as the main language. If you do not understand clearly, ask for explanation.
   - If new members arrive, take time to welcome them and make them feel included.

3. Clarify the ground-rules.

4. Ask participants if they all agree to list of ground-rules.

5. Discuss any with which participants have difficulty.

6. Encourage them to stick to the rules and ask them to remind you and one another if anyone breaks a rule.

7. Ask one group member to take responsibility for the list of rules on flip chart paper, and to remember to bring the list to each session. Refer to the list if rules are broken, and amend from time to time as needed.
Trainer’s notes:

Here are some helpful processes to encourage during the sessions:

- Listen actively to everyone.
- Learning can be painful. Too much pain or anxiety may block learning, but some tension can be motivating.
- Mention to participants that some of these sessions may evoke strong feelings. They should be prepared for this and can talk to the facilitator before or after sessions if they need to do so.
- Motivate participants to be ready to support each other.
Session 1

Activity 1c: The club and the greeting

Suggested method:

1. The facilitator should ask the participants what they think a group for adolescents is. Note the answers on the flipchart.

2. The facilitator should then ask the participants why they think there is a need for such a group. Again, note the answers on the flipchart.

3. Facilitator should explain that there are different kinds of groups. He/she can ask the group if they know of any others.

6. Facilitator can explain that this group has to do with sexual and reproductive health. He/she should ask the group what they understand by this term. Write responses on the flipchart and correct or provide additional information where necessary.

7. Introduce the concept of a teen “club” in preference to a “group”, and encourage participants to comment.

8. Ask the group to talk amongst themselves and come up with some names for their club. Write the suggestions on the flipchart and get agreement.

9. Introduce the idea of a club greeting. Demonstrate the high-five hand greeting gesture (two people simultaneously raise their hand to about head height and slide the flat of their palm against the palm of their partner). Or the group can invent their own club greeting.

10. Allow the group to break into pairs and practise.

11. Then arrange the group in a circle and allow the greeting to take place in one direction, so that first participant performs the greeting on the person on his left, who then greets the person on his left, and the greeting goes around the whole circle. This can be repeated in the opposite direction when it returns to first greeter. (This can also be used as an energiser.)

12. Introduce the idea of group confidentiality. (Group confidentiality means that any personal information disclosed during meetings of the group remains with the group members, and is not discussed outside the group with others.)

Trainer’s notes:

What groups can provide:

- Support and understanding from others.
- A place for participants to learn that they are all unique and special.
- A place to give support to others (being able to give is important for most people).
- Information about sexual and reproductive health that will help them make choices, and assist them to improve their sexual and reproductive health.
- Acceptance, to make up for non-acceptance in the outside world or in the family.
- A place to discuss practical problems and find practical solutions.

Activity

Personalising the sessions: discussion, demonstration and practice.

Outcomes

- Participants become involved in special “club” rites.
- Participants begin to see the advantages of their “club” being a place where they can experience a sense of belonging.
- Participants recognise that their sessions are a safe place to share and learn together.
- Group cohesion is enhanced.
- Participants understand that they can make choices.

Materials

Flipchart, marker pens.
A feeling of being empowered to take action.
Realisation that their own lack of knowledge is not unique.

A group that is about sexual and reproductive health aims to:

- Provide information about all aspects of sexual and reproductive health.
- Provide life-skills to assist in making informed sexual and reproductive choices.
- Provide knowledge about human rights and how to exercise these rights.
- In the case of an HIV-positive group, provide knowledge of the law relating to adolescents and HIV and a special commitment to confidentiality.
Session 1

Activity 1d: Talking about sex

This activity is an introduction to sexual and reproductive health information, and finding out who participants can talk to easily about friendship and sex

Suggested method:

1. Divide the group into single sex sub-groups of four.
2. Ask the sub-groups to think of a situation to do with sex and growing up, when they wanted to talk to someone and to get help.
3. Stress that it is sometimes difficult to speak openly about sex. Encourage participation. Mention that different generations and cultures have different approaches to talking about the subject.
4. Stress that young people are exposed to many different and confusing messages about sex and sexuality. Some messages emphasise the risks and dangers of sexual activities and others, such as TV shows and magazines, promote the idea that being sexually active makes one more attractive, grown up and mature.
5. Explain or demonstrate the concept of role-playing if necessary. Stress that it is strictly drama/ fantasy. Make sure that the entire group understands the fictional aspect of the activity.
6. Ask the group to think about and comment on situations where there might be a problem talking about sex. Take feedback and make notes of the different situations on the flipchart.
7. Discuss the different situations. Ask each group to choose one of the situations or use the case-studies below.

Activity
Stories, role-play and discussion.

Outcomes
• Participants develop a better understanding of why people sometimes have difficulty in talking about sex.
• Participants become familiar with positive ways of communicating.
• Participants gain awareness of the club being a comfortable place to address their concerns.
• Group cohesion is enhanced.
• Participants understand that they can make choices.

Materials
1a. Handout: Role-play scenarios, flipchart, markers

40 minutes

a. Simon is a friend of Betty’s father. Simon tells Betty that she is growing up so nicely. He wants to take her out for a good time in the city. She doesn’t want to be rude to an older man, so Betty agrees politely. Simon says that he talked to her father about the city outing, but her father says nothing to her about it. Betty is worried, because she has heard people saying that Simon loves to have many girlfriends and that he will soon have HIV. The day of the agreed outing is coming up and she wonders what to do.

b. One morning Ben had a nice dream about a beautiful woman who loved him. He felt so good. Then Ben woke up and found that his bed was wet and sticky. What could have happened? He felt very guilty because of the dream and thought that God had punished him with this terrible sickness. Who can he talk to?

c. Fikile was on her way to the shops. A car with four older boys drew up next to her and they asked her to get in. Fikile ran to the petrol station and hid in the bathroom until they went away. She is worried that the same thing will happen next time she walks to the shops.
d. Vusi’s friends are all planning to go to the Easter Show. Vusi knows that they plan to pick up some sex-workers on the way. Vusi is worried, because he has heard that having sex can lead to bad diseases.

8. Ask each group to choose one common situation for people like them. Ask: “Who would you turn to for help with this situation?”

9. Ask two people in each group to act a role-play, showing the person with the problem and the person they chose to help them talking together. The helper should talk and act in a helpful way.

10. Allow each group to act out the role-plays, while others observe. The observers should look out for what things make the helper understanding and good.

11. After each role-play ask:
   - What did you think of the role-play?
   - Does this type of situation happen?
   - How would you feel in this situation?
   - Why do you think the person with the problem was worried?
   - How did the person with the problem behave?
   - How did the helper behave?
   - Can you think of ways that the helper could improve the way that they helped?
   - Who could you go to for support and information?

12. Ask the group what they have learnt from this activity.

13. Make notes on the flipchart. Allow questions and answer any that may arise.

**Trainer’s notes:**

- If appropriate it would be useful (for group cohesion) for the sub-groups to share their findings in the larger group. If not, segregate the sub-groups by gender.
- In most societies parents find it difficult to talk to their children about sex.
- Caregivers and parents can be reluctant to talk openly about sexuality. The club can help counter confusing messages, and provide an environment where teens can ask questions and talk to each other about their sexual and reproductive health.
- Some of the reasons for the reluctance of caregivers/teachers reluctance to talk about sex include:
  - Many caregivers or teachers simply don’t know what to say.
  - Many caregivers or teachers are embarrassed to talk about sex. It makes them feel uncomfortable (ashamed) because their parents probably couldn’t talk to them about sex either.
  - In some cultures certain topics are considered taboo, meaning that they should not be spoken about. Some people believe that talking about something taboo will make it happen, for example if you talk about death, someone will die.
Anova Health Institute 2012

Background information: What is sexual and reproductive health?

Human sexuality is about how people express themselves as sexual beings. Sexuality unfolds as we develop. In early childhood, for instance, children start to explore their bodies and begin to ask questions about what it means to be a boy or a girl. In adolescence sexuality often becomes important for a variety of reasons, including an increase in sex drive because of hormonal changes in puberty and the appearance of secondary sexual characteristics (breast development in girls, muscular development and deepening of the voice in boys), which can contribute to sexual attraction.

Young people will at some or other time ask questions about their sexuality, and about that part of themselves that causes them to have strong emotions and to feel attraction to another person (be it a member of the opposite sex, or someone of their own sex). They start to wonder about their sexual thoughts and desires as they explore who they are and what they want sexually.

Although sexuality has to do with how a person functions biologically, culture has a strong influence. For example, culture can dictate rules about sexual contact, what is considered moral and immoral, and ideas about how relationships between the sexes should be conducted.

In order to make good decisions about their sexuality young people need to be able to explore their sexual attitudes, beliefs and values. They need information, interpersonal skills that can help them build satisfying relationships, and guidance to help them develop responsibility in sexual relationships.

When a young person understands and accepts his or her own sexuality, as well as the differences between people, the foundations are put in place for sexual health. Sexual health is about feeling comfortable with the changes that take place in puberty, being able to decide whether or not to become sexually active, and accepting the necessity of safe sex to avoid unwanted pregnancy and transmission of sexually transmitted infections.

For HIV-positive adolescents safeguarding their own sexual health and that of others means understanding and avoiding risks such as HIV transmission to a partner, infection with an STI or re-infection with a different strain of HIV.

Just like anyone else, HIV-positive adolescents should be able to enjoy safe and satisfying sexual relationships, knowing that should they want to start a family one day they can do so under the guidance and care of healthcare professionals.

• Others have the idea that if they talk to the young person about sex, it will encourage him or her to begin experimenting with sex.
• Some believe that any interest in sex shown by the teenager indicates that they are already sexually active.
A. Simon is a friend of Betty’s father. Simon tells Betty that she is growing up so nicely. He wants to take her out for a good time in the city. She doesn’t want to be rude to an older man, so Betty agrees politely. Simon says that he talked to her father about the city outing, but her father says nothing to her about it. Betty is worried, because she has heard people saying that Simon loves to have young girlfriends and that he will soon have HIV. The day of the agreed outing is coming up and she wonders what to do.

B. One morning Ben had a nice dream about a beautiful woman who loved him. He felt so good. Then Ben woke up and found that his bed was wet and sticky. What could have happened? He felt very guilty because of the dream and thought that God had punished him with this terrible sickness. Who can he talk to?

C. Fikile was on her way to the shops. A car with four older boys drew up next to her and they asked her to get in. Fikile ran to the petrol station and hid in the bathroom until they went away. She is worried that the same thing will happen next time she walks to the shops.

D. Vusi’s friends are all planning to go to the Easter Show. Vusi knows that they plan to pick up some sex-workers on the way. Vusi is worried, because he has heard that having sex can lead to bad diseases.
SESSION 2

Activity 2: Bridging the river of adolescence – the model

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group if they have any questions about the previous session.
8. Introduce the behaviour change Bridge Over the River Model to the participants.
9. Tell the group that this is the most important part of the programme. What they learn from it will help them identify the key skills to help them avoid risks and build a healthy future. “Bridging the River” is a visual way (using pictures) of presenting the concept of behaviour change.
10. Say that the activity itself will best demonstrate how the model works, but stress that they should ask questions at any stage if they need more clarity. The model will be introduced in more detail in the next session.
11. It is important for them to understand and “buy in” to the approach, so they can adapt and design the programme in a way that is useful and appropriate for them.
12. Tell the group that this session will continue with a role-play.

The Bridge Over the River Model teaches teenagers to move from just knowing the facts and having the information to behaviour change by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, they gain a heightened sense of what is right and wrong – their moral compass.

Activity
Role-play, brainstorm, discussion.

Outcomes
By the end of this session participants will be able to:
• Identify the risks facing young people in the community
• Identify life-skills that might help them to avoid risk and build a healthy and positive future
• List important life-skills:
  • Communication skills
  • Making good decisions
  • Solving problems and
  • Acting responsibly.

Materials
2a. The role play, Props for role play: chairs, blanket or towel to wrap around ‘baby’, markers or chalk.
13. Prepare and rehearse the role-play in advance. Ask two of your female participants to act in the role-play.

14. You might initiate a short energiser with the rest of the group and ask for a volunteer to take charge of the group in order to allow time to brief the actors.

15. Give the script to the two players and allow them to briefly read through their parts. Prepare the role-play with them away from the rest of the group (this will take about five minutes).

16. Arrange the chairs around it in a half circle. Place two chairs on the “stage” for Lulu and Refi.

17. Invite the group to watch the role-play, reminding them that it may be very similar to situations they are seeing in their community.

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**Part A: The Role Play**

Two characters: Refi (Refilwe) and Lulu

Props: Two chairs and a “baby” wrapped in a blanket (use a doll if possible)

Introduce the two role-players. Say:

*This is Refi.*

She was in Grade 12 when she dropped out due to unwanted pregnancy. She has been advising her friend, Lulu.

Point to Lulu:

*To stay in school and concentrate on completing her education and to avoid boyfriends, dating and sex.*

*Lulu is in Grade 11, and she has been doing very well in her classes.*

Role-play then starts.

Refi rubs her eyes and yawns. She sits, rocking her baby Khwezi in her arms and talking to him.

**Refi:** Oh baby – I am so tired. You are causing me so much trouble and work.

Why won't sleep at night. Why?

You cry and you cry. You scream all night. 

Won't you ever stop this noise and settle down? All I do is feed you and wash your clothes. All you do is scream and make a mess.

Lulu walks up to Refi.

**Lulu:** Hi, hello Refi – I’m so glad to see you.

(Refi welcomes her warmly.)

**Refi:** Hullo Lulu. I’m so happy to see you too.

(Lulu sits down.)

**Lulu:** How’s the little boy?

(She gets up and looks into the bundle making baby noises, then sits down again.)
Refi sighs: Oh Lulu, he's been so sick. I've had to take him to the clinic every day. He won't take his medicine. He vomits all over me. He won't eat. His nose is blocked. He screams all the time and I don't get more than two hours of sleep. I'm so tired. I just feel like crying a lot of the time.

Lulu: Eish shame Ref. He's a cute little boy though – poor you, getting no sleep. You do look very tired.

Refi: Yes, all I want is to find someone to look after him so I can get some rest. But why aren't you in school, Lulu?

Lulu: (Avoiding answering the question.) Does he cry when you bath him? I've seen babies that stop when you put them into the water.

Refi: No, he doesn't stop – he cries worse. But why are you out of uniform Lulu, it's not holidays?

Lulu: (Avoiding answering the question again.) And how is Justus? Does he think Kabzela is wonderful? Does he help with the nappies?

Refi: Justus? Huh? I haven't seen him or heard a word from him since this baby was born. I heard he has gone to his uncle in KZN and he's going to start at the college in Durban when the term starts.

Lulu: Yo Refi. (Looking around.) Doesn't your mom help you? Where's she?

Refi: My mom? She's gone to Simphiwe - remember my sister – to help her. She's got three now, and she's looking after Tumi's two as well. I can't go to Polokwane. (She looks out and sighs, and then turns to Lulu again.)

I was supposed to start college next month. Hmm. My marks were so high. I should be getting my books this week … but instead … look at me. Stuck here with a screaming baby, tired to death and feeling so depressed. Just avoid those boys Lulu. Stay in school. Your life will be over if you don't … so now tell me, why aren't you in school – it is a school day.

Lulu: (Looks down and fidgets.) My friend. Remember all the advice you have given me? Forget the boys, finish my studies, and stay in school.

Refi: Of course I do. Don't make the same mistake as me, Lulu. Please. Look at me. Avoid the boys. Don't give up your studies. You can't be anything without an education, Lulu. Abstain from sex. You'll get pregnant, or HIV or STI's … or maybe even all of them.

Refi: (Shudders.) I keep telling you to listen to me. If you and Isaac, that boyfriend of yours. (She giggles in a tired sort of way.) can't abstain, then use a condom. I gave you all those boxes from the clinic … Come on Lulu … Come on, my friend, what are you really doing here? Are you in trouble? What is it? What's going on?

Lulu: (Bursts into tears.) Refi, I'm pregnant. I did a test and I'm pregnant. Oh Refi!

Refi: Lulu! You stupid girl. I can't believe this! ( Raises her voice.) I gave you all that advice. I told you not to be like me. I told you all about sex, not to ruin your life. Why Lulu? Why?

Lulu: But he loves me. He promised to marry me.

Refi: I told you Lulu, Justus promised to marry me too. I told you many times of all the promises he made. A big wedding, a house, a car and a credit card for Jet Stores.

But why, Lulu, after all my warnings?
Lulu: I know, my friend. But Isaac said he would leave me if I didn’t have sex with him. He said if I really love him that was the way to show him my love. Everyone has sex when they date … Everyone. I didn’t want to be different from everyone else. I didn’t want him to leave me.

Refi: Oh Lulu, why didn’t you use condoms then?

Lulu: Isaac won’t use condoms. He said it means I am not a good girl, that I must be having sex with other boys if I use them. He said I must have HIV. (She looks down.) I couldn’t say anything. He hit me in the stomach when I refused.

Refi: (Shakes her head.)

Lulu: Well, why not? Why not have a baby now? Isaac is going to university next year. He’s going to be a big business man. I want to be his wife! What is the difference if I finish school? There are no jobs anyway. Look at Gugu … She finished matric and just stays at home now. He’ll marry me. He’ll marry me!

18. Invite group members to explore the situation. Ask questions like:
   a. Have you seen this type of thing happen to anybody you know, in your community?
   b. Do you think Lulu understood the risks of having sex with Isaac?
   c. If she understood what could happen and had all of the information, why do you think she had sex anyway?
   d. What were some of the things Isaac said to pressurise Lulu?
   e. Did Lulu have good reasons for not using the condoms Refi gave her?
   f. Could Lulu have insisted that Isaac use condoms?
   g. What will happen to Lulu now?
   h. What do you think will happen between her and Isaac?

19. You may wish to refer to some of the issues that will be covered in other sessions that form part of the Bridge the River Model.

20. Ask the question: Lulu was exposed to a lot of information to keep her safe from pregnancy, STDs, and HIV/AIDS, yet she got pregnant anyway. Why?

21. Explore the responses.
SESSION 3

Activity 3: Bridging the river of adolescence

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground-rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.
8. Reintroduce the Bridge Over the River Model to the participants.
9. Remind the group that this is the most important part of the programme.
10. Say that the activity itself will best demonstrate how the model works, but stress that they should ask questions at any stage if they need more clarity. It is important for them to understand and buy into the approach, so that they can adapt and design the programme in a way that is useful and appropriate for them.
11. Tell the group that this session will build on the role-play of session 2.
12. Explain the model to the participants. Tell them that it is a visual way of presenting the concept of behaviour change.
13. Draw a sketch on the flipchart, or put up poster 1.

Poster 1

Activity
Role-play, brainstorm, discussion.

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

- Identify the risks facing young people in the community.
- Identify life-skills that might help them to avoid risk and build a healthy and positive future.
- Be aware of important life-skills:
  - Communication skills
  - Making good decisions
  - Solving problems and
  - Acting responsibly.
- Describe the Bridge Over the River Model.

Materials
3a. Handout: Poster, 3b. Handout: Bridge Over the River Model, flip chart, markers, posters or Powerpoint presentation.
14. Point out that young people generally know about the risks of sexual activity.

15. Brainstorm some of the current topics that most young people are aware of: facts about HIV/AIDS, information on drugs or alcohol, pregnancy, STIs, etc. Use as an example the fact that most young people learn all about HIV/AIDS prevention in school.

16. Ask the group: Does that mean that no one gets infected? Emphasise that even though people have the knowledge, this does not mean that they do not engage in risky behaviours.

17. It is helpful to continually refer back to Lulu during this discussion.

18. Ask the group to think about the topics that young people need information about. Write up the list on flip chart paper.

19. Fill in any gaps from the list of group session topics below:

- My body now
- Conception
- Contraception
- Pregnancy
- Abortion
- STIs and HIV
- ARVs and adherence
- Alcohol and drugs
- Sexual coercion / violence
- Gender
- Legal rights

20. Now draw in some human figures at the top of the left-hand hill. Head a list with the word “knowledge”, under which you can fill in the various knowledge topics – or put up poster 2.
21. Point to the hill on the left. Explain: Information provides a solid foundation. Accurate health information will be the first step. In a sense, the young people are standing on the hill, on top of all of the knowledge they need to keep themselves safe from the challenges of life. Now ask them: How do we get from knowledge and information to a healthy lifestyle?

What is the goal? (On the other side of the river of adolescence.)

Poster 3

Draw a signpost on the right bank and insert the arrows across the river, or put up poster 3.

22. Explain: Equipped with nothing but knowledge, young people face the risk of falling into the “river of problems and challenges”. While gesturing towards the river, ask participants to suggest what is awaiting them (in the river) if they do not find a way to help them successfully cross from knowledge to a positive, healthy life.

Poster 4

Fill in drawings of the rocks, or put up poster 4.

23. Explain that the rocks stand for the problems and challenges in the journey through adolescence. Ask the group to think about the problems and challenges (rocks) that face them in the journey across the river of adolescence. List their suggestions on flip chart and fill in any missing items from the list below:
The rocks (challenges) in the river of adolescence include:

- Contraception
- Alcohol and drugs
- Peer pressure
- HIV and sexually transmitted infections
- Gender inequality
- Relationships
- Abuse
  - Transactional sex
  - Coercive sex and violence
  - Trans-generational sex
- Pregnancy
- Unfriendly clinics
- Sexual orientation
- Stigma.

24. Write each one of the problems or challenges identified onto a rock. If necessary, draw in more rocks so that all of the problems and challenges are represented by a rock.

Reiterate that young people face the risk of falling into a river and being hurt by rocks such as HIV infection, alcohol and so forth.

25. Ask the group:

- So what is missing?
- What does it take to help people to use their knowledge to lead a better life?

Now draw in ropes across the river, or put up poster 5.

26. Point out that we want to help young people move to the positive, healthy life side of the bridge. We want to help them use the knowledge that they have to live a stronger, healthier life, to help them avoid the consequences of risky or negative behaviour.

Use gestures to show this movement on the poster.
31. Lead a group brainstorming session about what it takes to get across the river, i.e. how to move from knowing the facts and having the information to behaviour change.

32. Continue to refer to Lulu and the role-play during this brainstorming session, using questions like:
   - What was Lulu missing?
   - Didn't she know the risks?
   - Did she have the information?
   - What did she need to help her to use the information she had to make the right decision?

27. Introduce the idea of planks on the ropes across the river. Draw in one or two to start.

   Explain that the planks stand for the **skills** needed to get across the river.

   You may need to guide the group to explore all angles of the situation so that you can get as many different suggestions as possible.

28. Write the ideas on flipchart. You might have to refer to the list of life-skills activities below to start the ball rolling.

   **Life-skills:**
   - Communication skills
   - Decision making
   - Understanding consequences
   - Good role-models
   - Resistance to peer pressure
   - Self-esteem
   - Solving problems
   - Assertiveness / building strength / self-confidence
   - Self-respect / self-esteem
   - Sense of responsibility
   - Empowerment for girls
   - New values for boys
   - Opportunities for the future.

Keep brainstorming. There should be many, many ideas.
29. Draw the planks across the river and fill in all of the skills that have been identified, or put up poster 6.

30. Explain that life-skills activities are interactive and experiential activities. These activities help the participants to gain greater understanding about themselves (enhance personal growth). Reiterate that some of the sessions have information and life-skills components. They concentrate on the development of the skills needed for life such as communication, decision-making, thinking, managing emotions, assertiveness, building self-esteem, resisting peer pressure and relationship skills.

31. Help the group to understand these links by referring to the role-play.

32. When the planks of the bridge are finished and all ideas are exhausted, process the concept with the group again:

   - These planks in the bridge are the life-skills— the tools a person needs to help translate the knowledge that they have into healthier behaviour.
   - These sessions help to develop these life-skills in people — to help them acquire the skills and tools necessary to lead healthier, happier lives.

So, the aim of the life-skills activities is not only to provide or update or expand on information, but also to help develop the skills (point to the bridge with your hand) to better use this information to lead a positive, healthy life. This means moving from knowing the facts and having the information to changing behaviour.

33. To ensure that the group understand the model, ask the participants to pair off and to explain the model to each other while referring to the bridge.

34. Move about the room and observe the level of understanding in the group and clarify points as necessary.

35. Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and answer any that may arise.
**Trainer’s notes:**

The *Bridge Over the River Model* used in this programme is a visual way of representing the concept of behaviour change. All of the sessions in this programme will link to the model – a model of behaviour change. A thorough understanding of this model is essential. It is the crux of the programme.

Part of the programme (the information component represented by the hill on the left) provides information based on the existing level of knowledge of the participants. The participants are encouraged to explore whether information and knowledge alone helps to avoid risky behaviour practices: “Does knowledge alone keep young people safe from making decisions with potentially life-changing consequences?”

You need to explain that in the early phases of a behaviour change intervention, information is rarely enough to motivate people to change behaviour.

Participants are asked to identify the goal on the other side of the river, which is revealed as a healthy life with a positive attitude.

Looking down into the river at the rocks, participants identify the problems that they can face as they move through adolescence. These are directly linked with their own life circumstances. The rocks stand for problems and challenges.

Participants are encouraged to ask themselves how they can use their knowledge to get through the river of adolescence to a stronger healthier life, and are introduced to the concept of life-skills. They are asked to identify what life-skills they need to deal with these challenges and these generally fall into the following categories:

- Communication skills
- Decision making skills
- Relationship skills.

The planks across the river represent these skills.

As these key life-skills are learned they are consciously integrated with the knowledge / information that will help participants avoid risks and build a healthy positive future.

Explore the appropriate plank/s at the end of each session to reinforce the message.

For example:

Activity 7: Pregnancy or termination of pregnancy:

Planks (skills) identified are communication / making decisions / understanding consequences / empowerment for girls / new values for boys.
**Background information:**

It is generally believed that behaviour change is the result of a combination of personal and social factors. Personal factors include personality, identity (including gender identity and perceived roles); self-concept, self-worth, self-esteem, self-efficacy, self-awareness; beliefs, hopes, attitudes and expectations; self-motivation; understanding; capacity for self-love and relationships; communication; awareness of feelings and emotions; life experiences; access to information and education; level of autonomy and locus of control; survival needs; drives; and the need for connection and acceptance from others.

Social factors include: family; culture; traditions; beliefs; rituals; spiritual aspects / faith, social norms; gender constructions; relationships; peer pressure; communication with others; roles; learned behaviour; life experiences; media; a sense of community connectedness; feeling part of something larger; laws and rights; experiences of the education sector; discrimination and stigma; violence and crime; change and transition; class; poverty; income; social services and networks.

Young people who are grounded in positive social networks are more likely to develop into healthier community members, able to resist unwanted pregnancy, relationships which are imbalanced in terms of power, HIV infection and drug and alcohol abuse. They are also able to live positively with HIV, offering inspiration to other young people.

Some of the challenges young people in South Africa today may experience:

- Normal life transitions, through the challenge of adolescence
- Political and economic transition in the country
- Beliefs, shaping their behaviour, which need to be explored
- Rising consumerism and materialism as a result of globalisation
- A lack recreational opportunities and facilities
- A struggle to access health services – there is a shortage of informed health workers and counsellors to deal with youth issues. Often, health care workers are unfriendly and overburdened, and it is difficult for young people to access health services
- Conflict and violence (social, emotional and physical) in their families and communities
- Sexual and identity challenges that are unprecedented, notably around rape, sexual assault and peer pressure to perform sexually
- Gender stereotypes
- Discriminating against people who are different – this may extend to xenophobia, homophobia, and HIV stigma and discrimination
- Poverty, unemployment, questionable educational standards
- An increasing gap between rich and poor.
Handout: Posters

Trainer’s guide to pencil drawing of the *Bridge Over the River Model*
Handout: Bridge Over the River Model

1. The river of adolescence

2. Knowledge

3. The goal - a healthy positive lifestyle

4. What are some of the challenges (rocks) of adolescence?

5. What will help to get across the challenges and problems without falling into the river?

6. Lifeskills
SESSION 4

Activity 4: From child to adult (Part 1)

Note: In the case of adolescents who are completely familiar with body changes, this activity can be omitted.

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge Over the River Model teaches adolescents to move from just knowing the facts and having the information to behaviour change, through learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, adolescents gain a heightened sense of what is right and wrong – their moral compass.

8. Two facilitators are required, preferably a female facilitator for the girls’ group and a male facilitator for the boys’ group.
9. In the mixed group, explain that this activity is to help participants learn more about their bodies as they grow towards adulthood. Explain that it is easier to divide the group into boys and girls because it is sometimes difficult to speak openly about these changes in a mixed group.
10. Encourage participation and stress that this is a fun exercise.

120-150 minutes

Activity
Drawing exercise, followed by a discussion.

Outcomes
Participants:
• Learn about wet dreams, erections, ejaculation and masturbation
• Learn about menstruation.

Materials
11. Explain that human beings are either male or female, depending on what type of sex organs they have.
   - Sex organs are also called reproductive organs because they are the parts of the body that make humans reproduce (able to have babies).
   - Females have reproductive or sex organs on the inside and the outside of their bodies. The proper name for the outside part is the vulva. Lots of people mistakenly call it the vagina.
   - Because it is sometimes embarrassing to talk about sex, people may use different names for the vagina, penis, scrotum and breasts.
   - Male sex organs comprise the penis and the scrotum (which contains the testes). Sperm is produced in the testes.

13. As an ice-breaker, ask the group to give the different names they use for the sex organs. Write up on flipchart paper, and discuss where these names come from and why they think they have been used. This can elicit a lot of laughter and helps the group relax and feel less embarrassed.

14. Divide the group into girls and boys, and separate them between two rooms, with a same-sex facilitator per group.

15. Give each participant the handout for the relevant adolescent body. Ask them to mark on the body all the changes that happen to people of their sex (male or female) during puberty. Also ask them to draw the internal (on the inside) sexual and reproductive organs and external (on the outside) sex organs.

16. Once they have completed their drawings, ask them: What happens to our bodies as we change from children to adults?

17. Provide a brief overview of puberty changes in girls and boys. Stress that these changes happen at different times for different people, and that some participants might still be undergoing some of these changes.

18. Break into groups and allow time for discussion. In each group discuss the changes and allow time for questions.

19. Use the following handouts:
   - 4a. Bodies
   - 4b. Puberty in girls
   - 4c. Puberty in boys
   - 4d. Masturbation

20. Allow for a break before proceeding with part B of the session.
Handout: Adolescent bodies
Hair may grow on the arms and legs, or darken in colour.

The feet may grow very quickly.

Oil glands in the scalp become more active – girls’ hair may become oilier and they may need to wash it more often.

The skin produces more oil, so a girl may develop pimples.

Sweat glands in the armpits become more active – adolescents may develop an adult body odour.

Hair grows under the arms.

Hair may grow on the arms and legs, or darken in colour.

The feet may grow very quickly.
- Breasts get bigger and may be tender or sore. (Breast budding may occur.)

- Nipples and the surrounding skin get darker in colour.

- Girls’ hips get broader.

- Girls grow taller and at a faster rate.

- Pubic hair begins to grow on the vulva (the area between the legs).

- Sexual feelings develop – a girl may experience excitement when touching her genitals.
There may be an increase in vaginal discharge.

**Notes on vaginal discharge**

- A clear (or sometimes milky white) discharge may come from the vagina.
- It might leave a stain on underwear as it dries.
- This is completely normal.
- Discharge helps to keep the vagina clean and healthy.
- It is made up of fluids and cells shed from the walls of the vagina.
- The amount and colour of discharge is different at different times of the month.
- The amount increases when a girl is sexually aroused.
- Sometimes infection causes changes in amount, colour and smell, as well as itching, burning or pain. This requires medical attention.
- Infections can be caused by poor hygiene, unprotected sex, and changes in diet or as a side-effect of some medications.

Girls may have their first menstrual period (although if a girl is HIV positive, HIV sometimes delays this).

**Notes on menstruation**

When a girl menstruates, a harmless bloody fluid flows out of the vaginal opening. This flow lasts from two to seven days. Grown women usually have a menstrual period about once a month, but girls who have just started menstruating may have their period more or less often than this.

HIV-positive girls can infect others more easily during unprotected penetrative sex if they are having their period.
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**Handout: Puberty in boys**

- Oil glands in the scalp become more active. The hair may become oilier and may need to be washed more often.

- The skin produces more oils, and so a boy may develop pimples.

- Hair grows under the arms.
- Sweat glands in the armpits become more active – a boy may develop an adult body odour.
- The voice becomes deeper.
Muscles become thicker and more developed, and body strength increases.

Boys grow taller and at a faster rate. Their feet grow first and their weight and height might increase rapidly. Arms and legs grow before the trunk of the body grows.

The feet might grow very quickly and become smelly.

Shoulders become wider and broader.

Nipples enlarge, darken in colour and may be tender or sore.

Breasts may swell and may remain enlarged for a year or two.

Sex organs grow and develop.

Pubic hair begins to grow on and around sex organs. Hair may grow on the chest, shoulders, back and elsewhere.

Hair grows on the upper lip and cheeks.

Hair on the arms and legs may increase or darken in colour.

Sexual feelings develop – a boy may experience excitement when touching his genitals.

Erections happen more often (when the penis gets stiff and hard for a while).

Boys may experience wet dreams.

During puberty, for the first time, a boy ejaculates. He releases white creamy fluid called semen from the opening on the tip of his penis.
Anova Health Institute 2012

HIV-positive boys can infect their sexual partner during unprotected penetrative sex.

Part B: Boys’ group. Wet dreams, erections, ejaculation and masturbation

1. Tell the boys group that this activity will cover the subjects of wet dreams, erections, ejaculation and masturbation. Topics regarding girls, for example menstruation, will be covered later.

2. Ask:
   - What is an erection?
   - What is ejaculation?
   - What is a wet dream?
   - What do they think happens in a boy’s body when he has a wet dream?
   - What is masturbation?

Make notes of the answers on a flipchart or encourage members of the group to write it in their language.

3. Correct the information and provide handouts. Allow time for discussion in the group.

4. Ask the group members how they felt doing this activity. Ask the group members if they have any questions.

5. Answer the questions and explain each point in detail using the illustrations and the notes below.

6. Ask group members to discuss and write down the good and bad things about erections. Prepare a flipchart with two columns: Good points and Bad points.

7. Ask members of the group to call out the good points. Write them up on the flipchart in the good points column. Ask members of the group to call out the bad points. Write them up on the flipchart in the bad points column.

8. Look at the bad points on the flipchart one by one, and talk about ways to make the bad points better.

9. Repeat Points 6-8 regarding ejaculation, wet dreams and masturbation.

10. Tell the group that you are going to give a short talk about girls and how their bodies work.

11. Ask the group if they know what menstruation is. (Notes for the girl’s session provide basic information for boys about menstruation.) Use the notes and handouts: Menstruation, 28-day cycle and the female reproductive organs, to provide information.

12. Allow time for questions.

13. Handouts include 4e. Inside the female body, 4e. Menstruation, 4f. Fertilising the egg, 4g. Menstrual protection, 4h. Male sex organs, 4i: Sperm.
Trainer’s notes:
- Make sure you are well prepared for this activity.
- Provide sufficient but simplified information about menstruation and the 28-day cycle.
- Different boys have different needs, identities, choices and life circumstances. Therefore, not all boys have similar concerns about erections, ejaculation, wet dreams and masturbation.

Erections
An erection occurs when the penis fills with blood and becomes hard. Most erections are caused by sight, thought or touch. Small babies, boys and adult men all have erections. They often happen during sleep. Sometimes, especially during puberty, they happen for no particular reason.

Although the head (or glans) of the penis is very sensitive to touch, touch alone does not bring about an erection. The brain is essential for arousal. Only after the brain receives signals will it give a message (via the central nervous system) to the blood vessels in the penis to relax.

The following stimulation may lead a boy or man to develop an erection:
- Sight: Seeing something that is sexually exciting (sexy TV images, seeing a person with revealing clothing).
- Thought: Thinking (fantasising) about things that are sexually exciting.
- Touch: Stroking, caressing, petting, kissing, etc.

When a boy becomes sexually aroused, the brain sends signals that relax the smooth muscles around the arteries that supply blood to the penis. The penis is made up of spongy tissue, and during an erection, the veins that carry the blood to the penis dilate (open wider) and allow more blood flow. The spongy tissue fills up with blood and swells up, causing the penis to become hard and longer and stick out from the body at an angle.

An erection can develop slowly or within a few seconds. Once erect, the penis can stay that way for some time, or the erection may disappear as quickly as it arrived. Sooner or later, the veins become narrow again, the extra blood is drawn back into the bloodstream and the penis becomes soft and floppy again.

Boys (and men) have only very limited control over their erections.

Erection continues until the signals from the brain stop. Erections are not consistent; the penis can soften and harden even during intercourse. During puberty having an erection in public places embarrass many young men. Most gradually become able to suppress erections when the stimulation is mild. It is also not always possible to make an erection happen, although sexual thoughts can cause an erection.

Impotence is when the penis does not stay hard long enough to have sexual intercourse. This is one of the most common sexual ailments in men. The cause of this can be psychological or physical. Anxiety, depression or stress can cause erectile dysfunction. Drugs, alcohol, some medical conditions and certain medication can also cause impotence. Usually it is a temporary problem that will go away.

Ejaculation
Ejaculation is when a boy has an orgasm and releases fluid from the opening on the tip of his penis. The penis usually becomes soft after this happens. Urine and semen leave the body through the same tube. However, during ejaculation a special valve closes, making it impossible for urine to come out.
Orgasm

It is difficult to explain exactly how an orgasm feels, but it is usually a very pleasurable experience caused by rhythmic contracting of muscles. The feeling starts in the sex organs and radiates outwards, sometimes involving the whole body.

Wet dreams

During puberty some boys have their first wet dream. A wet dream is when a boy ejaculates while he is asleep. He might wake up and find his pyjamas, sheets or blankets are wet. A wet dream has been described as “masturbation that is done by nature to keep a person sexually healthy”. Misconceptions around wet dreams are common, for example, some people believe that they cause weakness. Information is important since many boys who wake up with a feeling of wetness for the first time can experience confusion and anxiety.

Masturbation

Masturbation means touching or stroking of the genitals (sex organs) in a way that feels pleasurable. This may lead to a hard-to-describe feeling called orgasm. Both boys and girls masturbate and experience orgasm. Masturbation is a very safe alternative to having sexual intercourse.

Most people masturbate privately at some time in their life. Some people still believe that masturbation will cause all sorts of strange things to result. This is not true. Today most people don’t think that masturbation is wrong or sinful.

The amount of time spent masturbating is different for everybody.

Thinking things that are exciting whilst masturbating is completely normal. These are called fantasies.

Masturbation and other ways of obtaining sexual satisfaction

It is important for young adolescents (and those who are HIV positive) to know that there are many ways to experience sexual pleasure other than sexual intercourse, e.g. cuddling, caressing, kissing or masturbation. Masturbation refers to stimulation of the genitals (penis or clitoris) as a means of reaching orgasm. A couple can masturbate each other or an individual can masturbate in private, alone. Boy and men tend to masturbate more often than girls and women, but masturbation is common in both sexes.

There are many myths related to masturbation, ranging from the belief that it leads to mental problems to those that blame pimples on masturbation. None are true: masturbation is normal and healthy.

Sexual satisfaction can be achieved in many ways, such as sucking, licking or kissing the sexual areas of another person. However HIV can be transmitted if sperm or menstrual blood enters a person’s mouth, particularly if that person has bleeding gums or mouth sores, or if fluids such as menstrual blood or semen are swallowed.
Part B: Girls’ group. Menstruation and masturbation

1. Tell the girls’ group that this activity will cover the subjects of menstruation and masturbation. (Topics that are relevant to boys, for example, erections, ejaculation and wet dreams will be covered later.)

2. Ask:
   - What do you know about menstruation?
   - What is a monthly cycle?
   - What do you think happens in a girl’s body during her monthly cycle?

   You could ask the girls to dramatise or draw pictures. Make notes of answers on the flipchart.

3. Correct the information and provide handouts on menstruation, the 28-day cycle, menstrual protection and internal reproductive organs. Explain that these are very simple illustrations used for the purpose of this exercise.

4. Explain the process of menstruation in detail. Ask the group if they have any other questions and provide the answers (see notes).

5. Ask group members to discuss and write down: What are the good and bad things about menstruation? Prepare a flipchart with two columns: good points and bad points.

6. Ask members of the group to call out the good points. Write them up on the flipchart in the good points column. Ask members of the group to call out the bad points. Write them up on the flipchart in the bad points column. Ask if anyone has other concerns.

7. Look at the bad points on the flipchart one by one, and talk about ways to make the bad points better.

8. Ask:
   - How can we help each other to manage menstruation more easily?
   - How can girls help other girls?
   - How can boys help girls?

9. Ask the group if know what masturbation is. Fill in missing information using the illustrations and notes below as reference and allow time for questions and discussion.

10. Ask the group what wet dreams, erections and ejaculation are. The note in the boys’ session provides basic information for girls about wet dreams, erections and ejaculation. Fill in missing information from the notes. Allow time for questions.

11. Handouts include 4e. Inside the female body, 4e. Menstruation, 4f. Fertilising the egg, 4g. Menstrual protection, 4h. Male sex organs, 4i: Sperm.

Trainer’s notes:

- Make sure you are well prepared for this activity.
- Different girls have different needs, identities, choices and life circumstances. Therefore, not all girls have similar concerns about menstruation.
Menstruation

Girls are born with thousands of tiny eggs in their two ovaries. Each month one egg becomes ready and leaves the ovary. This is called ovulation. The egg goes down the Fallopian tube to the womb. The womb makes the inside wall thick like a nest, ready to house a baby.

If the girl has sex and the egg meets a sperm from a male, it can be fertilised. The joined egg and sperm stick into the wall of the womb where they grow into a baby. If there is no fertilisation, the inside lining of the womb breaks down. It leaves the body through the vagina as menstrual blood. This happens about 14 days after ovulation. This is the monthly period or menstruation.

When a girl menstruates, a harmless bloody fluid flows out of the vagina. This called the menstrual flow. This lasts from two to seven days. Grown women usually have a menstrual period about once a month, but girls who have just started menstruating may have their period more or less often than this.

In the case of HIV-positive people menstrual blood contains HIV. HIV-positive girls can infect others more easily with HIV whilst having unprotected sex during menstruation.

Menstruation is also called having periods because it happens every 21-35 days. Periods usually last 4-6 days.

Menstruation is a normal, healthy part of a girl’s life. It is not an illness, dirty or shameful. It means that she can now have babies, but only if she has sex. Going near a boy during menstruation cannot cause pregnancy.

Periods often do not come on time at first, but they usually settle down to a regular pattern. Menstruation continues every month from the teenage years (puberty) to menopause, when periods stop. Menopause usually happens between 47 and 55 years.

Menstruation stops when a girl is pregnant. It starts again some time after the baby is born. If a young woman has not started her periods by 19 years, she should see a doctor.

There is no need to keep menstruation a secret, although it is a private matter. Girls can do everything during menstruation that they normally do.

A girl can get pregnant before she starts her periods, because she has her first ovulation before her first period.

It is normal for periods to be heavy at first and then get lighter. If periods go on for longer than 8 days or are very heavy with thick blood, a girl should see a doctor.

Worry, sickness, weight loss or pregnancy can cause periods to not come. A young woman who is sexually active and does not have her period should have a pregnancy test.

Some girls have pain during menstruation as the muscles of the womb push out the blood. This is normal, not a curse. Exercises, resting and painkillers can help to stop the pain.

Girls should take sanitary protection to school in case they start their periods and stain their dresses. They can also take a plastic bag to keep used cloths/pads in.

Menstrual protection

During menstruation girls need to use something to catch the blood. This also helps prevents their clothes being stained. Some girls are afraid that other people can see the pads or cotton rags they use for absorbing their menstrual flow. This fear is usually unfounded.
If cotton rags are used, fold them well and place them inside the panties between the legs. Ask a friend or look in the mirror to check whether others can see the pad.

Change the cotton rags, pads or tampons frequently to avoid staining and bad smells. Menstrual blood can develop a smell when it comes into contact with air. It is also important to wash often.

Menstrual blood may be bright red, pink or even brownish in colour. The colour may be different from period to period, or even vary within the same period. There might also be thick lumps of blood (clots) in the menstrual flow.

Some girls bleed more heavily on the first days of their period, others start with a little blood and then bleed more heavily later, while others will bleed for a few days, stop or slow down and then start again. All of these patterns are considered normal.

If the blood soaks through a pad more than every hour for a whole day, then the flow is too heavy and a doctor should be consulted.

Girls can use lots of different methods to catch the blood:

Cloths: Any clean materials can be used that easily soak up liquid, like old cut-up T-shirts. Fold the material well into a pad-like shape and placed inside the panties between the legs. These should be changed often and washed with soap and then dried. If possible they should be ironed to kill germs.

Toilet roll, cotton wool, paper or tissues: Made into pads and placed inside the panties between the legs. Make sure that bits are not left in the vagina as they can cause infection. Cotton wool can be wrapped in thin material to keep it in place or used on its own.

Sanitary towels/pads: These are special towels made out of cotton wool and can be bought at chemists or supermarkets. They are also placed inside the panties between the legs.

Tampons: These are tubes of cotton wool that are inserted into the vagina to catch the blood. They should be used one at a time, and changed often to prevent infection. Make sure the last tampon is removed at the end of the period. Tampons do not effect urination (peeing) as blood and urine come out of different places.

Menstrual cups are available in some places. They can be worn for up to 12 hours at a time and can be worn overnight. They are easy to clean and easy to sterilise, and can last for years if looked after correctly.

*Masturbation*

Masturbation means touching or stroking of the genitals (sex organs) in a way that feels pleasurable. This may lead to a hard-to-describe feeling called orgasm. Both boys and girls masturbate and experience orgasm. Masturbation is a safe alternative to having sexual intercourse.

Most people masturbate privately at some time in their life. The amount of time spent masturbating is different for everybody.

Some still believe that masturbation will cause all sorts of strange things to result. This is not true. Today most people don't think that masturbation is wrong or sinful.

Thinking things that are exciting whilst masturbating is completely normal. These are called fantasies.
Orgasm

It's difficult to explain exactly how an orgasm feels, but it is usually a very pleasurable experience caused by rhythmic spasms of muscles contracting. The feeling starts in the sex organs and radiates outwards, sometimes involving the whole body.

Background information: menstruation

Many younger girls do not have information about menstruation and sometimes little is done to address myths and misconceptions. Different cultures have different beliefs about menstruation, some positive and some negative. For instance many societies seclude girls who are menstruating, believing them to be unclean. In other cultures menstruation is understood to be cleansing and purifying. Some believe that when a woman menstruates she has great powers.

For HIV-positive adolescents it is important to know that a girl can infect others more easily with HIV whilst having unprotected penetrative sex if they are having their period. This is because the HIV virus is found in menstrual blood.

Background information: masturbation and other ways of obtaining sexual satisfaction

It is important for adolescents to know that there are many ways to experience sexual pleasure other than sexual intercourse, for example cuddling, caressing, kissing or masturbation. Masturbation refers to stimulation of the genitals (penis or clitoris) as a means of reaching orgasm. A couple can masturbate each other or an individual can masturbate in private, alone. Boy and men tend to masturbate more often than girls and women, but masturbation is common in both sexes. However there are many myths related to masturbation ranging from the belief that it leads to mental problems to those that attribute pimples to masturbation. None are true, masturbation is normal and healthy.

Sexual satisfaction can be achieved in other ways, such as sucking, licking or kissing the sexual areas of another.

Masturbation is a good way to experience sexual pleasure without the risk of HIV transmission (International Planned Parenthood Federation 2010).

HIV can be transmitted if sperm or menstrual blood enters a person’s mouth, particularly if that person has bleeding gums or mouth sores, or if fluids such as menstrual blood or semen are swallowed.
The internal reproductive organs

- ovaries
- uterus (womb)
- cervix
- vagina
- vulva

Handout: Inside the female body
Menstruation

Girls have thousands of eggs inside their ovaries. At puberty these eggs start to mature and begin to pop out one at a time, every month. (At first this is not regular) If the egg is fertilised by a sperm from a male, pregnancy occurs. If not, a menstrual period occurs.

- Uterus lining (tissue) fills with blood every month in preparation for pregnancy.
- Egg travels towards uterus every month.
- Uterus lining shed every month if egg unfertilised.
- Fertilised egg = pregnancy.

An egg is smaller than a pinprick. Make a dot with a pencil to illustrate.
The menstrual cycle
A 28-day cycle.
Round and round
(Not regular at first)

Days 1-5
Period
Uterus lining being shed.
New egg starting to ripen.

Days 6-13
Period finishing.
New egg getting riper.
Uterus lining growing thicker in preparation for new baby.

Days 14-19
Ovulation time. Very fertile.
Good chance of pregnancy if unprotected sex occurs.
Egg is travelling towards the uterus. Lining of uterus thickening more.

Days 20-28
Egg reaches the uterus and starts dissolving if pregnancy does not occur. Uterus lining starts breaking down. When period begins, day 1 of the cycle begins again.
Girls have thousands of eggs inside their ovaries.

Every month an egg travels towards the uterus. If the sperm of the male reaches the egg during the time egg is in the uterus then the egg is fertilised and the girl becomes pregnant. (If not, a menstrual period occurs.)
All about menstrual protection

During menstruation girls need to use something to catch the blood. This also helps prevent their clothes being stained.

Change the clothes, pads or tampons frequently to avoid staining and wash yourself often. Menstrual blood can become smelly when it comes into contact with air.

Some girls are afraid that other people can see the pads or cotton rags. This fear is not usually necessary. Ask a friend or look in the mirror to check whether others can see the pad. It feels much bigger than it looks.

Pads are worn inside the panties

Tampons are worn inside the vagina

Wrap carefully in paper and dispose of sanitary towels/pads/tampons carefully. Do not flush down the toilet.

Menstrual protection

Girls can use lots of methods to catch the blood

Cloths:
Any clean materials that easily soak up liquid, like old cut up T-shirts. Fold the material well into a pad-like shape and place inside the panties between the legs. These should be changed often and washed with soap and then dried. It possible they should be ironed to kill germs.

Toilet roll, cotton wool or tissues.
Made into pads and placed inside the panties between the legs. Make sure that bits are not left in the vagina as it can cause infection.

Sanitary towels/pads.
These are special towels made out of cotton wool and can be bought at some shops. They are also placed inside the panties between the legs. Some have a sticky side to hold the pad in place. Some have “wings” that help prevent leaks.

Tampons are tubes of cotton wool which are inserted into the vagina to catch the blood. They should be used one at a time, and changed often to prevent infection. Make sure the last tampon is removed at the end of the period. They do not need to be removed when urinating.
Human beings are either male or female, depending on what type of sex organs they have.

Male sex organs are the parts of the body that allow males to reproduce (to make babies). The proper names for the male sex organs are penis and testicles.

Because it’s sometimes difficult (embarrassing) to talk about things relating to sex, people may use different names for the sex organs. During puberty, the body begins producing sperm.

Inside the male sex organs

Outside the body
All about male sex organs

Erections

What is an erection?
During an erection the spongy tissue inside the penis fills with blood, causing the penis to grow larger and stiff.

Sooner or later the erection goes and the penis becomes soft again.

Men and boys and even babies have erections. Erections happen whilst you are asleep, when the penis touched, or when you are excited or nervous. During puberty erections can happen for no reason at all. Penises are all different. There are many shapes and sizes: long, short, fat or thin.

Ejaculation

What is ejaculation?
During ejaculation a male has a very intense and pleasurable feeling that is known as orgasm.

A small amount (about a teaspoon) of sperm, mixed with seminal fluid (semen) is released from the opening in the tip of the penis. (This semen contains about 300 million sperm.)

The testicles continue to make more sperm all the time.

Some boys have their first ejaculation during a wet dream; others as a result of masturbation.

Masturbation

Masturbation means touching or stroking of the sex organs. Most people masturbate privately at some time in their life. Today most people do not think of masturbation as wrong or sinful.

Wet dreams

During puberty some boys have their first wet dreams.

What is a wet dream?
Waking up to find the bed or pyjamas a bit wet. This comes from ejaculating. Lots of boys have their first ejaculation while they are asleep. Wet dreams are part of growing up. They do not mean that a boy should start having sex.
What is sperm?

During puberty the testicles start producing sperm for the first time. Sperm are the male’s seeds or reproductive cells. When a sperm joins with a female’s egg, a baby can grow. Sperm look a bit like tadpoles and are very tiny. Each sperm has all the boy’s information inside it. Each female egg has all the girl’s information inside it. A baby has both parents’ sets of information. It only takes one sperm to fertilise an egg.
SESSION 5

Activity 5: From child to adult Part 2

Note. In the case of adolescents who are unfamiliar with body changes, it is recommended that Activity 4 should precede this session.

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

8. In the mixed group, explain that this activity is to learn more about the other changes (other than the body changes) that happen during adolescence as they grow towards adulthood.
9. Remind them that in the previous activity they discussed all the physical (body) changes that occur during puberty and adolescence. Ask the group what other changes happen during adolescence. Write up the responses on the flip chart.
10. Divide the group into four mixed sub-groups. Give each of the sub-groups a set of changes:
   a. Cognitive (thinking)
   b. Emotional
   c. Social
   d. Behavioural

Activity
Group work followed by presentation and discussion, discussion in pairs.

Outcomes
Participants:
- Become more familiar with the physical and emotional realities of the opposite sex
- Become more familiar with the mental, emotional, social and behavioural changes as they move through adolescence towards adulthood
- Explore changing potentially dangerous situations into positive ones.

Materials

120-150 minutes
11. Give each sub-group the appropriate handout. Tell them that they will be teaching the other groups about their subject.

12. Clarify the meanings of:
   a. Cognitive (thinking): changes happening to the mind, to the way we think
   b. Emotion: changes to how we feel
   c. Social: changes that happen in our social groups, with friends, community, etc.
   d. Behaviour: changes in the way that we behave towards others.

13. Allow participants to look at their handouts and clarify any of the points. Allow them thirty minutes to discuss their subject and to prepare a short presentation on these changes. This can be in form of a role-play, a song, a rap song, a dance, or a poster. Encourage sub-groups to be as creative as they can. Stress that they need to make their information very clear to the big group and to find a way to identify and present all of the points.

14. Allow each sub-group to present to the larger group. After each presentation allow time for questions and clarify any points.

15. Hand out the other handouts, making sure each participant has all four.

16. Ask the group what they have learnt from this activity. Make notes on the flipchart.

17. Allow questions and answer any that may arise.

**Trainer’s notes:**
- See stages of adolescent development.
- See some tips for supporting adolescents through early, middle and late adolescence.

### Background information:

**Early adolescence (12-15 years old)**

- Remember the role that the media plays with regards to images of beauty and being grown up.
- Promote healthy body image and self-esteem.
- Affirm and support the youth’s many physical, emotional and cognitive changes.
- Be flexible and responsive.
- Model respect.
- Provide information about safe sex and contraception.
- Provide opportunities for complex thinking and the pondering of big questions.
- Listen first.
- Recognize that challenging authority provides an outlet for new cognitive skills.
- Afford autonomy within limits of safety.
- Engage in honest, supportive talk about sexuality.
- Provide information and resources about healthy sexuality that affirm a range of sexualities and gender identities.
- Provide outlets for questioning faith, religion and creed.
- Have a sense of humour.
Middle adolescence (15-18 years old)

- Affirm that sexuality is a healthy part of human development.
- Provide information about safe sex and contraception.
- Be available for conversation; be a sounding board.
- Offer fair and grounded support around risk taking; provide safe limits.
- Enjoy youth’s ability to think critically, hypothetically, and conceptually.
- Encourage practices that celebrate youth’s mindfulness (such as journaling).
- Understand that new thinking skills may result in new criticisms.
- Encourage involvement in multiple realms of activity or achievement (e.g. music, faith, community groups, sports).
- Strongly encourage sustained engagement for youth with diverse peers and help identify role-models for young people who lack them.
- Learn and support young peoples’ realities and struggles.
- Engage openly with youth about moral reasoning.

Late adolescence (18-22 years old)

- Continue providing information about safe sex and contraception.
- Provide for self-care, including stress management.
- Respect the privacy and intellect of the young adult.
- Provide complex problems and questions to ponder.
- Tie activities to broader concepts or issues (i.e. philosophical, existential, social activist lenses).
- Understand that intimacy and identity development are tied together, and respect the young adult’s attention to this aspect of life.
- Provide models and conversations about vocations and life choices.
- Celebrate and channel the young adult’s moral idealism into action.
- Celebrate the process of searching that is part of late adolescence.

Cognitive development

What is cognitive development?

Cognitive development refers to the development of the ability to think and reason. For example, children (6 to 12 years old) develop the ability to think in concrete ways (concrete operations) such as how to combine (addition), separate (subtract or divide), order (alphabetise and sort), and transform (change things such as 100 cents = 1 Rand). These operations are called concrete because they are performed in the presence of the objects and events being thought about.

Adolescence marks the beginning of more complex thinking processes (also called formal logical operations), including abstract thinking (thinking about possibilities), the ability to reason from known principles (form own new ideas or questions), the ability to consider many points of view according to varying criteria (compare or debate ideas or opinions), and the ability to think about the process of thinking.
What cognitive developmental changes occur during adolescence?

During adolescence (between 12 and 18 years of age), the developing teenager acquires the ability to think systematically about all logical relationships within a problem.

The transition from concrete thinking to formal logical operations occurs over time. Each adolescent progresses at varying rates in developing his/her ability to think in more complex ways. Each adolescent develops his/her own view of the world.

Some adolescents may be able to apply logical operations to school work long before they are able to apply them to personal dilemmas.

When emotional issues arise, they often interfere with an adolescent’s ability to think in more complex ways. The ability to consider possibilities, as well as facts, may influence decision making, in either positive or negative ways.

Some common indicators indicating a progression from more simple to more complex cognitive development include the following:

**Early adolescence**

During early adolescence, the use of more complex thinking is focused on personal decision making in school and home environments, including the following:

- The early adolescent begins to demonstrate use of formal logical operations in schoolwork.
- The early adolescent begins to question authority and society standards.
- The early adolescent begins to form and verbalise his/her own thoughts and views on a variety of topics, usually more related to his/her own life, such as:
  - which sports are better to play
  - which groups are better to be included in
  - what personal appearances are desirable or attractive
  - what parental rules should be changed.

**Middle adolescence**

With some experience in using more complex thinking processes, the focus of middle adolescence often expands to include more philosophical and futuristic concerns, including the following:

- The middle adolescent often questions more extensively.
- The middle adolescent often analyzes more extensively.
- The middle adolescent thinks about and begins to form his/her own code of ethics (e.g. what do I think is right?).
- The middle adolescent thinks about different possibilities and begins to develop own identity (e.g. who am I?).
- The middle adolescent thinks about and begins to systematically consider possible future goals (e.g. what do I want?).
- The middle adolescent thinks about and begins to make his/her own plans.
- The middle adolescent begins to think long term.
- The middle adolescent’s use of systematic thinking begins to influence relationships with others.
Late adolescence

During late adolescence, complex thinking processes are used to focus on less self-centred concepts as well as personal decision-making, including the following:

- The late adolescent has more thoughts about more global concepts such as justice, history, politics, and patriotism.
- The late adolescent often develops idealistic views on specific topics or concerns.
- The late adolescent may debate and develop intolerance of opposing views.
- The late adolescent begins to focus thinking on making career decisions.
- The late adolescent begins to focus thinking on their emerging role in adult society.

What encourages healthy cognitive development during adolescence?

The following suggestions will help to encourage positive and healthy cognitive development in the adolescent:

- Include adolescents in discussions about a variety of topics, issues, and current events.
- Encourage adolescents to share ideas and thoughts with you.
- Encourage adolescents to think independently and to develop their own ideas.
- Assist adolescents in setting their own goals.
- Stimulate adolescents to think about possibilities for the future.
- Compliment and praise adolescents for well thought-out decisions.
- Assist adolescents in re-evaluating poorly-made decisions for themselves.
Handout: Cognitive development

- Cognitive meaning changes happening to our minds, to the way we think.
- We gain new mental tools.
- We learn to analyse situations.
- We think about cause and effect.
- We imagine situations that are not real.
- We can compare options (choices).
- We can make good decisions and plan for the future.
- We take on increased responsibilities.
- We develop a social conscience - an attitude of sensitivity toward and sense of responsibility regarding injustice and problems in our community.
- We develop values and ethical behaviour.

Ethical behaviour is characterised by honesty, and fairness. Ethical behaviour respects the dignity, diversity and rights of individuals and groups of people. Ethical behaviour is the standards that you hold for yourself of the attributes of honesty, responsibility, and how you treat others in all facets of your life. Ethical behaviour is applying these standards even when it is inconvenient to do so.
Emotions are our feelings: what we feel in our hearts.

We become more aware of what we feel.

We learn to express our emotions in our own way.

For example:

- When we are sad - we cry
- We get angry - we shout
- We find things funny - we laugh
- We get scared - we hide.

Some emotions are feelings of happiness, sadness, fear or anger.

When we become more self-aware, we are able to identify these feelings.

We are able to say to ourselves, “I am feeling happy/sad/worried at this moment.”

We develop skills such as empathy, which is the ability to put ourselves in the shoes of another person and try and feel what they are feeling. A person who is highly aware can identify how another person feels. This is called empathy and is the cornerstone of truly understanding others.

As we grow up we try out and gain a sense of who we are and what makes each of us special in our way.

We begin to develop a set of beliefs about our qualities, gender, ethnic identity, roles, goals, interests and values.

It is a good time to become aware of our own good (and bad) qualities and learn to really believe in our own uniqueness and like who we are.

- Liking who we are is called self-esteem.
- Self-esteem is how we feel about ourselves.
- Self-esteem is self-belief.
- Building our self-esteem is important.
Our social development is about our relationships.

Our peers become important, because by identifying with them, we become more independent from our families.

Peers are people belonging to the same group as you. For example, the same age / the same grade / the same status / equal.

We may argue more with our caregivers/ parents as we reach for independence.

It is normal to challenge, but we should still show respect and listen to our caregivers’ / parents’ ideas and wishes.

We start to have closer one-to-one friendships with people of the same or opposite sex.

We learn to co-operate with others and make friends.

We may feel sexually attracted to others and form sexual relationships.

As we get older and begin to believe in ourselves, we should become less influenced by our peers and more able to accept difference in others and ourselves.
Handout: Behavioural development

- As we grow up we use our new skills to experiment with new types of behaviour. We express ourselves in new and different ways.
- This is normal and helps us to shape our identities and develop our personalities, assess ourselves and gain peer acceptance.
- However, experimenting does mean taking risks. These risks can either work out well or badly.
- We need to learn to weigh up the benefits and dangers of different situations.
- We need to know our own strengths and weaknesses and make good decisions.
- We need to find positive ways to satisfy our need to take risks rather than harmful ways.
- For example, we might learn a challenging new sport rather than take drugs.
- As adolescents, we are a great resource for our communities. We have new skills, energy and creativity that we can put to good use. We can help our families and communities.
Cognitive development as we grow
Cognitive meaning changes happening to our minds, to the way we think.

We gain new thinking tools.
We learn to analyse situation.
We think about cause and effect.
We can compare options (choices).
We can make good decisions and plan for the future.
We take on increased responsibility.

(an action leads to a consequence)

We imagine situations that are not real.

We develop a social conscience – we feel sad or angry when we see things that are not fair or hurtful to other people.
(An attitude of sensitivity toward, and sense of responsibility regarding injustice and problems in our community)

Our values change and ethical behaviour develops.
Ethical behaviour is being honest and fair.
Ethical behaviour respects the dignity, diversity and rights of individuals and groups of people.
Ethical behaviour is the standards that you hold for yourself of the attributes of honesty, responsibility, and how you treat others in all facets of your life.
(Ethical behaviour is applying these standards even when it is inconvenient to do so.)
Emotional changes
Emotional development as we grow

We become more aware of what we feel.
Emotions are our feelings.
What we feel in our hearts

Some emotions are feelings of:
happiness, sadness, fear or anger.
When we become more self-aware,
we are able to identify these feelings.
We are able to say to ourselves, "I am feeling happy/sad/worried etc at this moment."

Expressing emotion

We learn to express (show) our emotions in our own way.
For example when we are happy we laugh, when we are sad - we cry.

We develop skills such as empathy which is the ability to put ourselves in the shoes of another person and try and feel what they are feeling.
A person who is highly aware can identify how another person feels.
This is called empathy and is the cornerstone of truly understanding others.

As we grow up we try out and gain a sense of who we are and what makes each of us special in our way.
We begin to develop a set of beliefs about our qualities, gender, ethnic identity, roles, goals, interests and values.

It is a good time to become aware of our own good (and bad) qualities and learn to really believe in our own uniqueness and to learn to like who we are.
Liking who we are is called self-esteem.
Self-esteem is believing in ourselves.
Self-esteem is how we feel about ourselves.
Building self-esteem is important.
We begin to learn to co-operate and make friends.
Social changes
Changes in our relationships as we grow

Our social development is about our relationships.
Our peers become important, because by identifying with them, we become more independent from our families.

What are peers? People belonging to the same group as you. For example: the same age/ the same grade/ the same status/equal.

Peer groups

We may argue more with our caregivers/parents as we reach for independence. It is normal to challenge but we should still show respect and listen to our caregivers/parents' ideas and wishes.

We start to have closer one-to-one friendships with people of the same or opposite sex.

As we get older and begin to believe in ourselves, we should begin to become less influenced by our peers and more able to accept difference in ourselves and others.

We learn to co-operate with others and make friends.

What is co-operation? The act of co-operating; common effort. An alliance, working together.

We may feel sexually attracted to others and form sexual relationships.
**Handout: Emotional changes**

**Behavioural changes**
Changes in our behaviour as we grow

- We express ourselves in new ways.
- We use our new skills to experiment with new behaviours. These new behaviours help us learn more about ourselves, shape our identities and gain acceptance from our peers.

- Experimenting does mean taking risks. These risks can either work out well or badly. We need to learn to weigh up the benefits and dangers of different situations. We need to know our own strengths and weaknesses and make good decisions.
- We need to find positive ways to satisfy our need to take risks rather than harmful ways.

- For example, we might learn a challenging new sport rather than taking drugs or drinking alcohol, or volunteering at the local centre to help with the children, or starting a community project to learn how to grow vegetables.

- As adolescents, we are a great resource for our communities. We have new skills, energy and creativity that we can put to good use. We can help our families and communities by using our knowledge and skills, strength and energy.
SESSION 6

Activity 6a: Body language, feelings and journaling

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

Part A: Body language

1. Explain that we “tell” each other things through our body language, as well as our words.

   Body language includes:
   - the expression on our face, (demonstrate by smiling)
   - how we stand or sit (demonstrate crossing your arms and turning your back)
   - how we place ourselves in relation to another person (demonstrate by standing away from the group with your back slightly turned).

People believe our body language more than our words. If we say one thing but our body language says another, people will not believe us.

Demonstrate by saying in a strong voice – but with a smile and very relaxed posture.”Get out of this room now before I throw something at you!”

Activity
Group activity, discussion and task.

Outcomes
By the end of this session participants:
- Are introduced to the concept of recognising feelings
- Learn to speak about feelings
- Gain an enhanced awareness of the importance of body language in our interaction with others
- Learn how body language can give them insight into another person
- Increase in emotional awareness
- Develop emotional literacy
- Develop tools for self-exploration.

Materials
6a. Flashcards, flipchart paper, markers.

120-150 minutes
2. Ask the group to break into pairs and give each pair a feeling to show without talking. Ask them to act this out without words (mime). They should take it in turns to demonstrate their feeling to the rest of the group. Some examples you can use are: angry, sad, frightened, and happy.

3. Ask the rest of the group to try and guess what they are miming.
   - What is happening?
   - What feelings are the two people showing?
   - What does the body language tell us about their status and power?
   - How will reading body language help us when we are situations that might be threatening?
   - How will understanding body language help when we are trying to talk to someone about something uncomfortable or embarrassing?

Explain that understanding body language and using listening skills will be integrated into the next part of this session.

4. Tell the group that this part of the activity is a game and a talk about feelings and how feelings can help people learn a lot about themselves. You could say:

   Feelings are hard to describe, but it is the way people responds to things. For example – a happy feeling happens when someone says nice things to you, or feeling sad is the feeling you get when something bad happens. Everybody has feelings. Feelings are things that you can’t touch but they are there somewhere inside you. Some feelings are nice and some are not. Sometimes people are scared to express their feelings because they think others won’t like them. Other times it’s hard to stop feelings from bursting out, like when a person cries. This activity will help you find out about your own feelings.

5. Ask the group what they think feelings are.

6. Ask the group:
   - Do you know these feelings?
   - What can you tell me about these feelings? (Can you describe those feelings?)
   - What makes these feelings come?

7. Note answers on flipchart.

8. Hold up the flashcards one at a time and ask the group to identify each of the feelings.

9. Place the flashcards / posters / flipchart paper drawings at various points in the room. Ask the group members to go and stand under the appropriate feeling after each of the sentences that you will read out. You can demonstrate this by reading the first sentence and then going to stand under the angry card.
   - The TV broke in the middle of your favourite programme. Stand under “Angry”.
   - The taxi broke down in the middle of the rising river. Stand under “Scared”.

10. Check if they understand how the game works.
11. Read the following sentences to them one at a time:

- You are standing in the middle of the highway whilst trying to cross, and the cars are racing towards you.
- You are locked inside when a fire breaks out.
- You received 100% mark on your assignment.
- The person you want to ask to the dance is walking towards you.
- You are about to go on a lovely trip to the seaside with all your friends.
- All your friends have left you under tree during a lightning storm.
- There's a noise in the house and you are all alone.
- Your teacher told you to stay after school and help clean the classrooms.
- You have just been picked for the soccer / netball team.
- You can't go out with your friend because she is sick.
- The neighbour's dog is trying to bite you as you walk past.
- All the snacks are finished and you didn't get one.
- Your brother hit you.
- You wake to find it's been raining and cold again for the third day.

Think of other sentences that are relevant to the group.

12. Ask group members how it felt to respond. Ask them how they felt about having different feelings to others. Tell them that it's quite normal and OK for people have different feelings about the same things.

13. Now ask group members to stand under the card representing how they are feeling now. Ask them to volunteer to talk about why they are feeling that way. If there is reluctance do not force them – just acknowledge that sometimes it is really hard to talk about feelings, but that it often does help to just say to themselves: “I am feeling …… .” It can sometimes help the anger or sadness or scariness feel a bit better, or make the happy feeling more special.

14. Tell them that the same feelings can be very weak, very strong or in the middle, depending on the circumstances. For example:

- Happy can be a little smiley, quite happy or laughing happy.
- Sad can be a little down in the dumps, sulky sad or crying sobbing sad.
- Angry can be irritable, grumpy angry or shouting and yelling furious.
- Scared can be a bit worried, quite nervous or really terrified.

Ask to give examples of the varying intensities if they can. They can act these out dramatically if they wish.

15. Now ask the group members to name other feelings they can think of. Write them on the flipchart. Ask them what can make those feelings happen.

16. Tell them that sometimes people don't allow themselves to name their feelings because:

- They don't know they are feeling them.
- They don't know they can name them.
- They don't know what to do with them.
17. Hand out paper and crayons and the handouts. Ask the group members to draw their own faces showing each of the feelings. Ask them to colour each of the feelings.
   - What colour is happy?
   - What colour is anger?
   - What colour is sad?
   - What colour is scared?

18. Allow time for discussion. Some questions to facilitate discussion:
   - Why did you choose that colour?
   - What did it feel like to draw your faces?

19. Mention some helpful ways of dealing with feelings. See notes below. You can say:
   “Everybody has fears and gets scared sometimes. It helps if you can find someone you trust who you can talk to about these fears. It may help to make a drawing of your fears, or write about them.” Link this to the next part of the activity, journaling.

Icebreaker

The facilitator can mime different feelings and the group can shout out the feeling they recognise. OR the facilitator can call out a statement, the participants can mime the response and call out the feeling.
6a. Flash cards

- Happy
- Sad
- Angry
- Scared
Activity 6b: Journaling

For Part B (Journaling), make sure that some sort of journaling resource is available.

It is recommended that an inexpensive notebook is purchased for each participant and that there is always a stock for newcomers. In resource-constrained settings, encourage the participants to find an old book they can rework, or make their own journals with newsprint folded into book size. Encourage creativity. They can use pictures from newspaper or magazines, homemade glue, paint, crayons, stickers, tinfoil, plastic wrap, cut-up packets, shiny paper, or even finger-paint with an available colourant or natural ingredients.

One cannot emphasise too strongly the importance of using journals or diaries when implementing this programme. Writing daily thoughts and ideas in a journal helps young people (and adults) develop thinking skills, manage emotions better, get to know themselves more deeply and clearly, and rely on their own counsel or advice more. Urge your group to start writing in a journal every day. You can provide simple exercise books or you can make journals with your group. Be creative. You may want to start out by assigning specific questions or topics to address in the journals, but after a while, participants will get the idea and start to use them everyday for their own feelings. Emphasise that a journal is private.

Ensuring privacy is a particularly difficult issue for teenagers in more disadvantaged homes, where they may share crowded spaces with other family members. Where privacy is not possible, there may be uncomfortable repercussions if contents of a journal are disclosed inadvertently and inappropriately to family members. A possible suggestion that could be made is that participants who feel uncomfortable about taking their journals home be allowed to leave them in the safekeeping of the facilitator(s), or explore other places where the journals could be stored.

Suggested method:

1. Now tell the group you are going to talk about journaling. Tell the participants:

   Journaling is about you and your lives and your feelings. It’s just an idea and you don’t have to do it if you don’t want to. You can draw or write or stick things in your journal or just make shapes if you want. You can write poems or rap songs or movie scripts. You can write or draw memories, stories, things that are happening to you, or just what you are thinking that day.
You can use your journal as a friend who listens. Draw things in it when it’s hard to use words. Use it to write down whatever comes into your head. Just have fun! You can use your journal to be creative, find out more about yourself, develop intuition and solve problems.

By getting thoughts out of your head and down on paper, you can gain insights (see things about yourself that you’d otherwise never see).

It’s a good way to help you think things through and can also help you make decisions.

You can use your journal to write down how you are feeling everyday, quote from your favourite song, cut out a picture or simply scribble in the colour of your feeling.

2. Hand out large sheets of flipchart paper, crayons, pens and glue. If available, hand out old magazines, scissors, glitter, paint, shiny paper, etc.

3. Ask group members to make a poster about things that make them happy. They can paste their face drawings onto their sheet. They can make a collage. (Stick things on.) They can make patterns, they can just use colours or they can make cut-outs. They can write words to a song they know or make one up. They can do it in any way they wish to. Stress that this is not an art competition, but just an experiment for them to see what it feels like to use art or words, or to use both to express how they are feeling.

4. In resource-constrained settings, send the group outside to find things from nature (leaves, pods, flowers, sticks), or anything that they feel can be used creatively for their collage.

5. Allow twenty minutes for this task. Once they have completed their sheets, ask each participant to give feedback about their poster. Tell them that they can make their own home journals if they want to.

6. Some ideas to give for home journaling:
   a. Draw a face of how you are feeling that day. (See list of feelings at the end of this activity.)
   b. Scribble in the colour of your feeling of the day.
   c. Draw a picture of an animal that you have invented.
   d. Draw your own news of the day in words or with drawings.
   e. Draw a picture of yourself in clothes of your own design.
   f. Cut out pictures in old magazines and stick them onto pages to make your own secret pattern or code.

7. Write about:
   a. My favourite colour is … because …
   b. If I could be an animal I would be a … because …
   c. Today I am complaining about … because …
   d. Today I am praising … because …
   e. Write about your day in 40 words.
   f. Write out the words of favourite song.
   g. Change the words to make it your own song.
h. Compose your own song.

i. Stick your favourite picture in your journal and write about why it's your favourite.

j. Write down three things you are thankful for.

k. Write down three things you don't like and how you would like to change them.

8. Hand out notebooks if available. If not, mention resource-appropriate alternatives. Group members can make their own out of newspaper or old school books with unused pages. Encourage group members to cover and decorate their journals in their own way. Stress that the journal is for themselves, that they should share the contents only if they wish to.

9. Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and answer any that may arise.

**Trainer's notes:**

Some of these sessions may evoke strong feelings at times. The facilitator should be appropriately trained to respond in the correct manner, and contain feelings and refer when needed.

During the session, stress the importance of kindness and motivate participants to support each other. For example, ask the participants to say something kind to the person sitting on their left and examine how they feel after they have said or done a kind thing, and then exchange roles.

For feelings, use the local language and/or simplify as needed.

Here is a list of possible feelings:

- Affectionate
- Anxious
- Contempt
- Depressed
- Disappointed
- Ecstasy
- Envy
- Fretful
- Grief
- Hatred
- Hostile
- Interested
- Lonely
- Miserable
- Rage
- Sad
- Shock
- Sorrow
- Angry
- Apathy
- Curiosity
- Desire
- Disgusted
- Embarrassed
- Euphoria
- Frustrated
- Guilt
- Hope
- Hysteria
- Jealous
- Love
- Pity
- Regret
- Satisfied
- Shy
- Suffering
- Annoyed
- Awe
- Bored
- Despair
- Dread
- Empathy
- Fear
- Grateful
- Happy
- Horror
- Indifferent
- Loathing
- Lust
- Proud
- Remorseful
- Shame
- Sober
- Surprised
SESSION 7

Activity 7: Adolescent pregnancy and termination of pregnancy

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.
8. Ask girls in sub-group 1 to think about and prepare a ten-minute play (role-play) of what happens to their body when they become pregnant, (the physical implications), how they would feel (the psychological implications) and what would happen socially, in their school, with their friends and financially (the socio-economic implications).
9. Ask girls in sub-group 2 to think about and prepare a ten-minute play (role-play) of how they would feel, what would happen socially, in their school and with their friends if they decided to terminate their pregnancy.
10. Ask boys in sub-group 1 to think about and prepare a ten-minute play (role-play) of what they think would happen to the body of their girlfriend if she became pregnant (the physical implications) and how they think the girl would feel if she were pregnant (the psychological implications). How would the male partner feel? What role would the male partner play in the pregnancy?
11. Ask boys in sub-group 2 to think about and prepare a ten-minute play (role-play) of what they think would happen socially, in their school, with their friends and financially (the socio-economic implications) if their girl friend was to become a pregnant teenager.

Activity
Group work, role-play and discussion.

Outcomes
Participants:
- Gain awareness of the impact that teenage pregnancy can have on their lives
- Gain awareness of the gender implications of teenage pregnancy
- Gain awareness of the physical, psychological, social and economic implications of teenage pregnancy.

Materials
Handouts:
7a. TOP quiz,
7b. Contraception,
7c. Am I pregnant?,
7d. Home pregnancy test, 7e. First signs of pregnancy, 7f. Things to think about, 7g. Possible consequences of teenage pregnancy x 4 pages
7h. About young fathers, 7i. Facts about abortion, 7j. Facts about condoms.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.
12. Give the groups 20 minutes to prepare for their respective role-plays.

13. Bring the sub-groups back and allow each one to present their role-plays. Note the highlights or emerging concerns in all of the role-plays. Ask the group to identify the different gender responses that become apparent.

14. After all sub-groups have presented, encourage them to clarify their doubts and questions.

15. Encourage discussion. Some questions to facilitate the discussion include:
   a. What do you think about this exercise?
   b. How did you feel during this exercise?
   c. How can one prevent pregnancy?
   d. Is abortion a good or a bad thing? Why do you say so?
   e. What are other consequences of unprotected sex?
   f. In your group of friends, how do you view pregnancy?
   g. Do you talk about the possibility of pregnancy and the possible consequences?
   h. Do you think a pregnancy affects the male partner in the same way as the pregnant girl?
   i. What would be different? What would be similar?
   j. Do you think the father would or should help financially?
   k. How much is a social welfare grant for single mothers?
   l. What could a person buy with that money every month?
   m. What might it be like for the babies born to mothers and fathers who were not ready?
   n. Do girls get the blame for becoming pregnant? Why?
   o. Is adoption a good thing? Would you consider it?
   p. How would you help a friend who became pregnant?
   q. What are the pregnancy risks for HIV-positive girls?

16. Ask the group what TOP is. Hand out the T.O.P quiz (7a) and allow ten minutes for them to complete. Use the following points to fill in any gaps.

- Explain that TOP stands for termination of pregnancy.
- An abortion is the termination (stopping) of a pregnancy by removing the foetus or embryo from the uterus using drugs or through a surgical procedure.
- An abortion can also occur by itself (in which case it is usually called a miscarriage).
- Abortion is legal in South Africa and is regulated in the same way as all other medical procedures.
- The law says: “If you are old enough to fall pregnant, you are old enough to have an abortion.”
- In some cases abortion is performed to save the life of the mother, to prevent harm to her mental or physical health, or where there is chance that the foetus will die or be disabled.
- Safe abortions are those performed by a trained medical practitioner in sterile conditions.
- Unsafe abortions are performed by untrained persons, usually in unhygienic places, or occur as a result of illegal and dangerous medicines.
17. After discussion, mention that all statements in the quiz are true.
   Divide participants into mixed sub-groups of 4 or 5. Ask the groups to appoint a scribe, to
discuss the statements together and to fill in the quiz. Hand out the TOP quiz.

18. Encourage discussion. Some questions to facilitate the discussion include:
   • What do you think about this exercise?
   • How would you react if a health care worker refused to perform an abortion on you?
   • What are your legal rights regarding obtaining an abortion? (Explore in detail, referring to
     Background information and Trainer’s notes.)
   • How did you feel during this exercise?
   • Have your ideas about pregnancy changed?
   • If yes, in what way?

   HIV issues
   • How will a sexually transmitted infection affect you as an HIV-positive teenager?
   • Will being HIV positive have any impact on a pregnancy?
   • How are these issues different for boys and for girls?
   • What about being HIV positive and the future of the baby?
   • Will being on antiretroviral therapy have any impact on the baby?
   • What issues does the HIV-positive pregnant person face?
   • What are the issues that the father of the baby faces?

20. Ask the group what they have learnt from this activity. Make notes on the flipchart.
    Allow questions and answer any that may arise.
### Handout: TOP quiz

<table>
<thead>
<tr>
<th>Statement</th>
<th>True or False</th>
</tr>
</thead>
<tbody>
<tr>
<td>1  Any girl can choose to have an abortion.</td>
<td></td>
</tr>
<tr>
<td>2  An abortion needs to be done as soon as possible.</td>
<td></td>
</tr>
<tr>
<td>3  There are two types of abortions, surgical or drugs.</td>
<td></td>
</tr>
<tr>
<td>4  Abortions done in health-care settings are very safe.</td>
<td></td>
</tr>
<tr>
<td>5  Most abortions happen in the first 12 weeks of pregnancy.</td>
<td></td>
</tr>
<tr>
<td>6  Abortion is legal in South Africa.</td>
<td></td>
</tr>
<tr>
<td>7  Jumping off a roof will probably break a bone, not abort a foetus.</td>
<td></td>
</tr>
<tr>
<td>8  Traditional healers are not trained to perform abortions.</td>
<td></td>
</tr>
<tr>
<td>9  Abortion pills bought from the side of the road are dangerous to use.</td>
<td></td>
</tr>
<tr>
<td>10 Sometimes deciding to have an abortion can make you feel sad.</td>
<td></td>
</tr>
<tr>
<td>11 It is good to have someone you can trust to help you at this time.</td>
<td></td>
</tr>
<tr>
<td>12 You have a right to get respect from your health care provider.</td>
<td></td>
</tr>
<tr>
<td>13 Nobody can force you to have an abortion if you do not choose to have one.</td>
<td></td>
</tr>
</tbody>
</table>
**Trainer’s notes:**

A useful resource for this activity is “Tell me about teenage pregnancy”.

Current reports refer to South Africa’s increasing epidemic of teenage pregnancies. This has come to represent one of several indicators of growing adolescent delinquency and sexual permissiveness.

Some of the risks contributing to the high rate of teenage pregnancy appear to be the following:

- Young people dropping out of school due to financial problems and / or poor school performance
- Growing up in poverty-entrenched areas (informal settlements, rural areas)
- An absence of parents at home (particularly the mother)
- Lack of communication / stigma about adolescent sexuality
- Lack of access to judgement-free health services
- Lack of knowledge about conception and contraception
- Power imbalances in relationships, resulting in men deciding on conditions under which sex happens. This often involves coerced or forced sex and violence
- Transactional sex (often as a direct result of economic insecurity)
- Multiple sexual partners
- Trans-generational sex.

These sources of risk often overlap due to the pervasive poverty in South Africa, resulting in a lack of information, poor self-esteem, no power to negotiate and few incentives to protect girls against pregnancy.

**Background information:**

Researchers have found that adolescent mothers have to contend with many challenges in pregnancy and motherhood, such as school dropout, loss of freedom to socialise, loss of friends, loss of respect from the family, partner rejection and difficulty in finding a consistent source of income (Rowbottom, 2007).

Teen pregnancy and childbearing detrimentally affects the well-being of adolescents and their babies in many different ways. For example, it can put the life of the young mother and her baby at great risk. In fact, the risk of dying from pregnancy-related factors is about five times higher for a girl aged 10-14 years than for a woman in her twenties. For very young adolescents complications in pregnancy can be related to the fact that the pelvic bones and birth canal may be smaller and may still be growing (Rowbottom, 2007).

The babies of very young mothers are often born prematurely and have a very low birth weight, particularly those infants that are born to very young adolescents.

*For young mothers who are HIV positive there is the risk that HIV will be transmitted to their child. Teenagers who are pregnant and HIV positive need support, information and referral for antenatal care and prevention of mother-to-child transmission (PMTCT). Infected adolescents often worry about whether or not they will be able to start*
a family some day. It is not unknown for health-care providers to advise young women against pregnancy in the future, sometimes out of ignorance or because they have personal beliefs about HIV-positive women and pregnancy. With planned pregnancy there are opportunities to discuss options with health-care professionals about how to have a healthy non-infected baby.

Termination of pregnancy (TOP)

It is law in South Africa that a girl can request TOP up until the twelfth week of pregnancy without parental consent. From twelve to twenty weeks there are other criteria that need to be in place for TOP to take place.

Some private clinics offer TOP but they are more costly.

Girls who have no access to free state abortion services and no money to pay for a private abortion are sometimes forced to seek help from a variety of illegal and dangerous sources.

Abortion is legal in South Africa and is regulated in the same way as all other medical procedures. In some cases an abortion is performed to save the life of the mother, to prevent harm to her mental or physical health, or where there is chance that the foetus will die or be disabled. Safe abortions are those performed by a trained medical practitioner in sterile conditions. Unsafe abortions are performed by untrained persons and/in unhygienic places, or occur as a result of illegal and dangerous medicines.

Choice on Termination of Pregnancy Act of 1996

Within South Africa, the Choice on Termination of Pregnancy Act of 1996 allows an expectant mother to terminate the pregnancy through safe and cost-effective abortions. The Act was amended in 2008.

Place where termination of pregnancy may take place:

3. (1) Termination of a pregnancy may take place only at a facility which –

   (a) gives access to medical and nursing staff;
   (b) gives access to an operating theatre;
   (c) has appropriate surgical equipment;
   (d) supplies drugs for intravenous and intramuscular injection;
   (e) has emergency resuscitation equipment and access to an emergency referral centre or facility;
   (f) gives access to appropriate transport should the need arise for emergency transfer;
   (g) has facilities and equipment for clinical observation and access to in-patient facilities;
(h) has appropriate infection control measures;
(i) gives access to safe waste disposal infrastructure;
(j) has telephonic means of communication; and
(k) has been approved by the Member of the Executive Council by notice in the Gazette.

(2) The Member of the Executive Council may withdraw any approval granted in terms of subsection (l)(k).

(3) (a) Any health facility that has a 24-hour maternity service, and which complies with the requirements referred to in subsection (l)(a) to (j), may terminate pregnancies of up to and including 12 weeks without having to obtain the approval of the Member of the Executive Council.

(b) The person in charge of a health facility contemplated in paragraph (a) must notify the relevant Member of the Executive Council that the health facility has a 24-hour maternity service which complies with the requirements referred to in subsection (l)(a) to (j).

(4) The Member of the Executive Council shall once a year submit statistics of any approved facilities for that year to the Minister.

(5) Notwithstanding anything to the contrary in this Act, the Minister may perform any of the functions that the Member of the Executive Council may or must perform, if it is necessary to perform such function in order to achieve any of the objects of this Act.

It is estimated that in sub-Saharan Africa about 14 million unintended pregnancies occur each year. Girls between the ages of 15 and 24 years account for almost half of those. What is more, an estimated 20 million unsafe abortions are carried out in sub-Saharan Africa. It is also estimated that around 90% of abortion-related deaths could have been avoided if effective contraception had been used (Rowbottom 2007). The decision to terminate a pregnancy is influenced by a number of factors, for example wanting to complete school or fearing rejection from peers. It should be remembered that safe abortion is a reproductive health right and when any teenage girl makes the decision to terminate pregnancy it is important that she is supported in her decision. Unsafe abortion or refusal to provide safe abortion brings with it a very high risk of complications.

There is some evidence to suggest that HIV-positive girls may have a higher risk of death following unsafe abortion than HIV-negative teens. HIV-positive girls can undergo both surgical and medical abortion. Little has been found out about the effects of abortion on adolescent girls. In terms of mental health, however, there is some indication that if they experienced mental health problems previously, for example depression, termination of a pregnancy can aggravate these problems. Delays in getting an abortion are problematic
(e.g. waiting until after the third month). Changes in the law that promote the right and choice to an early, safe and legal abortion do not mean that there are no longer any barriers to accessing termination of pregnancy (TOP) services. Many factors get in the way, including service provider attitudes and opposition, stigma, poor knowledge of the legislation and a lack, particularly in rural areas, of trained professionals.

Very few teens use pregnancy testing in the public-sector clinics, but prefer to confirm in other ways like home tests. However, there are often considerable delays in confirming pregnancy, sometimes as long as two months. This means there is a need to educate young girls about time constraints and to assist them in developing various strategies to monitor their menstrual cycle, for instance menstrual diaries.
**Handout: Contraception**

What the law says about contraception in South Africa:

Contraceptives, other than condoms may be provided to a child on request by the child and without the consent of the parent or caregivers if the child is at least 12 years of age; proper medical advice is given to the child and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.

A child who obtains contraceptives or contraceptive advice in terms of the Act is entitled to confidentiality in this respect.

See also Activity 20: Legal and human rights issues.

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**What is contraception**

Contraception means:

- birth control
- stopping pregnancy
- preventing fertilisation
- stopping the sperm of the boy from reaching the egg of the girl
Am I pregnant?

Quiz

1. Have you had unprotected sex?
2. Have you missed one or more periods?
3. Are your breasts sore?
4. Are your breasts darker around the areola?
5. Are you more sleepy than usual?
6. Are you urinating more than usual?
7. Are you feeling nauseous and/or vomiting?
8. Are you feeling moody?
9. Do you have an increase in discharge?
10. Are you craving strange foods?
11. Are you having headaches?
12. Have you had any bloating in your tummy?
13. Are your clothes tight?

If you answer yes to 9 or more of the questions then you are probably pregnant.
Home pregnancy test

You may want to test yourself at home with a home pregnancy test (urine test).

Home-use kits measure a hormone (human chorionic gonadotropin [hCG]) in your urine which can be detected about two weeks after your egg has been fertilised by the sperm. So when you have missed your period the test will be able to tell you if you are pregnant.

The results are either positive (you are pregnant), or negative (you are not pregnant).

If you are pregnant you will need a blood test done by your health care provider to confirm the result.

The blood tests not only find hCG but can tell how long you have been pregnant and can even detect possible problems with the pregnancy.
First signs of pregnancy

Everyone experiences pregnancy differently. Some girls will have symptoms right from the beginning and others may not experience any symptoms at all.

<table>
<thead>
<tr>
<th>March</th>
<th>April</th>
<th>May</th>
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</table>

- **tender/painful breasts**
- **swollen ankles**
- **usually the first sign of pregnancy is when you notice your period is late**

**Other possible signs**

- **morning sickness** nausea (feeling sick) with or without vomiting
Handout: First signs of pregnancy

- Food cravings or food aversions (wanting to eat certain foods, or some food/smells making you feel sick)
- Increasing need to urinate (wee) and/or constipation
- Tiredness
Sometimes there is no one to talk to or to help guide you through making a decision about having unprotected sex and falling pregnant.

The reality of having a baby is not something that is easily taught or shown.

It is difficult for a teenager to know what it is like to become a parent. You can’t begin to imagine the possible consequences.

Lust and desire are all normal but this doesn’t mean you are ready to have sex, or get pregnant.

It is very easy to get “carried away” and have sex in a hot moment.

If you are old enough to have sex you are old enough to protect yourself and your partner.

What if you get infected with HIV or other STIs?

A good relationship includes closeness, caring and respect before sex happens.

Sex will not make someone love you, fix a broken relationship or improve one that is bad.
Handout: Some things to think about before falling pregnant...

Think about yourself and where you would like to be in three or five years time.

Think about the consequences of a wrong decision and how the rest of your life will be affected.

Will you continue with your education?

What about your parents or caregivers? Will they support you?

Will you be able to get a job to support the baby?

How will a pregnancy affect your life in the community?

Are you ready to become a mom?
Is your boyfriend ready to become a dad?

Lots of boyfriends want to be responsible for their child and want to be involved in the child’s life, but poverty often prevents them from fulfilling that role.

What about the future of the baby?
Who will look after the baby?
Who will pay for the baby?
Will your boyfriend help support the baby?
How much is the child grant?
What costs will it cover?
How much does it cost to feed, clothe and raise a baby?
Health

Through having unprotected sex, girls put themselves at risk of not only becoming pregnant, but exposure to HIV and STIs.
More chance of problems (complications) during pregnancy and a higher risk of dying in childbirth.
More chance of lower birth-weight baby and a higher risk of death.

Mental health

Unwanted teenage pregnancy can be a very stressful time.

Many girls having to confront the difficulties of single motherhood are left to face the consequences with little support, and often in hostile environments.

Depression is common (and often undiagnosed) and has particular significant implications for mother/baby attachment.

If you are feeling overwhelmed, sad and depressed, ask your health care team to refer you to a place where you can get emotional and psychological support.
Handout: Possible consequences of teenage pregnancy

Education

- Dropping out of school.
- Lower marks or failing subjects.
- Less chance of job due to lower level of education.

- Child can develop more slowly.
- Child has less chance of getting an education.
Economic

Feeding, clothing and educating another person can cause:

- income of the family to be lower
- level of poverty to become higher and the child is most likely to be poor.
Handout: Possible consequences of teenage pregnancy

Social - in the community

- Stigma and discrimination.
- Less chance of marriage.
- More chance of being abused.
- Unsupportive place for child.
- Increased behavioural problems among children.
Boys of a younger age who father babies are no different from girls.

They tend to:
- come from low income homes
- have poor school performance
- low educational attainment
- have little or no financial resources to support their child or the mother.

They are often motivated to be part of their child’s life because they had no father in their lives, but very few have the money and this leads to them absenting themselves from their child.
When can an abortion be performed?

Abortions using pharmaceutical drugs can be performed up to 7 weeks (medical abortions).

Other methods of abortion that clean the walls of the uterus using medical instruments or suction can be performed up to the 12th week of pregnancy (surgical abortions).

After the 14th week of pregnancy other abortion methods can be used, such as using drugs to start labour or performing a caesarean section, but there have to be special reasons at this stage of the pregnancy.

Dilation and evacuation can be performed between the 14th and 20th week of pregnancy.

Other factors that influence the abortion procedure:
- What procedures (if any) can be done near your home?
- How far will you have to travel?

Many girls have to travel far to have access to a safe abortion. Sometimes this can delay the abortion and their options might be limited. Pregnant girls need to find out about available abortion resources as quickly as they can.

What health conditions do girls have that might limit their options? Some procedures can be done only in early pregnancy. The type of abortion possible will firstly depend on how many weeks pregnant a girl is. (It is possible to work this out by counting how many weeks it has been since the first day of the last menstrual period.)

There are different methods of performing abortions and they will depend on the age of the embryo or foetus.

Where can an abortion be performed?

Abortions can be done in 24-hour clinics, hospitals or free-standing abortion clinics. Abortion is legal in South Africa and is regulated in the same way as all other medical procedures.

Facts on contraception, condoms and the law

Section 134 of the Children’s Act (Act No. 38 of 2005) regulates access to contraceptives to children.

What the law says about contraception in South Africa: Contraceptives, other than condoms may be provided to a child on request by the child and without the consent of the parent or caregivers if the child is at least 12 years of age; proper medical advice is given to the child and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child.

A child who obtains contraceptives or contraceptive advice in terms of the Act is entitled to confidentiality in this respect.

What the law says: No person may refuse to sell condoms to a child over the age of 12 years or provide a child over the age of 12 years with condoms on request, where such condoms are provided or distributed free of charge.

A child who obtains condoms, contraceptives or contraceptive advice in terms of the Act is entitled to confidentiality in this respect.
Safe sex means that young people who are HIV positive learn to take responsibility for reducing the spread of HIV and others STIs by making sure that contact with the body fluid of a partner is avoided. This means wearing a condom during vaginal, anal or oral sex, and using appropriate water-based lubrication. A condom is the only form of contraception that provides protection against both pregnancy and STIs, including HIV. Most are made of very thin latex rubber and work by creating a barrier that keeps sperms from the vagina whilst also protecting against other infections that are spread through skin to skin contact like herpes or discharges from the penis or vagina, for example gonorrhoea.

Condoms are very effective in reducing the risk of pregnancy and STIs but must be correctly used. There are many myths about condoms, for example that they can cause a boy to become sick because the sperm backs up inside the condom or that they can easily get lost inside a girl. None of this is true.

Condoms are nothing new. They have been around for hundreds of years but for a very long time they were so expensive that they were only used by rich people. Today condoms are available in all shapes and sizes, in a variety of colours and some are even flavoured. Family planning and sexual health clinics usually provide condoms free of charge but they can also been obtained from supermarkets, chemists, and dispensers in public toilets.

Condoms should be readily available to adolescents accessing health-care and other community facilities, including HIV-positive adolescents.

Like the male condom, female condoms also protect against pregnancy and STIs. They are a lining made of thin plastic that fits loosely into the vagina and can be inserted up to 8 hours before sex.

Condoms are the most popular choice of contraceptive amongst adolescent boys and girls. Some use the “Double Dutch” method (condom and hormonal contraception), whilst oral contraception (“the pill”) and injected contraception (Depo Provera) are used to prevent pregnancy.

In the case of HIV-positive teenagers

The safest way for an HIV-positive adolescent boy or girl to protect against transmission, re-infection with a different strain of the HIV virus, other STIs and the risk of pregnancy is not to have sexual intercourse or to delay sex. This is an option that many young people choose, but others don’t want to wait to have sex and will act on the sexual feelings that are natural and normal in puberty. This is why it is so important to encourage young people to take responsibility for safeguarding their own health as well as the health of others by using a condom.
SESSION 8

Activity 8a: Sexually transmitted infections (STIs)

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

![Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.]

Part 1

1. Tell the group that they will play a game to learn about STIs.
2. Ask the participants to divide into two sub-groups. Ask them to choose a name for their sub-group.
3. Ask the two sub-groups to sit facing each other. Place the box of questions in the centre of the two sub-groups.

**Note:** Adapt the game to the developmental stage of the group. It might be more appropriate to divide the cards in half and give each of two sub-groups time to answer the questions on a sheet.

4. Divide a flipchart page into 2 columns to keep scores, using the names of the sub-groups as the headings. Each sub-group will alternatively take one question card out of the box. They will have 2 minutes to answer the question. If a sub-group fails to answer correctly, the question will be passed to the other sub-group.

Activity

Question and answer competition, rap song activity.

Outcomes

Participants gain awareness of:
- the signs and symptoms of infections spread through sex
- condom usage and the role of condoms in STI prevention
- the consequences of untreated STIs
- HIV infection in relation to other STIs.

Materials

8a. Handout: STI cards, printed and cut, box for question cards, answer sheets, small rewards for winners (sweets or stars or certificates).
5. Each correct answer will be worth 1 point. If the question is passed to the other team and correctly answered, it will receive a bonus point (1+1).

6. The scores will be added up after the final question has been answered. The winners will receive a reward. The facilitator will provide the correct answer if both teams fail to give the correct answer.

7. Refer to the question and answer sheet in the Trainer’s Notes. Add up the scores and present the winning team with their prize.

**Part 2**

1. Tell the group each member is going to be given a few STI symptoms to memorise. (If there are too many group members, allocate STI symptoms to small groups.) Tell them you are all going to make up a song to help them remember the symptoms.

List of symptoms for the rap/song game

(Make sure they understand words like glands, ulcers, temperature, discharge and urinate. Substitute easier words if necessary.)

| 1. One hard ulcer (sore) on penis/vagina/anus - not painful |
| 2. Temperature that won’t go down |
| 3. Sore throat |
| 4. Patches of hair falling out |
| 5. Rash on the palms of hands and under feet |
| 6. Rash on chest and back |
| 7. Lots of painful soft sores on sex organ/anus |
| 8. Glands are swollen but only on one side |
| 9. It hurts when urinating (peeing) |
| 10. Inside of legs is tender and sore |
| 11. Yellow stuff is coming out of sex organ |
| 12. Unusual discharge from sex organ |
| 13. No appetite, don’t feel like eating |
| 14. Feel sick and vomiting |
| 15. Itching all over body |
| 16. Pain on the right side of stomach under ribs |
| 17. Pain in joints |
| 18. Eyes have gone yellow in the white parts |
| 19. Urine is very dark |
| 20. Anus/bum is itchy or burning |
2. Ask the group to make a circle. They should start clapping and stamping to get the beat and sing or rap the chorus. When they know the chorus and have the beat, stop the chant but keep up the clapping.

3. Let the first person or small group run into the middle of the circle and shout their symptom. They can act it out if appropriate, to make it more fun, for example, they can clutch their throat to emphasise their symptom of a sore throat, or act out vomiting, or painful urination, etc.

4. The chorus should follow this. The first person can go back into the circle.

5. Let the next person run into the middle of the circle, say their symptom followed by the chorus, and so on until everyone has had a go. (If preferred, the group can make up any rap song with a chorus and the symptoms can be fitted in.)

6. Use this example of a rap song / chorus, with each person saying their symptom as they clap and dance.

7. When all of the STI symptoms have been used up, encourage the participants to clap and whistle and stamp, applauding their own efforts loudly. Allow them to settle down.

8. Encourage a discussion of the exercise based on the responses of the participants. You can ask the following questions:
   a. Did you know as much about sexually transmitted diseases as you thought you did? Why/Why not?
   b. How would you start a conversation with your friends/peer group on STIs? What would you say?
   c. Did the exercise help you understand more about STIs?
   d. Are there still things you don’t understand and need to ask?
   e. What are the best ways of avoiding STIs? Why?
   f. Can you be sure of your sexual partner’s STI status? Why/Why not?

Chorus: STI? Check it out! Take it to the clinic and clear your doubt.

For example: Person one shouts out: It burns when I wee. (Bends over clutching stomach.)

Chorus responds: STI? Check it out! Take it to the clinic and clear your doubt.
Circumcision

9. Ask the group if they know what male circumcision is. Explain that circumcision is the removal of the foreskin of the penis (in males), and that it is a promising prevention approach for various STIs (refer to information sections at the end of this session).

10. Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and answer any that may arise.

11. Encourage the group to read through all the notes at home, and to come back to the next session with any questions they need answered.

**Trainer’s notes:**
You might need to explain in more detail or in local language what some of the questions and answers mean.

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**STIs: Questions and answers**

1. **What are the diseases called that people get through sex?**
   - Sexually transmitted infections

2. **What is an STI?**
   - Infections caused by germs that go from person to person during sexual intercourse. STIs are sexually transmitted infections, previously known as sexually transmitted diseases. These are passed on through sexual intercourse and intimate body contact, especially if exchange of body fluids takes place.

3. **Name two sexually transmitted infections.**
   - You can use local language and slang for any STIs you have heard of. The medical names for some of the most common STIs are gonorrheoa, syphilis, herpes, HIV/AIDS, genital warts, chancroid. Some other names: the drop, the itch, bad blood, morning drip, crabs, fever-kiss, and the clap.

4. **Are STIs curable?**
   - Most are curable, but not all. The incurable STIs are herpes, HIV/AIDS and hepatitis B. These are the STIs that are caused by a virus (not bacteria or a fungus).

5. **You will know immediately that you have an STI.**
   - Not always. You may have an STI but may have no symptoms for a long time (chlamydia for both sexes, gonorrhoea for girls). Many people have no signs of STIs at first, especially girls. But the germs are inside their organs causing harm. People can infect others without knowing it, even though they look healthy.

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**In the case of HIV-positive groups:** When an HIV-positive adolescent develops an STI, the consequences can be more severe. For this reason it is important that young people understand the health risks associated with STIs. These include the fact that STIs greatly increase the chances of transmission of HIV, and that STIs are often more severe and more resistant to treatment in HIV patients.
6. **Boys often show signs of STIs earlier than girls.**
   True - because their sex organs are outside their bodies and easier to see.

7. **Symptoms of STIs can be:**
   - Bad-smelling liquid coming from the penis or vagina: True
   - Pain and burning on passing urine: True
   - Blood in the urine and / or wanting to urinate often?: True
   - Sores, rashes, blisters, on or around the sex organs (penis, vagina) or anus: True
   - Warts on or around the penis, vagina or anus: True
   - Swelling in the groin: True
   - Pain in lower belly above sex organs: True
   - Headaches, fever and shaking in girls: False

8. **You need to tell your sexual partner if you have an STI.**
   True - so that they can also get treatment.

9. **Why are some STIs dangerous?**
   If not detected and treated, the infection can spread, cause you to become very sick and can cause sterility in girls (not being able to have children). Your baby might be born with defects or die. Syphilis can lead to death. The presence of an STI also helps HIV transmission.

10. **Is HIV/AIDS an STI?**
    Yes, since the virus can be transmitted by sexual intercourse.

11. **How can you protect yourself from STIs?**
    Abstinence (no sex), both partners being faithful, correct condom use

12. **What is the first thing you should do when you think you have a STI?**
    See a doctor or nurse to get proper diagnosis and treatment. Inform your sexual partners that you may be infected.
13. Your doctor/nurse 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 whole time prescribed.

14. Do STIs make it easier for sexual partners to get infected with HIV? 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.

15. Can a pregnant girl who has an STI pass the infection to the baby?

Yes, children born to infected mothers can become infected with a STI during delivery. HIV can also be passed on to the baby through breastfeeding.

16. Should you 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 both completely cured. Both partners need to be treated.

17. HIV-infected girls and boys can't get infected with HIV again.

False. They can get infected with a different type of HIV as well as increasing their viral load.

18. STIs can be cured by having sex with a virgin.

False. This is a total fallacy. In fact, it is likely that you will infect the virgin with STI.

19. 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.

20. You will not contract STIs if you are careful and wash your genitals with soap and water after having sex.

False. STI viruses/germs cannot be removed through washing or bathing.

21. Only women can spread STIs.

False. STIs can be spread by any person who is infected.

22. Birth control pills are a good method for STI prevention for women.

False. Birth control pills do not prevent STIs. Only the use of condoms can reduce the risk of STIs.

23. You can buy medicines from a chemist to treat the STI infection without going to the doctor or clinic.

False. STIs must be diagnosed and treated by a qualified doctor or clinic.

24. Anyone who has sex without a condom can get an STI.

True. The more sexual partners we and/or our partners have, the higher our chances of getting an STI.
<table>
<thead>
<tr>
<th>Name of STI</th>
<th>Symptoms</th>
<th>Cause</th>
<th>Curable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td>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</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Chancroid</td>
<td>Ulcers – painful, multiple, soft, painful swelling of lymph nodes (one side)</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Herpes genitalis</td>
<td>Multiple ulcers, shallow erosions, incurable, severe pain, fever, difficulty urinating, tenderness on the inside of the legs</td>
<td>Viral infection</td>
<td>No – but treatable</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Thick yellow discharge from penis/vagina, pain urinating and, or, during sex</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Abnormal discharge from the penis/vagina, infertility, bleeding/pain during intercourse, pain while urinating</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Severe infection shows: Loss of appetite, nausea/vomiting, fever, joint pains, jaundice symptoms, dark urine, pain in abdomen</td>
<td>Viral infection</td>
<td>No – but treatable</td>
</tr>
<tr>
<td>Urethritis</td>
<td>Mild/severe pain while urinating, pus/mucous discharge from penis/vagina</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Proctitis</td>
<td>Itching/burning around anus, pus/mucous discharge in stool, mild/severe pain during bowel movement, occasional diarrhoea or fever (3 out of 10 boys show no symptoms)</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Genital warts</td>
<td>External warts around anus, penis or vagina</td>
<td>Viral infection</td>
<td>No – but treatable</td>
</tr>
<tr>
<td>Crabs</td>
<td>Lice in hairy parts of the body, itching more severe at night</td>
<td>Parasite</td>
<td>Yes</td>
</tr>
<tr>
<td>Scabies</td>
<td>Itchy red spots or rash on wrists, ankles, hands, penis/vagina, chest and back</td>
<td>Parasite</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV</td>
<td>No symptoms initially Later weight loss, cough, TB, skin conditions, frequent infections</td>
<td>Viral infection</td>
<td>No – but treatable</td>
</tr>
</tbody>
</table>

**Note:** Some STIs do not produce any symptoms, particularly in females.
Background information: Circumcision

What the law says: Circumcision of male children under the age of 16 years is prohibited except when the circumcision is done for religious purposes and in accordance with the practices of the religion; it is performed for medical reasons on the recommendation of a medical practitioner. Older children can be circumcised if they have given consent and have had proper counselling. Every male child has the right to refuse circumcision.

There is new evidence to suggest that male circumcision is a promising prevention approach for various STIs, some of which do not have obvious symptoms but which can eventually lead to serious health complications. Although it does not protect against all STIs, for example circumcision will not prevent gonorrhoea or chlamydia, it does give protection against a wide range of medical conditions like urinary tract infections, HPV and certain cancers, as well as against the most common non-viral sexually transmitted infection in the world (trichomonas vaginalis), which is a serious health threat to women and girls.

In Africa the numbers of adult men who have been circumcised ranges from 90% in countries like Angola to 83% in Kenya and 35% in South Africa. In East and Southern Africa the age at which most males are circumcised is between 12 and 22 years (WHO, 2009c). In many countries where traditional circumcision was once practised it was abandoned for various reasons. However in many cultures, such as the Xhosa culture for example, the umkhwetha (circumcision ritual) is widely practised as an important passage from adolescence into manhood (WHO 2009c).

Because male circumcision helps to protect males from acquiring HIV – without a foreskin, the penile shaft is less susceptible to viral infection – it has become a significant aspect of HIV prevention programmes. In fact studies of male circumcision have found that the procedure may reduce HIV infection risk by around 60% (Avert 2011).

Adolescent boys, in particular, are the focus of circumcision programmes since male circumcision brings with it opportunities to provide the knowledge and skills necessary for maintaining sexual and reproductive health. The provision of male circumcision services by the formal health sector offers young people access to safe, affordable and effective procedures with important opportunities for sex education.

Although traditional circumcision is favoured in many communities, it is often associated with a number of risks. In the context of HIV infection, contaminated instruments may be used, and in some cultures, circumcision takes place after young people have become sexually active and they may engage in, or be encouraged to have sexual intercourse before the wound has healed.

Medical male circumcision provides an alternative to traditional male circumcision in East and Southern Africa and there is now a growing trend towards circumcision conducted by the formal health-care sector (WHO 2009). Nevertheless, circumcision does not give complete protection against HIV infection and should be used in conjunction with other preventative measures. In the context of the sexual and reproductive health of HIV-positive adolescents, health-care providers need to emphasise the importance of condomisation.
Medical male circumcision has a protective role in HIV prevention, since other forms of circumcision (such as traditional circumcision) do not always remove enough of the foreskin to provide protection, and may even enable transmission of HIV if the instruments used are not sterilised. The distinction is important, since adolescent males undergoing traditional circumcision may incorrectly believe there is a protective function when this is untrue.

**Background information: sexually transmitted infections**

Sexually transmitted infections (STIs) among adolescents are a real concern for health-care providers as well as for teenagers themselves. There are many factors that can result in a young person acquiring an STI. They include unprotected sex, the kind of sex that the person engages in, the number of partners that he or she has, and the extent to which condoms are used.

Biologically girls are more at risk than boys, but adolescent girls tend to worry more about pregnancy prevention than STIs.

There is a great deal of embarrassment and guilt associated with contracting an STI so it might be hard to tell anyone that there is a problem. This is why some teenagers wait so long before they go for help. The situation is made worse when service providers are unsympathetic and unfriendly.

There are a number of complications associated with untreated STIs. They include pelvic inflammatory disease (PID), infertility in males and females, cancer of the cervix, chronic abdominal pain, and birth defects in babies. When an HIV-positive adolescent develops an STI, the consequences can be more severe. For this reason it is important that young people understand the health risks associated with STIs. These include the fact that STIs greatly increase the chances of transmission of HIV and that STIs are often more severe and more resistant to treatment in HIV patients.
1. What are the diseases called that people get from sex?

2. What is an STI?
   You can use local language.

3. Name two STIs.
   You can use local language.

4. Can STIs be cured?

5. You will know straight away when you have an STI.

6. Boys often show signs of STIs earlier than girls.

7. Symptom of STI?
   Smell from sex organs.

8. Symptom of STI?
   Pain, burning when passing urine.
10. Symptom of STI? Sores, rash blisters on/around sex organs/anus.

11. Symptom of STI? Warts on/around sex organs or anus.

12. STI Symptom? Swelling in the groin.


14. STI Symptom in girls? Headaches, fever or shaking.


16. You must tell your sexual partner if you have an STI.

9. Symptom of STI? Wanting to urinate often or blood in urine.
| 17. | Why are some STIs dangerous? | 21. | Doctor gave you pills to take for 10 days. Your STI went away after 5 days. Can you stop your medication? |
| 18. | Is HIV an STI? | 22. | Do STIs make it easier for sexual partners to get infected with HIV? If so, why? |
| 19. | How can you protect yourself from STIs? | 23. | Can a pregnant girl pass her STI on to her baby? |
| 20. | What is the first thing you should do when you think you have an STI? | 24. | If you have an STI you should not have sex. |
25. HIV-infected people can’t get HIV again if they have unprotected sex.

26. STIs can be cured by having sex with a virgin.

27. You can only contract STIs from sex workers.

28. You will not get STIs if you wash genitals after having sex.

29. Only girls can spread STIs.

30. Birth control pills/injections are a good way of preventing STIs in girls.

31. You can get STI medicine from the healer without going to the doctor.

32. Anyone who has sex without a condom can get an STI.
SESSION 9
Activity 9: Sex and love

Suggested method:

Two facilitators are preferable, a female for the girl's group and a male for the boy's group. The two groups can work together for the first and third part of the session.

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

8. Tell the group that this session is about sex, sexual feelings and love. Once again, explain that it's easier to divide the group into boys and girls because these activities can sometimes cause embarrassment. The group will work together in the first and third parts of the activity.
Part A: What is love?

1. Ask participants to write down what the word ‘love’ means to them. Take feedback, and write up on the flip chart, exploring what the word ‘love’ refers to.
   - Does the word love apply to the love someone has for his or her boyfriend or girlfriend alone?
   - Does this word love also apply between brothers and sisters or to school friends?

2. Ask the group to agree on how they use the word. (Will it apply just to the love they have for their boyfriend or girlfriend (romantic love) or is it used for everyone?) If not used for everyone, can they find other words or expressions to describe love that is non-romantic?

3. Once everyone has agreed upon one or two words or expressions meaning love, ask everyone to divide into pairs, preferably with someone they have not worked with before.

4. Explain that we’re going to begin by talking about love between friends, or family members, that is love that does not involve romance and sex.

5. Ask each pair to take it in turns to describe three things you do to show love to a brother or sister or close friend.

6. Call everyone back to the full circle. Ask participants to share their thoughts, first on things they do to show love to this person and then things they expect from him or her. If there is general agreement, move on. If not, encourage participants to discuss the different views further in the whole group.

7. Ask the participants if they believe that their “things to show love” would be agreed on by the person they were thinking of? (A brother or sister or friend.) Ask in what ways might their views differ?

8. Explain that now we are going to talk about love between people who have a relationship together (girlfriend or boyfriend).

9. Ask each pair to take it in turns to describe to each other three things they would do to show to a partner (girlfriend or boyfriend) that they love him or her, and then three things they expect a partner who loves them to do to show love to them. (Note: If the participants are not currently in a relationship, they can describe an imaginary relationship instead.)

10. Call everyone back again to the full circle. Ask them again to share their thoughts, first on things they would do to show love to a partner and then things they would expect from a partner who loves them. Again, if there is not common agreement, encourage participants to discuss the different views further in the big group.

11. Ask them to name the things partners do to each other that are hurtful.

12. Finally, if there are some clear differences in the things they do to show love to partners compared with those which show love to sisters and brothers or friends, point these out to participants.

13. Ask them to define these differences more clearly. Encourage them to try to explain why these differences exist. Ask them:
   - How does sex or marriage alter ways of showing love in relationships?
   - Does love = sex or does love = marriage?
   - Do they automatically go together?
   - How should each person in a relationship show love and respect to each other?
   - Can boys and girls be good friends without having sex?
Handout 9a: What is love?

- Love is a special feeling that fills your heart.
- Love is putting yourself in someone else’s shoes and caring about how they feel and their lives.
- Love is accepting and loving people just as they are and caring about them enough to help them to do better.
- Love is wanting to enhance the other person’s life.
- When you are being loving, you help others to feel important and happy. They become gentler and kinder. Love is catching – it keeps spreading.
- Sharing is a way to show love. Share your belongings, time, feelings and ideas.
- You can be loving to people you don’t know, by caring about what happens to them and sending loving thoughts.
- You show love in a smile, a pleasant way of speaking, a thoughtful act or a hug.
- Love is treating people just as you would like them to treat you – with care and respect.
- Love is treating people with special care and kindness because they mean so much to you.
- Love is being trustworthy and loyal.
- Love is sharing the good times and bad times.
Trainer’s notes:

This exercise is designed to encourage participants to focus on their own perspectives first and only on their partner’s perspective when asked to do so. It is likely that issues such as trust, sharing, responsibility, sex and money are all mentioned. Friendships between boys and girls are good; they help boys and girls to understand each other better and get new ideas from each other.

Some points to discuss:

Boys and girls who are friends can help to change the bad ideas that people have about their friendship.

If a boy and a girl are sexually attracted to each other, spending a lot of time alone may lead to a sexual friendship.

If boys and girls spend time together as friends, it is best to be clear that they just want to be friends and to spend time with other friends as well. It may be best to refuse gifts, in case this leads to pressure to have sex.

Traditionally boys and girls were not allowed to spend time together before marriage, because people thought that they would have sex. But they still met in secret.

We need to encourage older people to accept friendships between boys and girls. Times have changed. Boys and girls marry later and need to get to know each other as friends before marriage. This helps to improve gender relations.

Part B:

1. Divide the group into same sex groups.

2. In the separate groups, ask what they think the word “sex” means. Write responses on the flip-chart.

3. Explain: When we speak of a person’s sex we are referring to whether an individual is male or female, according to different sexual organs (anatomical differences). The term sex can also refer to the act of sexual intercourse, as in “having sex”. This can include, amongst others, penile-vaginal penetration, oral and anal sex as well as non-penetrative caressing and touch.


5. Ask the group what they think sexual feelings are. Write responses on the flip-chart.

   Explain that sexual feelings are feelings of wanting to have sex, and these feelings can be very strong. It is a natural part of growing up that adolescents start to have these feelings. However there can be problems when they act on these feelings before they are physically emotionally or socially ready. This part of the activity has to do with some of these problems.

   When a person “has sex” when they are not ready physically (in the body), emotionally (in the mind or feelings) or socially (within their group/community) there can be many consequences or effects. Having unprotected sex is one of the actions that have a lot of consequences.

6. Ask the participants to divide up into groups of 4 or 6. Give each group flipchart paper and pens and ask them to appoint one presenter and one scribe per group.

7. Ask them to brainstorm (talk about) the following and then to write down their list on the paper:

   a. What are some of the reasons you might have unprotected sex?

   b. What do you think the consequences of having unprotected sex can be?
c. How do you think these consequences affect your life now and in the future?

d. How will you deal with the consequences?

5. Allow the groups 30 minutes to do this exercise.

6. Then bring both groups together. Invite the groups to present their lists. Afterwards facilitate a discussion using the following questions:
   - What did you learn from this exercise?
   - How could alcohol or drugs make a person have unprotected sex?

7. Allow questions and answer any that may arise.

Part C

1. Explain that in this activity, they are going to find out what girls and boys think and feel about sex. Stress that we all feel embarrassed and shy to talk about our feelings to do with our sexuality.

2. The boys will answer questions from the girls and the girls from the boys.

   **Friendships and love between boys and girls (and men and women) would be happier and safer if they were able to talk to each other more freely about their feelings and thoughts and what they would like.**

3. Give each participant a piece of paper and pen or pencil.

4. Ask all the participants to think of two questions that they would like to ask the opposite sex. Tell them to think of things that they want to understand better about the opposite sex and the way that they feel, think and act. These things might make them feel embarrassed, happy, curious, confused, worried or cross.

5. The boys and girls themselves will answer the questions as a group, so tell them not to direct questions to one person or make the question about one person, or to choose insulting questions because they will not be answered.

6. Ask participants to write their two questions on the paper, fold it and bring it to you. They should write in the top corner "girl" or "boy" (or if available, the papers can be in two different colours). When you have all the questions, select the best ones, taking out insulting or personal ones and duplicates. It is important that girls and boys are not pushed into telling the group personal stories about sexuality, which may put them at risk of harassment or punishment.

7. Divide participants into separate sub-groups of girls and boys and give the boys the girls’ questions and the girls the boys’ questions as selected by you. Give the sub-groups time to discuss the questions and decide how to answer. Arrange each group into a semi-circle facing each other.
8. Read the boys' questions one by one. Ask the girls to talk about each question, giving their answers. Ask the girls to:
   a. speak clearly so that the boys can hear them talking
   b. feel free and say what they think
   c. not answer questions that offend them
   d. not talk about their personal experiences. Talk instead about 'girls like us', with no names. Remind them about the listening and body language activities.

9. Ask the boys to sit and listen quietly while the girls talk. They should not talk or make noise. They will have a chance to talk about the exercise later.

10. Repeat the same process with the boys answering the girls' questions.

   Once again, ask the boys to:
   a. speak clearly so that the girls can hear them talking
   b. feel free and say what they think
   c. not answer questions that offend them
   d. not talk about their personal experiences. Talk instead about 'boys like us', with no names.

11. Then make one large circle. Ask the following questions:
   - How did you feel about this exercise?
   - What were the good and bad points about it?
   - Was anyone surprised by what they heard?
   - Girls, has it changed your ideas about boys?
   - Boys, has it changed your ideas about girls?
   - In what ways?
   - How?
   - What are the good things about boys and girls understanding each other better?
   - What are the bad things about boys and girls understanding each other better?
   - How did listening skills help those that were listening?
   - How did listening skills help those that were talking?
   - How did reading body language help with knowing how the other person was feeling?

12. Put girls and boys in pairs to discuss:
   - What more can boys and girls in this group do to understand each other better?
   - What have you learned from this session?
   - How will you use what you have learned in the future?

13. Encourage boys and girls to continue talking to each other.
Background information: romantic relationships and teenage sexuality

Teenagers begin to have more interest in peers as romantic or sexual partners during adolescence. Young adolescents often have intense feelings of love, and although they are likely to move in and out of relationships they can experience pain or unhappiness as a consequence of these experiences. The term “tender love” is sometimes used to describe the kind of love that adolescents experience since it involves feelings of tenderness and devotion, but infatuation is also common and can be equally distressing. Infatuation is different from “tender love” or “love” because it starts quickly but doesn’t last as long. When adolescents are infatuated they will tend to think of little else but the object of their infatuation.

The transient nature of relationships in these early years means that adolescents who enter sexual relationships lay themselves open to hurt, rejection and shame. Many young girls, for example, say that having sex did not make them feel nice or special. Mostly sexual intercourse is not planned and just “happens”. Others are influenced by factors such as peer pressure, power and money. Either way, when adolescents have sexual intercourse before their minds and bodies are mature they are often forced to deal with consequences for which they are ill equipped.

Sexual behaviour in adolescence tends to unfold in sequence, as young people get romantically and sexually involved. It usually starts with hugging and holding hands, progressing to kissing and touching of genitals, at first over and then under clothes. More intimate behaviour follows, such as undressing in front of each other and from there to activities such as oral sex and sexual intercourse. Others are forced into sex against their will.
Handout: What is sex?

What is sex?

1. Gender according to sexual organs

- Sex: Female (Girl)
- Sex: Male (Boy)

2. The ACT of having sex.
   (A boy putting his penis into the vagina of a girl)

Sexual intercourse
Handout: What are sexual feelings?

When girls and boys approach adolescence many things change. There are changes in their bodies but also in their minds and hearts. They begin to develop an interest in the opposite sex. This happens to all adolescents at some stage.

Sexual feelings are the feelings of wanting to have sex, but bodies are ready for sex long before minds and emotions.

Sexual feelings are very strong and can overcome a teenager’s common sense. This can lead to risky behaviour. A teenager’s decision to have sex is often without any real understanding of what can happen afterwards.

The physical (of the body) signs of sexual feelings:
In boys is when the penis becomes erect.
In girls is if wetness in the vagina.
SESSION 10

Activity 10: Gender, sexual orientation and respect

Suggested method:

Part A

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

8. Tell the group that this session is all about gender. Ask: What is the difference between sex and gender? Refer to Activity 9 and clarify if there is still confusion. Remind the group about the meaning of the word.
   - A person’s gender is male or female.
   - Our sex describes the biological differences between males and females, e.g. boys have a penis and girls have a vagina.
   - When we refer to a person’s gender we are talking about how biological differences translated into social differences.
   - A person is born a boy or girl but learns how to behave like a boy or girl (gender roles). These behaviours are affected by many things (culture and different beliefs) that may impact positively or negatively on a person.

9. Ask the group to shut their eyes and think back to the time when they were growing up.

Activity

Group work, role-play, understanding gender and sexual orientation.

Outcomes

Participants gain awareness:

- About the roles they are expected to play as males and females
- Of how these roles are changing
- About how gender roles affect their choices in their sexual and reproductive
- Health and well-being
- Of basic lesbian, gay, bisexual and transgender issues
- Of the relationship between gender, STIs and HIV, unwanted pregnancy, abuse and rape
- Of the need to reduce the degree of violence and coercion in relationships.

Materials

Fip-chart, markers.
They should imagine themselves when they were about 5 years old. Ask them to draw a simple picture of:

- What they remember doing at that age
- How they were dressed
- Who they were playing with
- What they were playing with or what game they were playing.

10. Stick their drawings up on the wall, with the girls’ pictures on one side and the boys’ pictures on the other. Ask them to walk around and look at all of the pictures. Ask them to notice what the differences are between what they see in the girls’ and boys’ drawings:

- Are they dressed differently?
- Are they playing different games or doing different things?
- Ask them why they think these things are different in girls and boys?

11. Now ask them:

- What is your earliest memory of realising that you were male (boy), or female (girl)?
- Were you treated differently from the opposite sex?
- Were you aware of being treated differently?

12. Break them into same-sex groups and ask them talk to each other about the things they did that were different from what the opposite sex was doing.

13. Then ask each group to work together to develop a short role-play that demonstrates these differences. Ask them to prepare to present to the other group. Allow ten minutes for this task.

14. Ask the female group to make a five-minute presentation. After they have completed the role-play ask the male group: What did this tell you about being male or being female?

15. Ask the male group to make a five-minute presentation. After they have completed the role-play ask the female group: What did this tell you about being male or being female?

16. Ask the whole group: how did they feel sharing this memory with the others?

![Make sure they talk about feelings, not thoughts](/content/[
- What did the memory tell them about being males or being females?
- What were the different expectations their caregivers had of them?
- How did they feel about the different expectations their caregivers had of them?
- What have they learnt from this activity?
**Part B**

1. What are people told about the ‘proper’ way for a girl or boy to behave? Gender roles are learnt by copying! Often they are qualities and behaviours that are encouraged in one sex, but discouraged or disapproved of in the other. For example, ‘boys don’t cry’ is one idea.

2. Make one sign saying ‘agree’, one saying ‘disagree’ and one saying ‘not sure’. Stick up the signs on the wall in three corners or with adequate space between them.

3. If necessary, adapt the sentences below to the developmental stage of the group. Explain that you are going to read out some sentences one by one and people should go to the corner that best says what they think about the idea in the sentence. Everyone should stand in the middle of the room to start with. If they agree with the sentence, they stand under the ‘agree’ sign. If they disagree, they stand under the ‘disagree’ sign. If they are not sure, they stand under the ‘not sure’ sign.

4. Read out the first sentence. Repeat it and make sure that everyone has understood it. Ask people to think about the sentence and then go and stand under the appropriate sign.

5. When everyone is standing under their sign, give them a few minutes to talk together about why they chose that sign. Let each group explain to the other groups why they have chosen that corner (they can choose a volunteer to represent their group or individuals can give their view, whichever is more comfortable).

6. Then let each group explain to the other groups why they have chosen that corner. Ask the other groups to listen carefully and try to understand each group’s views well.

7. Ask:
   - Did the boys choose different corners from the girls? Why?
   - Which of these ideas protect us from unwanted sex, pregnancy, STIs and HIV infection? (Or re-infection in the case of an HIV-positive group?)
   - Which of these ideas put us at risk of unwanted sex, pregnancy, STIs and HIV infection? (Or re-infection in the case of an HIV-positive group?)
   - Does anyone want to change groups now that they have heard other people’s reasons for agreeing or disagreeing? If yes, ask them to explain why they are changing.

Provide information and challenge harmful ideas as needed.
Sentences

- Boys should never cry, it means they are weak.
- Girls have to say ‘No’ to sex, but they really mean ‘Yes’.
- Boys need to have sex with many different girls so they can please their wives later.
- Condoms are only for people who have many sexual partners.
- Boys with no money can never get a girlfriend.
- Girls are lucky because they can get money and gifts from men.
- The man should be the ‘boss’ in the relationship because he is stronger.
- A girl should always do what her boyfriend tells her.
- Beating is a good way to make children or women behave properly.
- If a boy gives a girl a gift she has to have sex with him.
- Girls should only speak when men have finished and if they are invited to speak.
- A person is born gay.
- Lesbians should be raped to make them ‘normal’.
8. Read out another sentence and repeat the activity until the group understand how it works.

9. When all the sentences have been read out, ask:
   - What have you learned from this part of the activity?
   - Where do we get our ideas about these topics?
   - Are our ideas changing?
   - Is that good or bad?

10. Break into small sub-groups. Tell the participants in this part of the activity that you are going to think about 'differences' between people. Ask the groups to think about a person who is different from them in some small way. For example:
   - Sipho has small ears
   - Tumi is very small and short
   - Pinky has very light skin
   - Neo bites her nails
   - Lindiwe stutters.

Ask them to talk about whether these differences make the person weird, or bad. Take feedback.

11. Explain that there is nothing wrong with these differences. Then ask them to think of the similarities they still share with this 'different' person (same age, same class, same community, same school, same hairstyle, etc.).

12. Now ask the group what gay and lesbian mean. (Let them use local words for these concepts.) Take feedback and allow questions, linking responses to the fact that we are all different in some way and that it doesn't mean we should discriminate against anybody who is different in any way.

13. Explain that some people are gay and that means they have romantic and/or sexual feelings for people of the same gender and that is the only thing that makes them gay. The difference isn't bad either – people can love whomever they want. Love is still love and there's nothing bad about love.

14. Explain you can't tell for sure if someone is gay by how they act. Some males are girlish (effeminate), and some females are masculine but are not gay. It's normal to be curious about the bodies of your same-gender friends. This does not make someone gay. Some young people have sexual experiences with friends of the same gender during adolescence. This does not mean they will be gay when they become adults. Not showing interest in the opposite sex does not mean the person is gay either.

15. There are people all over the world, as well as here in Africa who are sexually attracted by people of the same sex, rather than by people of the opposite sex. There are no real answers why some people like to have sex with people of the same sex. Most people today agree that same-sex attraction is caused by lots of different factors (biological, genetic, social and environmental).
16. Summarise the learning and stress that:

- Harmful gender norms for males and females can put us in danger of STIs, HIV infection, re-infection in the case of HIV-positive people, as well as unwanted pregnancy, abuse or rape (e.g. if a girl has been brought up to believe that boys are more important, then she will not know that she has a right to refuse to have sex if she doesn't want to).
- It is good to think about our own gender values and see whether we need to change any.
- We can improve sexual health by achieving equality and caring friendships between boys and girls.
- Peoples’ attractions differ.
- Go over the definitions if there is extra time.

Victimisation on the basis of sexual orientation is frequent in schools, and gay males experience sexual abuse/rape at schools to almost the same degree that females do.

**Trainer’s notes:**

**Sexual orientation**

This refers specifically to a person’s attraction to a person of the same sex, one of the opposite sex or to both sexes. Heterosexuals are attracted to people of the opposite sex. Homosexuals are attracted to people of the same sex. Bisexuals are attracted to both sexes. There are no real answers why some people like to have sex with people of the same sex. Most people agree that there are two main theories as to what causes homosexual attractions. One is that a homosexual orientation is essentially dictated by genetic and or biological factors: put simply, that people are ‘born gay.’ The other theory is that homosexual attractions develop primarily as a result of psychological, social and environmental influences and early experiences.

It should be noted that a person’s sexual practices do not necessarily indicate sexual orientation or sexual identity. For example, one person may practise sexual behaviours with another person for reasons other than sexual orientation (for example, for survival, money, or power over another individual), or a person may practise sexual behaviours that conform to societal norms, even if the practice is not consistent with that person’s sexual orientation.
Definitions:

- **Lesbian**: A woman attracted to women.
- **Gay**: A man attracted to men. Colloquially used as an umbrella term to include all lesbian, gay, bisexual and transgender (LGBT) people.
- **Bisexual**: A person who is attracted to both men and women, but not necessarily simultaneously or equally.
- **Transgendered**: Transgendered people are those whose psychological self (‘gender identity’) differs from the social expectations for the physical sex they were born with, for example, a female with a masculine gender identity or who identifies as a man. It is an umbrella term for transsexuals and people who identify as neither a man or as a woman. Transgendered is not a sexual orientation; transgendered people may have any sexual orientation.
- **Men who have sex with men (MSM)**: MSM may identify as gay or may see themselves as heterosexual.

Gender

Gender has to do with practices, rules and customs that make the biological differences between boys and girls into social differences. So for example, the concepts of masculinity and femininity are associated with certain qualities or characteristics. These qualities are influenced by many factors, including culture. For instance, in some cultures boys are expected to be strong and dominant – they are the ones that make the decisions. Girls are expected to be submissive and passive. This way of seeing men and women starts from a very young age and can be shaped over time. Think about the media and films where men are shown as violent and aggressive and often abusive to women (WHO 2009b).

Gender relations play a very important role in sexual and reproductive health. Whilst it is often believed that a person can make his or her own decision about whether or not to have sex or use a condom, this is not always the case. Sexual risk taking by girls is often the result of unequal gender relations, meaning that men fail to see that the wishes and needs of women and girls should be respected. For example, many men are brought up to believe that they have control over a woman’s sexual and reproductive health, and as a result many women and girls are exposed to physical, emotional and sexual violence, for example, when they want to use condoms or oral contraceptives. These beliefs have little to do with the biological differences between boys and girls, and a lot to do with what people are raised from birth to believe about being a male or female.

Gender-based violence refers to acts of violence that are directed against women by men. The most common form is intimate partner violence, such as dating violence when girls are forced or coerced into sex. The health consequences of gender-based violence are numerous, including the risk of STIs or unwanted pregnancy because girls are afraid to negotiate condom use. Physical injury and emotional problems such as depression and anxiety are other outcomes of gender-based violence (WHO 2009b). In adolescence, many girls see controlling behaviour in their relationships as proof that a boy loves them. Knowing when behaviour is abusive or coercive is important, so that girls can recognise when relationships are unhealthy and bad for them.
Although violence and coercion represent a negative aspect of masculinity, there are many positive aspects too, and ideas and beliefs about masculinity can change.

Early adolescence is a good time to challenge gender stereotypes and to encourage boys and girls to start thinking about, and experiencing relationships that are not based on unequal power relationships but on care and respect for each other. In the context of sexual and reproductive health this means that young people can learn to enjoy an equal partnership within which safe and responsible sex is practised and, when the time comes, joint decisions can be made about starting a family. Unfortunately sexual coercion and violence against girls continues to remain a worldwide problem. This is because women are still seen as subordinate and inferior to men and social norms continue to make violence against women acceptable. By helping adolescents to talk about these issues boys can become more aware of what makes sexual behaviour appropriate or inappropriate, and become more sensitised about what constitutes a respectful relationship.

Girls can be helped to make decisions and build the self-confidence necessary to say what they want and what makes them feel comfortable. To help protect themselves from violence, status-related stigma, pregnancy, STIs, HIV infection or re-infection with a different strain of HIV, girls need to be empowered to exert control over their bodies and their lives. This extends into the future, when as wives and partners, respect for their reproductive rights should include the right to choose whether or not they want children, how many and when.
SESSION 11

Activity 11: Multiple concurrent partnerships (MCPs)

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.


Simplified:
- Multiple: many
- Concurrent: within the same time period or overlapping
- Partners: people you are having sex with

MCPs are relationships where a person has two or more sexual relationships that overlap in time. These relationships can last for a short time (short term) or may last for a long time (long term). They may be different in nature, ranging from a one-night stand with a stranger or a sex worker, to relationships that last a long time.

9. Break the participants up into small groups of 4 or 5. Ask them to discuss the questions in the quiz and together agree on what they think the correct answers are.

10. Hand out the quiz. Allow 15 minutes to complete it.

11. Clarify answers. Allow time for any other questions that may be asked.
13. In the large group give each participant the handout on *Travelling pubic lice*. Allow them a few minutes to read the comic.

14. Hand out copies of the handout on *Join the dots*. Ask the group to link the dots to indicate who is having sex with whom based on the comic story. Allow about ten minutes for this task. Then ask participants to share their join-the-dot solution with their neighbour and see if they have the same solution.

15. Ask the group:
   - What do you see happening in the picture?
   - Who is having sex with whom?
   - What are some of the reasons they are having sex? (Explore each relationship.)
   - What are some of the consequences?
   - Who of this group would have been infected with Pthirus’s family?
   - Would having sex with a condom have stopped Pthirus from infecting the next person?
   - How risky would this MCP interaction be in terms of other STIs?
   - How risky would this MCP interaction be in terms of HIV?
   - What would help stop Pthirus from spreading?

16. Ask the group what they have learnt from this activity. Answer any questions that may arise.

**Trainer’s notes**

*Check the understanding of viral load. If necessary revise, using the information provided in Session 3: What is HIV?*

**Answers to quiz**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. What does MCP stand for?</td>
<td>$a$</td>
</tr>
<tr>
<td>2. Why do some people engage in MCP?</td>
<td>$a + b + c + d$</td>
</tr>
<tr>
<td>3. Unprotected sex is a risk for HIV infection.</td>
<td>$a$</td>
</tr>
<tr>
<td>4. What is a viral load?</td>
<td>$c$</td>
</tr>
<tr>
<td>5. The viral load of a person with HIV is very high.</td>
<td>$a + c$</td>
</tr>
<tr>
<td>6. If a person’s viral load is very high they can they pass on their HIV infection more easily.</td>
<td>$a + b$</td>
</tr>
<tr>
<td>7. Why do MCPs increase the incidence of HIV?</td>
<td>$a + b + c$</td>
</tr>
<tr>
<td>8. What is monogamy?</td>
<td>$b$</td>
</tr>
<tr>
<td>9. What is serial monogamy?</td>
<td>$b$</td>
</tr>
<tr>
<td>10. What is group sex?</td>
<td>$a$</td>
</tr>
<tr>
<td>11. Why is there less chance of contracting HIV if you wait for one relationship to end before starting another?</td>
<td>$c$</td>
</tr>
<tr>
<td>12. MCPs increases the risk of STIs.</td>
<td>$a$</td>
</tr>
<tr>
<td>13. Intergenerational sex means ….</td>
<td>$b$</td>
</tr>
<tr>
<td>14. Transactional sex means ….</td>
<td>$b$</td>
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</tbody>
</table>
**Background information:**

*Multiple concurrent partnerships*

There is an ongoing debate about whether or not MCPs are major drivers of Africa’s HIV epidemic. According to the Africa Centre, which is part of the University of KwaZulu-Natal, the results show that HIV prevention messages need to be clear and directed at reducing the number of sexual partners “irrespective of whether these partnerships overlap”.

Another study found that HIV spread 10 times faster in the populations who have concurrent partnerships, than in those who had only one partner at a time.

Other new research suggests that the high rate of new HIV infections is driven by multiple sexual partners rather than concurrent ones.

The Southern Africa Development Community (SADC) officially recognises that the practice of MCP is a key contributor to the spread of HIV in Southern Africa.

Most research agrees that overall some of the main factors contributing to HIV prevalence in South Africa are:

a) High rates of MCP
b) Intergenerational sex
c) Transactional sex
d) Low rates of male circumcision
e) Inconsistent / incorrect condom usage.

**What are multiple and concurrent partnerships?**

Multiple and concurrent partnerships are relationships where a person has two or more sexual relationships that overlap in time. These relationships can last for a short time (short term) or may last for a long time (long term). They can range from a one-night stand with a stranger or a sex worker, to long-term relationships.

There are different forms of MCP. Some are:

- Steady partner and a ‘side’ partner
- Intergenerational sexual relationships
- Transactional sexual relationships
- Polygamy.

Concurrency is also thought to be an important driver of HIV transmission because those involved in concurrent relationships may be more likely to have sex with a second sexual partner during the month-long period immediately following infection, known as the **acute phase of HIV**, while they are most infectious. Furthermore each one of the sexual partners may have their own network of partners with whom they are having unprotected sex. All it takes is the HIV to enter the network through one individual for everyone to be at risk of infection.
When a person is first infected with HIV, their viral load (the amount of virus present in the blood and sexual fluids) is very high, making it very easy to transmit the virus to their partners. A person is highly infectious and this increases the chances of passing on the virus to sexual partners through unprotected sex during this period. In MCPs, this may mean that many people become newly infected and spread HIV within the sexual network, in a short period of time.

There are several common factors that promote multiple and concurrent partnerships, some of which are:

- Negative cultural and social norms, including polygamy and gender inequality, which create serious power imbalances and fuel MCP. Negative social norms have made it 'normal' for men to have more than one sexual partner, while at the same time condemning women who engage in MCP.

- Lack of communication between partners in sexual relationships, especially in ‘steady’ or long-term relationships

Identifying and understanding sub-groups of people who are more vulnerable to, and more like to, transmit HIV is essential for improving the effectiveness of HIV prevention methods.

Addressing MCP in HIV prevention requires targeted and locally informed and culturally relevant messages to raise personal awareness of risk and change social-cultural norms around sexual partnering.

What is intergenerational sex?

This is sex between two different generations - where young people (usually girls) become sexually involved with adults who are much older than they are, sometimes the age of their parents or even older.

Some studies have revealed that age-disparate relationships are meaningful and perceived as beneficial at a number of levels, including social, physical, psychological, as well as economic and symbolic.

In the context of pervasive poverty and cultural expectations for men to give and women to receive a compensation for sex, relationships with older men are a common and readily available way through which younger women get money, gain status, affirm self-worth and increase or otherwise add value and enjoyment to life.

Awareness of HIV risks in these relationships remains low. A more comprehensive policy on publicising the risks of intergenerational sex, and promoting the role of men as protectors and supporters of women is recommended.

High HIV infection rates among young women aged 15-24 years seem to be as a result of their relationships with older-aged partners. Whereas early studies emphasised economic concerns in the context of poverty as driving girls to accept or seek the attentions of older employed men, further studies have revealed a complex interplay of meanings and motives that prompt both men and women across socioeconomic strata to engage in intergenerational sex.
Transactional sexual relationships

These are sexual relationships where the giving of gifts or services is an important factor. Transactional sex relationships are distinct from other kinds of sex work, in that the transactional sex provides only a portion of the income of the person providing the sex.

Those offering sex may or may not feel affection for their patrons. In some places, transactional sex can involve a woman living in extreme poverty. She might have sex with the person she is renting from if unable to pay her rent one month. Any number of other services, legal and illegal, can be paid for with sex acts.

Transactional sexual relationships in sub-Saharan Africa often involve relationships between older men and younger women or girls. In many cases, the woman in a transactional sexual relationship may remain faithful to her boyfriend, while he may have multiple sexual partners. In other cases, the woman may have multiple partners. In both of these cases, transactional sex presents an increased risk of HIV infection. As a result, transactional sex is a factor involved in the spread of HIV.

Intergenerational and transactional sexual relationships are closely entwined with MCP and gender dynamics. Women who engage in intergenerational and transactional sex in order to survive or to obtain gifts are at higher risk of HIV infection than women who are not dependent on older men for money or gifts.

Underlying reasons for engaging in MCP are a combination of economic, human, and social factors that are significantly influenced by age and gender.
Circle the correct letter. There may be more than one correct answer.

1. What does MCP stand for?
   a. Multiple concurrent sexual partners
   b. Male chauvinist pig
   c. Many couples party.

2. Why do some people engage in MCP?
   a. For pleasure
   b. To increase social status
   c. For material gain
   d. They believe it is their cultural or social right to have more than one partner.

3. Unprotected sex is a risk for HIV infection:
   a. Always
   b. Sometimes
   c. Only if your partner looks sick.

4. What is a viral load?
   a. A popular internet story of a loaded truck
   b. A virus loaded with dangerous germs
   c. The amount of HIV in the blood and sexual fluids of an HIV-positive person.

5. The viral load of a person with HIV is very high:
   a. Shortly after HIV infection has taken place
   b. Right through the process of their infection
   c. Shortly after HIV infection if they progress to AIDS Stage 4
   d. Only if they drink alcohol.

6. If a person’s viral load is very high they can they pass on their HIV infection more easily:
   a. Only if they have unprotected sex with a person
   b. Yes, it is much more likely even when having oral sex
   c. It makes no difference; HIV is HIV.

7. Why do MCPs increase the incidence of HIV?
   a. Because the more sexual partners one has, the more chance one has of being exposed to HIV
   b. Because one is more likely to be exposed to a sexual partner who has a high viral load during the period following HIV infection
c. Because those involved in concurrent relationships may be more likely to be exposed to a sexual partner during the period immediately following infection, when they are most infectious.

8. What is monogamy?
   a. A name for a single cell structure in biology
   b. Having one sexual partner
   c. A game with mono’s.

9. What is serial monogamy?
   a. A nutritious breakfast
   b. Waiting for one relationship to end before starting another
   c. An infection in the eye.

10. What is group sex?
    a. Having sex with many people in one session
    b. A rock group having sex
    c. A group of sex workers.

11. Why is there less chance of contracting HIV if you wait for one relationship to end before starting another?
    a. The time in between gives your body a chance to rest
    b. The virus will die in the meantime
    c. No overlap of sexual partners, thereby lessening the exposure to HIV during the acute infectious phase.

12. MCP’s increase the risk of STIs.
    a. True, if sex is unprotected
    b. False
    c. STIs are not easy to pass on

13. Intergenerational sex means:
    a. Having sex while the TV show is on
    b. Having a sexual relationship with someone much older or much younger than yourself
    c. Having a few sexual relationships and then becoming celibate (having no sex at all).

14. Transactional sex means:
    a. Having sex while buying something
    b. Having sex in exchange for money or gifts
    c. Not having sex unless a condom is used.
11b. Handout: Join the dots

Who is having sex with whom?

Link the dots with lines.

Jane
Prophet
Sibongile
Rose
Peter
Kenny, Zinzi and twins
Zola
Handout: Travelling pubic lice

This is Pthirus, a pubic louse. He is very tiny about the size of a pencil dot.

Pthirus is currently living with his family in Prophet’s pubic area. They are laying more eggs every day.

Aaaweeee every night I get this ITCH.

This is him — under a microscope.

Prophet doesn’t know Pthirus is breeding in his pubic area.

Lice get hungry at night.

Hmm... I like to feed on blood inside a pubic hair follicle.

This can cause a rash.

Jane and Prophet have been having sex for six months.

A few of Pthirus’s children have moved from Prophet and laid eggs on Jane’s pubic area.

Meanwhile - Rose comes to town and spends the night with Prophet. They are old friends.

These eggs will hatch into new pubic lice in about two to four weeks.

Rose goes home to her boyfriend Peter (with extra passengers).

Peter sometimes has sex with Shongile who is a sex worker.

Peter spent the weekend with Zola. They train together and have sex when Rose is away.

Zola’s boyfriend is Kenny. He is much older and has a wife and children.
SESSION 12

Activity 12: Sexual violence and the law

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Activity
Group work, role-play and discussion.

Outcomes
Participants:
• Gain awareness of sexual violence
• Learn about the law regarding sexual violence
• Understand the implications of sexual violence.

Materials
Handouts:
12a. Statements, 12b. Handout and Poster: Unwanted sexual contacts: Spidergram (This should be enlarged prior to the session if possible), 12c. Physical pressure, 12d. Emotional pressure, 12e. Verbal pressure, 12f. Harassment and voyeurism, 12g. Avoiding unwanted sex, 12h. Some things to say to your boyfriend, 12i. Older people and sexual abuse, 12j. What to do in the case of rape, 12k. What is rape?, 12l. Homework.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

8. Tell the group this activity is about sexual violence. Explain: There are many different types of forced sex. Stress to the group that it is important to understand the differences between them, as well as how they are linked together.

9. Divide the group into three smaller mixed sub-groups. Give each sub-group one of the statements to consider (see 12a. Handout: Statements):
   a. “She asked to be raped by wearing that short skirt.”
   b. “Only women can be raped.”
   c. “That child is lying – the father is a good man, he couldn’t have molested her.”

10. Tell the groups to each choose a writer to make notes and a reporter to present their opinions. Allow them ten minutes to discuss their statements.

11. Take feedback from one group at a time. Encourage debate and discussion. (This can become quite heated.)
Trainer's notes:

- Point out that unfortunately because of the silence that surrounds sexual assault, many myths have been created. Stress that NOBODY asks to be raped, nor are they to blame for the behaviour of the rapist.
- Tell them that sometimes people get into situations where they are forced to have sex against their will.
- There are many types of unwanted harmful and aggressive sexual behaviours.

1. Put up the poster of unwanted sexual contacts (see 12b. Handout: Unwanted sexual contacts).

2. Using the diagram, explain that that these behaviours include rape, sexual abuse, child sexual abuse, sexual assault, sexual harassment and sexual coercion. Point out that the common thread of sexual assault is the loss of power and control that the victim experiences. Explore understanding of 'loss of power and control'. (Violence against us robs us of power and control. We may feel powerless in general or in certain situations). See Trainer’s notes.

3. Hand out a copy of the Spidergram to each participant. Tell participants to look at the box that contains the words ‘sexual coercion’. Ask the group if they know what the words ‘sexual coercion’ mean? Tell them that this is one of the most common forms of sexually aggressive behaviour and a lot of people are not aware of what it is or how it is recognised. Explain that sexual coercion is difficult to define because it is sometimes difficult to recognise.

Coercion is defined as ‘the act of forcing (or attempting to force) another individual through emotional manipulation, violence, threats, pressure, verbal insistence, cultural expectation, economic circumstance, alcohol or drugs, to have sexual contact against his or her will’.
AND

‘A persons’ lack of choice to pursue another option without severe social physical or emotional consequences’, i.e. a person is not able to say no because they believe they will face consequences that could be difficult for them, e.g. being beaten, being shut out, being threatened, being emotionally tortured, being deprived of things, being punished in some way.

There are so many different situations where sexual coercion occurs. It can occur even when two people have been in a relationship for a long time.

Both partners have to agree to have sex, and on what terms. If one person forces their partner to have sexual contact against their will, this is coercion.

All of us can sometimes get into situations where we are forced to have sex against our will.

**Stress firmly to the group:**

- Nobody can force you to have sex against your will.
- Remember you can decide if you want sex, when you want sex and how you want sex. It’s your choice.
- It’s your body, your choice, your decision and your right.
- The law says you have the right to make decisions about getting pregnant.
- NOBODY can force you to have sex or get pregnant if you don’t wish to.
- If it feels wrong to you, it is wrong.
- Listen to your feelings.
- Violence in a relationship is never acceptable.
- Girls sometimes think they have to do what the boy says. (The reverse applies as well.)
- Some boys believe that it is their right to make the decisions. This is not right.

4. Now explain that you are going to look at pressure to have sexual contact – in this case physical, verbal or emotional pressure. Stress that this applies in the case of boys pressurising girls, girls pressurising boys, as well as either sex pressurising people of the same sex. (Female teenagers pressurising young males to have sex with them in order to prove their masculinity is also a common pattern in South Africa.)

5. Explain that you are now going to give them each a chance to do a presentation on types of pressure to the rest of the sub-groups.

6. Break participants into three sub-groups. Write the following each on a piece of paper. Give each of the groups one of the following handouts.
   a. physical pressure
   b. verbal pressure
   c. emotional pressure.

7. Tell each sub-group to prepare a short mime (play without words) using the information and illustrations on their handout, to demonstrate physical verbal or emotional pressure.
Encourage them to be as dramatic as possible. Allow 15 minutes to prepare for their respective mime/role-plays.

8. Bring the sub-groups back together and allow each one to present their mime/role-plays. (Be aware of any emerging concerns in the mimes/role-plays and address them appropriately.) After each presentation encourage discussion. Some questions to facilitate the discussion include:
   - Does this type of thing happen in your community?
   - Did you realise that it is sexual coercion?
   - Could drugs and alcohol play a role in this type of coercion?
   - If yes – in what way?

9. After all of the groups have presented, use the following questions to continue and broaden the discussion:
   - What do you think about this exercise?
   - How did you feel during this exercise?
   - Have your ideas about sexual violence changed?
   - If yes, in what way?
   - How can one stop sexual violence from occurring?
   - What are some of the consequences of coercion?
   - In your group of friends, have you ever spoken about coercion using other words for it?
   - Do you think coercion happens to boys in the same way as girls?
   - What are the HIV implications in the case of coercion?
   - Do you think coercion affects a boy in the same way as a girl?
   - What would be different? What would be similar?
   - If you experienced any type of coercion or harassment would you seek help?
   - If so, from whom?

10. Encourage each member to think about a person they trust who they could go to in any circumstances. Brainstorm a list of local resources where help and support could be found.

11. Ask if there are any other questions.

12. Finally, provide a brief overview of the role of drugs and alcohol in sexual coercion as well as sexual harassment and voyeurism (see Trainer’s notes for extra information).

Stress:

- In the case of any type of coercion or sexual harassment, do not keep silent. They should seek help from someone they can trust.
- Always report rape to the police.
- All sexual offences (including knowledge of any sexual offence committed against a child) should be reported to the police.
- It is everyone’s right to be treated with dignity, confidentiality and respect.

13. Homework tasks:

   Ask participants to go through the handouts and make a list of questions or comments.
   Ask them to answer the quiz (one for girls and one for boys).
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Trainer’s notes:
[Some extra information for the group. These can be given as additional handouts.]

Alcohol and drugs and sexual violence

- Alcohol and drugs can harm your judgement, make it hard to resist a sexual situation and could make your partner more aggressive.
- If drugs are slipped into your drink you could pass out and become a victim of date rape.

What is sexual harassment?

- Sexual harassment is:
  - Unwelcome behaviour of a sexual nature.
  - Behaviour that makes you feel uncomfortable.
- Learn to recognise when you feel uncomfortable as a result of another person’s behaviour.
- Sexual harassment may include any unwanted physical, verbal or non-verbal conduct. The scale ranges from unwanted comments and unwanted touching at one end, to sexual assault and rape on the other.
- Because there are so many subtleties (as in the case of coercion), many young people don’t realise that they are being sexually harassed, nor do they realise they have any rights.

What is voyeurism?

- A voyeur is a person who gets sexual excitement from observing the naked bodies or sexual acts of others, especially from a secret vantage point.

Violence and abuse

When we experience violence it is frequently a private crisis. Many survivors feel isolated because of a lack of support or because sexuality or victimisation is surrounded by shame in our culture.

This creates a difficult set of reactions that may be experienced by girls who have been raped, battered, sexually harassed, abused as children, robbed violently, or hurt by other forms of violence. (Many of these reactions are common to all people – soldiers in wartime, robbery victims, friends and families of murdered loved ones – who have experienced trauma.)

It can help to recognize the commonality in our experiences. Mental health professionals have classified some of the common reactions listed below as post-traumatic stress disorder (PTSD).

PTSD is a term used to describe the re-experiencing of trauma and the distressing recollection of the event in images, thoughts, or perceptions that keep on coming back. It can include flashbacks, hallucinations, nightmares, a lack of connection to one’s body or surroundings, an intense negative response to things that remind you of the trauma, troubled sleep, irritability or outbursts of anger, difficulty concentrating, hypervigilance, and an exaggerated startle response. For some of us, having a name to give to these reactions is helpful.

It is important to note that the reactions of one person may vary greatly from those of another, and that our reactions may increase or decrease in intensity at different times in our recovery.

Some of the feelings we may have:

- Self-blame and feelings of shame and guilt. We may feel ashamed or guilty about violence done to us because many of us believe that we have to please people. Friends or family may blame the victim in order to feel safe themselves: “She got raped because she walked alone after midnight. I’d never do that, so rape won’t happen to me.”
• **Fear, terror, and feeling unsafe.** There may be nowhere that feels safe anymore.

• **Anger and rage.** While it is normal to feel anger and rage, these emotions are often hard for people to express. For many of us, directing anger toward the assaulter may generate intense feelings of terror. We may sometimes direct our feelings of anger toward others in our life, where it feels safer. While this can be confusing for our loved ones, and us it is, unfortunately, quite normal.

• **Anger turned inward, depression, and suicidal feelings.** If we have a hard time realising our anger or expressing it, we may turn it inward. This can lead to depression and self-destructive feelings, or even a desire to take our own life.

• **Substance abuse.** Many of us who experience violence find no outlet for the feelings associated with the trauma and may self-medicate with alcohol or drugs to help cope with overwhelming feelings of terror, grief, and anger.

• **Eating disorders.** Survivors often develop eating problems in the wake of violence and abuse. These may take several forms, including bulimia, anorexia, compulsive overeating, and other forms of disordered eating. Each of these can develop into serious threats to one’s health.

• **Physical symptoms.** These may include headaches, body aches, stomach and intestinal problems, fatigue, or chronic illnesses.

• **Self-harm.** Some survivors engage in various self-destructive behaviours as a way to deal with the pain. These may include risk-taking, cutting oneself with sharp objects, or hitting or burning oneself. Many of us feel that the physical pain evoked by self-injury diminishes the intense emotional pain. Self-injury can also be a way of expressing anger and other strong emotions that were repressed. For others who feel totally numb, self-injury may be a way to convince themselves that they feel something. For still others, self-injury is a way to replay an abusive experience in order to regain control of it emotionally.

• **Grief and loss.** The violence we have experienced may challenge our ideas of whom we can trust or where we are safe. We may experience grief over parts of our life that we feel we missed. Some of us feel a loss of innocence or a loss of our basic sense of self.

• **Loss of control, powerlessness.** Violence against us robs us of power and control. We may feel powerless in general or in certain situations.

• **Isolation.** We may feel as though no one can possibly understand. Or we may feel embarrassed that we are not getting better quickly enough. Family members may be encouraging us to “just put it in the past” or “get on with your life” while our feelings are still very real and troubling. We may not want to talk to anyone about the violence for fear of being disbelieved or rejected.

• **Flashbacks and nightmares.** Flashbacks and nightmares can feel overwhelming and frightening, although they are common after experiencing violence. A flashback is a memory that is experienced with one or more of the physical senses. A nightmare is a dream that sometimes involves aspects or pieces of the assault but can be combined with other events or aspects of the person’s life.

• **Sensory triggers.** Survivors may re-live violence with all senses. Triggers are certain smells, sights, sounds, places, or even times of the year that may bring about feelings related to the assault.

• **Dissociation.** During the violence or afterwards we may feel like we have left our bodies or are numb and cannot feel anything. These feelings of detachment are a psychological defence mechanism that helped us to cope with a traumatic situation in the past but may create difficulties in the present.

• **Changes in sexuality and intimacy.** While some of us experience fear and aversion to sex and intimacy, others find we want more sex than before. This may change as the healing process progresses.

• **Spiritual crisis.** Violence against us often results in an intense spiritual or religious crisis. We may feel a death of our spirit. We may feel angry toward a supreme being or lose our faith completely.
Common reactions to sexual assault or rape

Sexual assault or rape can be one of the most painful and upsetting things that can happen in someone’s life. The person who has been sexually assaulted often experiences emotions that bounce back and forth between wanting to run away and wanting to harm the person(s) who has hurt them.

Some common feelings and reactions that teen and adult survivors of sexual violence have reported:

- Wondering “why me?”
- Fear
- Anger or rage
- Numbness or emptiness
- Stomach-ache or headache
- Difficulty sleeping
- Disbelief
- Shame
- Betrayal
- Sense of loss
- Loss of control
- Nightmares
- Guilt
- Inability to concentrate
- Withdrawal
- Panic
- Reluctance to go to school/work.

The person may find him or herself constantly thinking about the sexual assault or refusing to think about it at all. All of these feelings and reactions are normal.

It is important that the person who has been sexually assaulted give themselves permission to take as long as they need to heal and recover and to remember that no matter what the circumstances of their sexual assault, it was not their fault.

Healing after sexual assault – some tips

1. Breathe. When we get scared or feel anxious, we stop breathing normally. Try to relax and take deep breaths.
2. Appreciate yourself and your strength for having survived. You may wish that you were able to do things differently to try and prevent what happened, but you made important decisions that allowed you to survive.
3. Be patient with yourself. It takes time to heal feelings and emotions.
4. Reassure yourself. Your feelings are natural. There is no one “right way” to feel after an assault.
5. Address immediate concerns, particularly medical and legal issues. Identify all your choices and options.
6. Look for people (therapist, clergy, friends) who can guide, support, and facilitate your healing.
7. Go to a support group for survivors. Survivors are wonderful allies. It is very powerful to share your healing journey with others who understand what you are going through. Contact your local rape crisis centre for a support group nearest you. If there is no support group in your community, find ways to help in setting up a group in your area.
8. Educate yourself about sexual assault. Read books or contact your local rape crisis centre to get information about the common myths and misconceptions surrounding sexual assault.
a) How do you feel about the statement: “She asked to be raped by wearing that short skirt.”

b) How do you feel about the statement: “Only women can be raped.”

c) How do you feel about the statement: “That child is lying – the father is a good man, he couldn’t have molested her.”
Poster and Handout: Unwanted sexual contacts

Unwanted sexual contacts

Understanding the web of unwanted sexual contacts and how they are all linked
Handout: Physical pressure

Physical pressure to have sexual contact can include continuing to kiss the victim as he/she tries to pull away.

Hitting, beating, kicking and slapping, holding the victim down, continuing with the sexual behaviour after being told to stop.
Emotional pressure can include nagging, manipulating, threatening to break up, making the girl feel guilty, saying that “everyone is doing it”.

Using a position of authority to get sexual favours.

For example: “You can be sure of good marks this term if we have sex”.
Verbal pressure can include threatening to use physical force, shouting, name calling, tricking, lying or blackmailing. For example - “If we don’t have sex tonight I will leave and never come back” is coercion.

Giving gifts and/or money, then expecting sex as a payback is coercion.
What is sexual harassment?

Unwelcome behaviour of a sexual nature.
Behaviour that makes you feel uncomfortable.
Learn to recognise when you feel uncomfortable as a result of another person’s behaviour.

Sexual harassment may include any unwanted physical, verbal or non-verbal conduct.

The scale ranges from unwanted comments and unwanted touching on one end - to sexual assault and rape on the other.

Because there are so many subtleties (as in the case of coercion), many young people don’t realise that they are being sexually harassed, nor do they realise they have any rights.
Handout: Harassment and voyeurism

What is voyeurism?

A voyeur is a person who gets sexual excitement from observing the naked bodies or sexual acts of others, especially from a secret vantage point. This is generally called voyeurism.
Learning to avoid unwanted sex

Trust your feelings and follow your instincts if you feel uncomfortable with a situation in any way or recognise signs of possible sexual coercion or harassment. If it feels wrong - it is wrong.

- Say no firmly and then leave immediately. Seek help if needed.
- Avoid alcohol and other drugs.
  Drugs and alcohol can:
  - Harm your judgment.
  - Make it harder to resist a sexual situation.
  - Make your partner more aggressive.

Learn to respond to sexual pressure.

Sit with your girlfriends and talk about and practise ways to say no.
Handout: Avoiding unwanted sex

In order to say NO to sex you need to:

- be motivated (have reasons for saying “no” to sex)
- learn to recognise and avoid places or situations where you might be at risk - don’t go to deserted places and always go out in groups
- learn and practice the skills to make a stand and say “no”
- know that it is against the law for older people/adults to engage in sex with a younger person

When you say NO:

- be direct and use strong body language
- stand tall and square
- face the person and look them straight in the eye.
**Handout: Some things you can say to your boyfriend**

*Examples of saying “I do not want to have sex yet”:*

You could say:

- “I really like you – I’m just not ready to have sex.”
- “If you really care about me, you’ll respect my decision.”
- “I said no. I don’t owe you an explanation.”
- “I have made a decision to abstain from sex until I am older and ready.”
- “I’d like you to respect my views.”
- “Abstinence is the only 100% effective way to avoid pregnancy, STI and HIV infection.”
- “What would happen if one of us got an STI or HIV or if I fell pregnant?”
- “I want to protect my fertility and life until I am ready to have a baby.”
- “I want to finish school and secure my future.”
- “I think sex before we are living together or married is wrong. I would feel bad if I went against my beliefs.”
- “Let me tell you what I want in my life and where I want to be in three years’ time.”
- “Having a baby or getting sick would stop me from getting to where I want to be.”
- “Let me tell you about what my parents/caregivers hope for me, and how they would feel if I fell pregnant or got an STI or HIV.”
**Handout: Older people and sexual abuse**

**Older people and sexual abuse**

- It is wrong for older people to have sex with you.
- They can go to prison for this.
- It is wrong for them to touch your sexual organs.
- Any touch that makes you feel afraid, shy or bad is wrong.
- You always have the right to say ‘No’ to any touch or behaviour that you do not like.
- Sexual abuse is never your fault.
- No one has a right to ask you to keep sexual activity secret.
**Handout: Older people and sexual abuse**

**Some tips**

- You can say: “No, stop it, I don’t like that, go away, that’s wrong” to older boys/men who do things that make you feel bad.
- Say that you will tell someone what they are doing.
- Run away and/or shout for help so that others will hear what is happening.
- You should not physically fight them unless you are sure that you are stronger than them.
- It’s best to refuse gifts or promises of money from older boys/adults because they may expect sex afterwards.
- Always try to move in pairs or groups when you have to be with an adult you do not know well.
- Wear clothes, such as shorts and trousers that will give you more protection.
- Avoid isolated places.
- When you are with an older boy/adult, if you feel that something is wrong even if they don’t do anything, trust your feelings and get away from them.
- Tell an adult that you trust, if you don’t like the behaviour of a man (or woman) even if it is a teacher, relative or family friend.
- If they don’t listen to you, keep trying until you find someone else.
**Handout: What to do in the case of rape**

- Try not to panic.
- Common sense is your best defence.
- You cannot always defend yourself and your resistance may cause serious injury.
- If the attacker is dangerous, cooperate and try to negotiate.
- Submission is not consent.
- Try and remember what the attacker looks like – his age, race, height, hair colour, scars, tattoos, clothes, voice, jewellery, etc.
- Scream, yell, and blow your whistle or run away if you possibly can.
- Do not bath or change your clothes after an attack – keep all the evidence so that it can be used by the police for further investigation.
- Report the crime to the Police Service straight away – go to the police station or phone 10111.
- Request PEP to avoid HIV infection.
- After a rape, every survivor of rape responds differently – but it is likely that you will benefit from help.

**Some rape prevention tips**

- Do not allow a stranger into your home – even if he is delivering something or providing a service.
- Ask for an identity document or phone his/her office to check his/her identity.
- Invest in the best locks and security you can afford.
- Never tell anyone that you are alone at home – and make sure other children also know not do so.
- Know your neighbours – and together plan ahead for how you will respond in a crisis.
- Know your local police station – and discuss safety matters with the police.
- Become involved with local crime prevention efforts with the community police forum or police.
Handout: What is rape?

Rape is sexual activity – specifically penetration or sexual violation of the genital organs or anus – perpetrated by one person against the will of another, either by using force or coercion, or by rendering the victim incapable of resisting. The penetration by genital organ or any object (such as finger or bottle) into the mouth, anus or vagina of another person also constitutes rape.

More broadly, it may be defined as forcing a person to submit to any penetrative sex act, and is generally considered one of the most serious crimes.

It is an act of violence that uses sex as a weapon.

There are many different types of rape that are important to distinguish as well.

**Stranger rape** happens when the victim does not know his or her offender. Many people believe that this type of rape only happens to women who dress a certain way, walk alone at night, or park in parking garages. The reality of stranger rape is that it happens during the day and at night, to people from all different walks of life, and in lots of different places.

**Acquaintance rape** describes a rape in which the victim and the perpetrator are known to each other. The perpetrator might be a partner, co-worker, best friend or neighbour. A high percentage of rapes happen among people who know one another. In many cases someone they know, trust, or love rapes a person.

**Date rape** is a specific kind of acquaintance rape, referring to a rape that occurs between two people who are dating partners. Often times the victim is emotionally manipulated, drugged or coerced into having sex with his or her partner.

**Marital rape**, one of the least talked about forms of sexual violence, is rape between husband and wife. Because of personal and societal barriers to reporting marital rape, it probably happens more often than is known about. Even in a marriage, one partner is permitted to say NO to sex.

**Same-sex rape** occurs between people of the same sex.

**Child rape** is when a child is raped.

**Baby rape** is the raping of a baby.

These are all unspeakably evil crimes.
Handout: Homework

For girls

If you can answer yes to any of these questions, you may be experiencing sexual coercion:

- Do you feel pressure from your boyfriend or friends?
- Are there times you don’t want to have sex, but feel like you can’t say no?
- Have you ever had sex because you have been given money or gifts?
- Have you ever had sex because your boyfriend said you have to prove that you love him?
- Have you ever had a sexual experience that left you frightened, angry or feeling guilty?
- Have you ever had sex without using a condom because your partner didn’t want to use one?

For boys

If you can answer yes to any of these questions, you may be being sexual coercive:

- Do you ever pressurise your girlfriend to have sex?
- Are there times you know she doesn’t want to have sex, but you know she can’t say no?
- Have you ever had sex because you gave her money or gifts?
- Have you ever asked a girl to have sex to prove that she loves you?
- Have you ever had a sexual experience that left you feeling guilty?
- Have you ever had sex without using a condom even though your partner wanted to use one?

For boys or girls

If you can answer yes to any of these questions, you may be experiencing sexual coercion:

- Do you feel pressure from your girlfriend/boyfriend or friends?
- Are there times you don’t want to have sex, but feel like you can’t say no?
- Have you ever had sex because you have been given money or gifts?
- Have you ever had sex because your girlfriend/boyfriend said you have to prove that you love her/him?
- Have you ever had a sexual experience that left you frightened, angry or feeling guilty?
- Have you ever had sex without using a condom because your partner didn’t want to use one?
SESSION 13

Activity 13: Saying yes or no to sex

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

Cards A, B and C offer two options:

A: “Boy wants to have sex but girl does not want to”;
B: “Older girl / same-age girl wants boy to have sex but he does not want to”;
C: “Older boy/ girl offers girl/ boy money or a present if she/he will have sex with him”.

Choose the more appropriate card, with either same sex or opposite sex making the offer. Select the one most appropriate for the particular group. Hold up or pass around the picture you have selected.
8. Tell the group that this is an activity to help them practise saying "no" if they decide they do not want to have sex.

9. Ask the group:
   - What do you see happening in the picture?
   - Who are the girl and the boy?
   - What do you think the girl is thinking?
   - What do you think the girl is feeling? (If the group are unsure of how to respond, give some examples of possible feelings by asking: Is she feeling scared / angry / helpless / powerful / powerless?)
   - What do you think the boy is thinking?
   - What do you think the boy is feeling? (If the group are unsure of how to respond, give some examples of possible feelings by asking: Is he feeling angry / strong /  / powerful / powerless?)

10. Ask the group to discuss with the person next to them: What will the girl say next? What will the boy say next?

11. Make notes on the flipchart of the different responses and discuss them. Point out how girls and boys respond differently if this is the case. Ask the group:
   - What is the worst thing that might happen if it was you?
   - What is the best thing that might happen if it was you?

   Make notes on the flipchart of the different responses and discuss them.

12. Remind the group:
   - Saying 'No' to sex is their choice.
   - Sometimes they can be forced against their will.
   - That people can get 'carried away' by strong feelings.
   - That sex has consequences.
   - That people have sex for different reasons, so they need different ways to avoid having sex.
   - That sex does not only happen between people of the opposite sex.
   - That perceptions of respect can make them respond against their will (such as an older person telling them what to do).
   - Sometimes close friends or family members can behave in unexpected ways.
   - Sometimes relatives or friends of the family try to get young people to have sex.
   - Young people often trust them until they try to touch them in a bad way. They should learn to react strongly to this.
   - Young people are often afraid to talk about being sexually abused.
   - If they are with an older person and they feel that something is wrong (even if the situation is not sexual), to trust their feelings and get away from the older person.
   - To tell an adult that they trust, if they don't like the behaviour of a man or woman, even if it is a relative or family friend.
   - To call Childline or appropriate local resources.
   - To tell a trusted adult if anyone:
• touches them in a way they do not like
• touches their private parts or asks them to take off their clothes
• talks to them about sexy things or having sex.

If the first person they tell does not believe them, talk to another person until someone does believe them.

13. Remind them that this exercise will help them understand that saying no to sex needs them to:
   • Be motivated (have reasons for saying “no” to sex)
   • Learn to recognize and avoid places (parties) or situations (drugs, alcohol) where they might be at risk
   • Learn and practise the skills to make a stand and say “no”
   • Learn that it is against the law for adults to engage in sex with a younger person (refer to the abridged Children’s Act described earlier).

14. Ask the group: How could the girl (or boy) avoid getting into a situation like this?

Make notes on the flipchart and explore:
   • Avoiding places where this might happen
   • Trusting their feelings if they feel that something is wrong
   • Getting away
   • Places or people they can go to.

Some answers might be:
   • Avoid being alone with a potential partner until you have built up trust
   • Find a safe place to talk, where you won’t feel like getting romantic
   • Before things get romantic say that you do not want to have sex yet
   • If you feel uncomfortable with the way someone is behaving or talking to you, move away
   • Make sure there are other people around when you meet with this person
   • Tell the girl before things get romantic that you do not want to have sex.

Ask the group to think of other answers that would work for them.

15. Ask the group to think about whom they could talk to: people they can go to, and people they can tell. Ask them to try and identify someone that they could go to if this should happen and try to provide appropriate resources / referrals – Childline, etc.

16. Ask the group: What words could the girl use to tell the boy “no” (or vice versa).

Some answers might be:
   • Say in a strong voice, “I do not want to have sex yet”.
   • Say, “I want to talk to you now, before we go too far”.

Ask the group to think of other answers that would work for them.

17. Get the girls and boys to role-play practising saying no in same-sex pairs. Observe the tone of voice and the body language used, and comment on how both need to reinforce the verbal no message.
18. Ask the group after the role-plays:

- Which ways worked well to keep to their decision about delaying sex?
- What was it like to hear Thando saying “no”?
- What was it like to say “no”?
- Which ways used by the proposer was difficult to resist? Why?
- Which were the best ways to resist them?

Examples of saying “I do not want to have sex yet”:

- “I have made a decision to abstain from sex until I am older and ready.”
- “I’d like you to respect my views.”

(Abstinence is the only 100% effective way to avoid pregnancy and STIs.)

- “What would happen if one of us got an STI or HIV or (the girl) got pregnant?”
- “I want to protect my fertility and life until I am ready to have a baby.”
- “I think sex before we are living together or married is wrong. I would feel bad if I went against my beliefs.”
- “Let me tell you what I want in my life and where I want to be in three years’ time.”
- “Having a baby or getting sick would stop me from getting to where I want to be.”
- “Let me tell you about what my caregivers hope for me and how they would feel if got pregnant or got an STI.”

19. Ask the group why they think older people might want to have sex with younger girls and boys. Make notes on the flipchart and then explain the following points, one at a time:

- It is wrong for adults to touch their sexual organs.
- Adults can go to prison for this.
- Any touch that makes them feel afraid, shy or bad is wrong.
- They always have the right to say “No” to any touch or behaviour that they do not like. (Their body language has to say “no” as well.)
- Sexual abuse is never their fault.
- No one has a right to ask them to keep touching and keep sexual activity secret.

They can say:

- “No, stop it, I don’t like that, go away, that’s wrong” to adults who do things that make them feel bad.
- That they will tell someone what they are doing.
- They can also run away and/or shout for help so that others will hear what is happening.
- They should not fight another person who pressurises them for sex unless they are sure that they are stronger than them.
- It’s best to refuse gifts or promises of money from adults because they may expect sex afterwards.
- Always try to move in pairs or groups when they have to be with an adult they do not know well.
- Wear clothes, such as shorts and trousers that will give them more protection.
- Avoid isolated places.
• If they feel that something is wrong when with an adult, even if they don't do anything, trust their feelings and get away from them.
• Tell an adult that they trust, if they don't like the behaviour of a man or woman, even if it is a relative or family friend.

20. What words could the younger person use to tell the older person “no”?
  • Say in a strong voice, “I do not want to have sex”.
  • Say, “I do not want to break my word to my caregiver”.

21. Get the girls and boys to role-play practising saying no in same-sex pairs.

22. Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and answer any that may arise.

23. Ask the group to write any other questions they wish to ask on paper without their names and place in a box.

**Trainer’s notes**

*Certain key points in this activity are repeated in Activity 12: Sexual violence.*

• Many young people have sex without thinking carefully about the results.
• Sex can be used as a ‘feel good’ drug, much the same as alcohol.
• Young people often do not make a decision to have sex. It just ‘happens’ to them in an unplanned way.
• Sex is a very powerful feeling and can overcome people’s common sense.
• Some young people are forced into sex against their will.
• It is very important that young people learn to make strong decisions on whether to have sex or not – to say the real ‘No’ and the real ‘Yes’ when it is right for them.
• Young people may decide to have sex for a number of reasons, including love, desire, power, money or to be part of a group.
Handout: Saying no to sex
Handout: Saying no to sex
Handout: Saying no to sex
180a. Handout: Saying no to sex
Handout: Saying no to sex
SESSION 14

Activity 14: Confidentiality and stigma

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

Part A

1. Tell the participants that this activity is in two parts. The first part is playing a game from which they can learn about confidentiality. Explain that during these sessions, some of the members might want to share their experiences or talk about things that are a secret from most other people and that this activity will help them understand how important confidentiality is to everyone.

In the case of an HIV-positive group of adolescents the emphasis would be on HIV status, disclosure and other HIV-related issues.
2. Hand out small pieces of paper and pens and instruct participants to write down on a piece of paper something that is secret or something they have done that is naughty that not many people know about, something that they have not shared with many people. For example – that they “borrowed” their friend’s jersey, that they told a lie about something, that they cheated in an exam, etc.

3. After they have written this down they should fold up their paper. Walk around and:
   - Take the first few papers, carefully read and place in your pocket.
   - Tears up some of the papers with or without reading them.
   - Crumple some and throw onto floor with or without reading.

4. How did those people whose paper was crumpled or torn feel after having trusted the facilitator with their secret? What were some of the feelings they might be experiencing? Possible reactions could include anger, hurt, shock, betrayal.

5. How did those people feel, whose paper was carefully removed, yet kept by facilitators? How did those people feel after the facilitator did not even read their paper? How did those people feel after the facilitator read their paper? Possible reactions could include suspicion, unease, discomfort, embarrassment/shame, humiliation, vulnerability, surprise, betrayal, anger and hurt.

6. Contain and validate reactions. Ask the group: How should I have responded to your secret? Should I have been:
   - Supportive
   - Warm
   - Empathetic
   - Respectful
   - Told you that I know how hard (risky) it was for you to share?

7. Ask the group: Should I have advised group members in advance that I would be reading their notes? Why is confidentiality important?

In the case of an HIV-positive group

Explore who would need to know their status: health care team members, treatment assistants, etc. (See Trainer’s notes at the end of this session: What the law says: National HIV counselling and testing (HCT) policy guidelines regarding confidentiality).

- Ask why is confidentiality important in the context of HIV?
- Ask what are some of the risks an HIV-positive adolescent faces if s/he discloses her or his status?
8. Explain that during the support group sessions, some of the members might want to share their experiences or talk about something that is secret.

9. Link responses with how other members of the group might feel if trust (confidentiality) is broken by another member. Link responses with the needs of the members of the support group and stress that each group member needs to feel safe within the group.

10. Stress that some people in the group might have told other people about their secrets (e.g. abuse, pregnancy, being sexually active, drugs, alcohol, transactional sex, intergenerational sex, HIV-positive status), but others might not have, therefore it is very important to respect other people’s secrets or HIV-positive status.

11. Make sure that all the papers are placed in a container after the activity and shredded or disposed of in a way that assures confidentiality.

**Part B**

1. Explain that the second part looks at stigma and discrimination, creates a fundamental sense of trust and complicity within the group.

   In the case of an HIV-positive group, this also prepares the way for a greater understanding of the process of disclosure. As a foundation, before (further) disclosure takes place, participants should become aware that most people have suffered stigma and discrimination in some way. It’s not a nice feeling, but it is helpful to know that others have also been discriminated against – that they are not alone. People who discriminate against others often don’t like themselves very much (have low self-esteem). They feel better if they make someone else feel or seem bad. They may be very ignorant and they also may be scared.

2. Give a simple overview of what stigma and discrimination mean: Sometimes we feel bad because people don’t value us because of how we look, speak, how we behave, our religion, our tribe, our colour or race, our state of health, or our family. This is called **stigma**. Sometimes people ignore us, pay no attention to what we say, leave us out of the team they are choosing, ignore our rights. This is called **discrimination**.

3. Ask the group to stand in a circle.
   - Ask the question – has anyone been discriminated against because they are poor?
   - Tell the ones who have experienced this to go into the middle of the circle.
   - Hold hands with the others in the middle of the circle, swing their arms and smile at each other.
   - Now look at the people in the outside circle.
   - Ask them to go back into the big circle.
   - Repeat the activity using different reasons why people might be discriminated against:
• Girl/boy
• Not having a girlfriend or boyfriend
• Not going to school
• Not having parents
• Getting food parcels
• Being part of a feeding scheme at school
• Too young/old
• Race/colour of skin/religion
• Short/tall
• Thin/fat
• Wearing glasses
• Disabled
• Bad at sport
• Lack of education/not clever enough
• Not able to read or write
• Being an albino
• Lesbian or gay
• Taking medication for diabetes, asthma, etc.

Taking medication for HIV
HIV/AIDS/TB (Ensure prior disclosure)

4. Ask participants to call out ways they have been discriminated against, or where they are aware of others being discriminated against. Allow time to discuss how they felt and explore the different forms of discrimination.

5. Ask them:
   • What they have learnt from this exercise?
   • How does it feel to be discriminated against? List on a flip-chart.
   • What effect did it have on them? List on a flip-chart.
   • How does stigma affect someone in the case of deciding to disclose his or her HIV status?

6. Now ask them to think of a time when they discriminated against someone. It could be in the form of laughing at someone else, ignoring someone, excluding someone from a game or activity, or any other behaviour that made the other person feel left out and/or different.
   • How do they think that person felt?
   • What effect do they think it had on that person?
7. List the responses on the flipchart and explore how it feels being on the receiving end of stigma, and how it feels being responsible for it.


9. Bring the group together and share the reasons why they discriminated against someone and the reactions from the other person, not the incident itself. Ask:
   - What does this teach us about discrimination?
   - What are the causes of it?
   - What are the consequences?
   - How does being in a group like this one help with stigma and discrimination?

10. Link the responses to group support and shared confidentiality.
    - Mention that that increased self-esteem can be derived from doing something good.
    - Ask them to increase their awareness of how they feel inside when they behave like a ‘hero’ in some way.

Shared confidentiality, in the case of HIV-positive groups.

In the case of a support group, the meaning of shared confidentiality needs to be carefully understood. Within this type of ready-made group disclosure, there should be the clear understanding that others may not talk about their status, without being given permission. The knowledge about each other’s HIV infection stays safely in the group.

Discuss with them that one of the reasons for this club/support group is to create a safe place to talk about being a teen with HIV. Assure them that all the people in the group are all HIV infected and stress that this is a very special group, helping them feel connected and happy that their peers are sharing the same experiences as them. Having a support network that knows their status can be enormously beneficial to their happiness, and help them with their treatment adherence.

Explain that in this group it is important that they should all agree to share confidentiality about each other’s HIV status. Ask the group if they all agree to not to talk to others about the special secret they all share. Ask them if they understand why stigma is important to understand. Stress that being HIV positive is nothing to be ashamed of, but that there are some people who do not understand that because they are uninformed and scared, and they can make the person with HIV and their family feel bad.

Give them a few minutes to talk within the group about how they feel about group confidentiality.
11. Introduce the keeping-the-secret manifesto. Explore the idea with the group. Ask them what significance it might have and if they like the idea, draw up a draft manifesto.

*Example:*

**MANIFESTO**

Name of group

We understand that this is our safe place.

We fully understand how important it is to respect the secrets of all the members and what the consequences of telling those secrets might be.

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12. Ask them what they would change or like to add. Personalise and finalise the manifesto.

- Read the manifesto to them.
- Ask them if they would all like to sign it.
- Pass the manifesto around for everyone to sign.
- Reinforce with the club greeting.

*Note: Remember to explain and introduce each new member to this manifesto when they join the group.*
13. Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and answer any that may arise.

**Trainer’s notes:**

- By helping to change behaviour, participants can behave in a supportive sensitive and caring manner, rather than being stigmatising and discriminatory.
- Participants become more aware of the need to change their attitudes, values, beliefs and behaviours.
- Adolescents often experience feelings of inadequacy or non-acceptance by their peers. These feelings may impact on decisions regarding the sexual and reproductive health of the adolescent. Identifying and exploring the various aspects of stigma may enable choices to be made from a different and ultimately healthier viewpoint.
- Using a sensitive and experiential educational process that:
  - Helps people own and internalise their knowledge
  - Goes beyond providing facts and information
  - Encourages people to explore their fears, prejudices and feelings
  - Raises awareness about stigma that can then be translated into action
  - Illustrates that the root of stigma often lies in ignorance.

Researchers (Paxton 2002) have found that public disclosure can help to reduce stigma and discrimination, can be a powerful tool in breaking the silence surrounding the disease and can help individuals overcome fear and prejudice.

- Adolescents can gain more insight into why disclosure is difficult for them and their caregivers.
- By introducing the subject of stigma to adolescents, sensitivity can be heightened and through understanding, the impact of stigma can be mitigated – from an early age.

**How can we all help prevent stigma in the case of HIV?**

We can all help to prevent stigma and discrimination in our daily lives in many different ways.

Those of us with HIV are the same as any other person with an illness. We do not expect to be treated differently – better or worse than anyone else.

We need friends and family to share our worries and feelings about our illness with, and sometimes, practical help. We need friends who challenge and educate those who stigmatise, tease, bully or reject us. We have faced the reality of HIV and can take the lead in helping others to take the actions they need to take to protect them; and support those of us with HIV. We can promote changes in our culture, gender norms and environment that make it easier for people to have happy and safe sexual lives.
Empower people with the knowledge, skills and self-confidence that they need to cope with the epidemic.

Join those of us with HIV to challenge stigma and take charge of coping with HIV in our communities.

Speak out against all forms of stigma and discrimination: for example, against women, young people and sex workers. Learn and teach others about how HIV is spread and not spread to reduce fear of being with people with HIV:

- How any one of us could be infected with HIV or become infected if we have sexual relationships or have injections, cuts or contact with blood for any reason, or were born and breastfed during the epidemic.
- How those of us living with HIV can live positively for many years without being ill.
- How health care workers can treat illnesses caused by HIV to help people to live longer and healthier lives.
- How drugs which reduce the amount of HIV in the body and greatly prolong healthy life are becoming more and more available to people with HIV everywhere.
- How we all lose when people with HIV are treated badly, because HIV spreads more quickly and has a worse effect.
- How we should all work to fulfil the human rights of people with HIV.
- How with loving care we can all contribute to preventing HIV, caring for those of us infected and affected and stopping the worst consequences of the epidemic.

**Background information**

**Stigma and HIV-status disclosure**

What the law says: No person may disclose the fact that a child is HIV positive without consent. Consent to disclose the fact that a child is HIV positive may be given by the child if the child is 12 years of age or older, or under the age of 12 years and is of sufficient maturity to understand the benefits, risks and social implications of such disclosure.

Disclosure to friends, romantic partners and sexual partners is important for various reasons. For example it can mean more social support, more chance of talking about risk reduction with a partner, better adherence to treatment, and more opportunity to plan for the future. Despite these benefits there are also risks involved, including abandonment, blame, violence and discrimination.

Many sexually active adolescents express concern for their partners’ health but fear rejection and accusations of being unfaithful if they disclose. Hard as it is for an adolescent to tell his or her partner that he or she is living with HIV, it is the right thing to do. It is the best way for a young person living with HIV to safeguard his or her health and that of his or her partner. For
some the outcome may be different from what they expected. They might find that their partner is accepting and supportive. Some teenagers say that they experienced a sense of relief and felt much closer to their partners. For others it meant the realisation that their HIV status would never be accepted within a particular relationship.

But whatever happens young people need to remember that being badly treated by anybody just because they are HIV positive is not acceptable.

The support group offers a good opportunity for young adolescents to begin to explore ways of disclosing their status. According to the International Planned Parenthood Federation, some of these ways might include practising disclosure with a trusted person, identifying a place that feels safe and comfortable to have a conversation, or sounding out a person out by asking questions about HIV and gauging his or her reaction.

It can also be helpful for adolescents to think about questions like: why they want to disclose, why they feel it might be necessary for a particular person to know their status, whether that person will understand the need for confidentiality, what the advantages and disadvantages of disclosure in a particular context might be, what they expect to be the outcome of disclosure, whether or not their expectations are realistic, and if they are likely to experience regret or feel better about having told.

In many instances fear of stigma and discrimination underlies reluctance to disclose. Stigma describes how a particular label influences the way in which people react to an individual with HIV, for example by being unfriendly or insensitive. The word “stigma” comes from a mark that was made on people who were slaves or criminals decades ago. It came to represent disgrace and people who carried the mark were treated badly. Although there are often no visible signs or marks to show that a person has HIV, people who are known to be HIV infected can be stigmatised. Even if a person chooses to keep his or her status private, this does not mean that he or she will not hear hurtful remarks about HIV and AIDS that are made by others. Not surprisingly, rather than being made to feel bad, young people often isolate themselves from others and may compromise their medical care by avoiding health facilities where they could be recognised.

When a young person internalises stigma, that is to say they believe what others say about them, this can have negative consequences for their mental health and well-being.
To understand stigma it helps to understand something about disease stigma, which has to do with fear and blame. When people associate HIV with certain negative behaviours, like promiscuity, and attribute the behaviour to a certain group, like HIV-positive people, they can often without consciously realising it create an “us” and “them” situation. They do this in order to put a distance between themselves and the group that is stigmatised. This is reassuring because it strengthens the belief that there is less chance of them being infected.

Stigma may also have to do with too little or incorrect knowledge about HIV and AIDS, for example worries about “catching” HIV from a teacup. HIV-related stigma needs to be addressed wherever possible and support groups are a good beginning. HIV-positive teens need information and skills to help them deal with inaccurate beliefs and fears that so often cause discomfort and hurt in relationships.

For teenagers, disclosure might seem a challenge, but work with adolescents around the world has shown that disclosure to friends, romantic partners and sexual partners can greatly improve the self-concept of HIV-infected teens.

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**What the law says:** National HIV Counselling and Testing (HCT) Policy Guidelines
(Refer to National Department of Health © 2010 for full text)

6.2.4. In terms of confidentiality and privacy, all clients must be assured of the confidentiality of their test records, of the system of record keeping and of their test results:

The results of the client should be documented in the client's file, and may be communicated to other members of health-care team involved in the management of the client, with client’s consent.

Disclosure to sexual partners should be encouraged; however, the decision to disclose should be taken by the person undergoing the test.

According to the National Health Act (Act No. 61, 2003, Section 140):

- All information concerning a client, including information relating to his or her health status, treatment or stay in a health establishment, is confidential.

- No person may disclose any of this information unless:
6.2.5. Shared confidentiality

In most cases, sharing information about HIV status with partner, family, trusted friends and community members and medical staff may benefit the client and their families and should be encouraged where appropriate. However, the counsellor should always take note of the following points:

- Sharing HIV status should always be voluntary and discussed with the client. The sharing or disclosure can only occur with the informed consent of the client, specifying to whom such disclosure may be made.

- Disclosure by service providers should be limited only to those who contribute directly to the client’s care.

- HIV status should never be shared with the client’s employer unless the client specifically requests this action.

- Discussion about sharing confidentiality should explore the barriers faced by the client in disclosing. Where the client is in an abusive relationship, he/she should not be pressurised to disclose to an abusive partner and should be referred to appropriate service providers for support.

7.1.4 Confidentiality regarding HIV test results (in the case of children)

The Children’s Act (no. 38 of 2205, Children’s Amendment Act No. 30 of 2007, Sections 130-133) says that every child has the right to confidentiality regarding their HIV status.

The HIV status of a child may be disclosed with the consent of the child is:

- 12 years of age older, or

- Under the age of 12 years and of sufficient maturity to understand the benefits, risks and social implications of such disclosure.
## MANIFESTO

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In 1998, HIV/AIDS activist Gugu Dlamini was beaten to death near KwaMashu township outside Durban after publicly disclosing her HIV-positive status. Her death, an example of the depth of HIV stigma, shook South Africa. Dlamini’s death almost destroyed her daughter, Mandisa, who was just 13 years old when her mother died. Now 25, Mandisa spoke about her experience as part of this year’s Nkosi Johnson memorial lecture, named for South Africa’s youngest HIV activist who died in 2001, at the SA AIDS 2011 Conference.

“I remember it was December... when my mother came out about her HIV status. She came to me first and said, ‘Mandisa, I will go and tell everyone about AIDS.’ I didn’t know what AIDS was, but my mother went on national TV and told her story. Her friend came over a few days later and said, ‘Let’s go to a party.’ I never saw my mother again.

“When they were [at the party], people said a guy came in and pushed [my mother] outside and asked her, ‘What are you doing here? You want to kill us all?’ Then they [members of the community] started beating her with anything they could find. When they were done, they pushed her down a cliff and they told the neighbour, who was also [HIV] infected and a friend of my mother’s, ‘Go and tell them to come and fetch their dog, we are done with it.’

“I had to go there with [my mother’s] boyfriend to fetch her. We went and looked for help from the neighbours but they wouldn’t because they thought their cars would also be infected and they would die of AIDS.

“I couldn’t go to the hospital until Wednesday and I couldn’t even recognize her because she was so swollen. She had died on Monday.
SESSION 15

Activity 15: Self-esteem – the ‘me’ brochure

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Reminder: The Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

8. Tell the group this activity is about liking ourselves. Link to the Bridge Over the River Model.
9. Tell them that it is about:
   - Something you can’t touch, but it affects how you feel
   - Something you can’t see, but it’s there when you look at yourself in the mirror
   - Something you can’t hear, but it’s there every time you talk about yourself
   - Something called your self-esteem.

10. Ask them if they know what the word self-esteem means. Note answers on flip-chart.
   
   Explain: To help us understand self-esteem, break the term into two words.

   - Self means yourself
   - Esteem (ess-teem) is a big, smart word meaning that you think someone important, or valuing that person.

   You can use the example: “If you really admire your friend’s dad because he works hard and looks after his family, it means you hold him in high esteem. You honour him, you respect him and you look up to him.”

Activity
Didactic input, group activity, lecture and discussion, story, discussion.

Outcomes
Participants gain:

- Awareness of from where self-esteem is / is not created
- Awareness of how they can alter negative input and increase their esteem
- Awareness of the benefits of sharing positive feedback with peers.

Materials
Markers/crayons/coloured pencils, one A4 sheet of paper (preferably coloured) and one paperclip per person.
Handouts:
Now if you put the two words together – it’s easier to see what self-esteem is.

- It’s how much you value yourself and how important you think you are.
- It’s how you see yourself and how you feel about your achievements.
- Self-esteem isn’t boasting about how cool or wonderful you are.
- It’s more like quietly knowing that you are worth a lot, that your opinions matter, that you are a valuable human being.
- It’s not about thinking you’re perfect — because nobody is — but knowing that you’re worthy of being loved and accepted.

11. Hand out markers, a piece of A4 paper, and a paper clip to each participant. Tell them this is a brochure about themselves.

12. Explain the method using the “Me brochure” illustration below as a guideline. It can be passed around if necessary.

Tell the participants to decorate the front flap with their name in any manner they want. Then have them open the brochure and read out the categories to them to list on the inside:
a) My proudest moment  

b) My best feature  
c) My favourite activity  
d) Something I am good at  
e) What I like about myself  
f) What makes me happy  
g) My best achievement/s.  

(Add others if you wish).  

13. After the participants list the categories in their brochure, they should provide an answer. For example: “My proudest moment was when I finished the race.”

14. Tell them that no one else will be looking at these, so they can feel free to write anything, as long as it is a positive thing about themselves.

15. When everyone has completed their brochure, participants fold up the brochure and paperclip it shut.

16. Then ask everyone to pass their brochure to the person on their right. Tell them when they receive the brochure from their neighbour they should note the name on the front and identify the person, then turn it over (never opening it) and write a good comment about that person on the back.

17. If they don’t know the person well, it can be a simple thing like “I like your voice” or it could be a very personal note to someone they know well. These can be anonymous, or people can sign their names.

18. The brochures should be passed all around the circle until everyone has signed each of them and the participants receive theirs back.

19. Allow them to spend 5 minutes quietly and silently reading what people said about them.

20. Ask the group:
   - What was it like to read things others had written about you?
   - Was anyone surprised about what was written?
   - Do any of them need clarification about something they can’t read or don’t understand?
   - Was it easy to compliment (say nice things) about others?
   - Was it difficult to compliment (say nice things) about others?
   - Were you ready to receive compliments?
   - What did it feel like?

21. Discuss further. Explore the “good feeling” when they have been kind to someone. Link this to the development of self-esteem / self-belief based on good values, ethics, etc.

At the end of the discussion encourage everyone to keep their brochure and reread it when they are not feeling too good about themselves.

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**Icebreaker**

**Part B**

1. Here participants will learn more about where self-esteem comes from, through the story of how baby elephants are trained. Handout 15a: Baby Elephants.
2. Read out the following story: how baby elephants are trained.

*Elephants used in the circus or on elephant safaris are trained, at an early age, not to run away. One leg of the baby elephant is tied with a rope to a wooden post planted in the ground. The rope confines the baby elephant to an area determined by the length of the rope. At first the baby elephant tries to break free from the rope, but the rope is too strong.*

*The baby elephant “learns” that it can’t break the rope. When the elephant grows up and is strong, it could easily break the same rope. But because it “learned” that it couldn’t break the rope when it was young, the adult elephant believes that it still can’t break the rope, so it doesn’t even try!*

*Humans operate in a similar way. We learn something about ourselves at an early age and still believe those things when we grow up. Even though it may not be true, we operate as if it is.*

*But the good thing is that humans are born with the ability to make (conscious) choices, an important step in changing how you see (perceive) yourself.*

*Human beings can choose to change things, to make different choices despite being “trained” at a young age.*

3. Now say to the group; “Let’s find out some of the beliefs you learned when you were younger that continue to influence your self-esteem or your belief in yourself.”

4. Ask them to fill in the following worksheet:

5. Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and answer any that may arise.

**Trainer’s notes**

Self-esteem is the way that we feel about ourselves. If we have high self-esteem, we feel good about ourselves, we respect ourselves, we are confident to say what we think and feel clearly and expect people to treat us well.

Ways to develop high self-esteem include praising each other when we do well and say what we like about each other. If someone does something that we don’t like, tell them how we would like them to change in a helpful way as a friend. Don’t tease or mock people in ways that make them feel sad.

Find things that we are good at and remember them when we feel bad about ourselves. Listen to each other and accept each other as special people.

Don’t be too hard on ourselves. We all make mistakes and we can learn from them.

Believe in ourselves, because we can achieve a lot, one step at a time.

You should be familiar with the self-esteem handout below.
Handout: Baby elephants

Year 1 - Walking around tied to the pole

Year 3 - Walking around tied to the pole

Year 3 - Walking around untied - believing that he can’t move away
When you were young, what messages /beliefs about yourself did you get from:

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<th>a. Your mother/ female caregiver</th>
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<td>b. Your father/male caregiver</td>
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<td>c. Sisters / brothers</td>
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<td>d. Friends</td>
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<tr>
<td>e. Teachers</td>
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<td>f. Others</td>
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Ask them: *Do these messages/beliefs help or not help you in increasing your self-esteem?*

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<th>Which of these messages stay in your mind today?</th>
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<td>Which ones support, and which ones take away, your confidence, happiness and satisfaction?</td>
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<td>Are these messages really the truth or are they a belief that comes from thinking about it so often that you believe it is truth?</td>
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<td>Which messages do you want to change to improve your self-esteem?</td>
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<td>Write the new thoughts you choose to believe to support your positive self-esteem, confidence and happiness:</td>
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Keep your completed self-esteem worksheet handy.

The next time you are feeling low self-esteem, unhappy or are judging yourself harshly read your “What I believe worksheet” and identify the beliefs that detract from positive self-esteem. Then create a new belief to boost self-confidence. Notice your attitude change!
Negative messages (if you hear something often enough you can start to believe it) lead to low self-esteem.

We don’t have to believe the negative things we heard while we are growing up and in the present. We can make a decision and change how we see ourselves. Change the negative messages into positive ones.

Change your body language - change the response - it can all start with “actually…”
Self-esteem is the opinion you have of yourself. Self-esteem is a state of mind. It is the way you feel and think about yourself, and it is measured by the way you act. Self-esteem is an internal belief system and how you experience life externally.

Self-esteem is based on your attitude to the following:

- Your value as a person
- Your achievements
- How you think others see you
- Your purpose in life
- Your place in the world
- Your potential for success
- Your strengths and weaknesses
- Your social status and how you relate to others
- Your independence (ability to stand on your own feet).

Why self-esteem is important

Self-esteem isn't like a cool pair of jeans that you want. Self-esteem is knowing inside yourself that you are a worthwhile human being.

A teenager needs to have self-esteem.

Good self-esteem is important because it helps you to hold your head high and feel proud of yourself and what you can do. It gives you the courage to try new things and the power to believe in yourself.

It lets you respect yourself, even when you make mistakes. And when you respect yourself, adults and other teens usually respect you, too.

Having good self-esteem is also the ticket to making good choices about your mind and body. If you think you’re important, you’ll be less likely to follow the crowd if your friends are doing something risky or dangerous.

If you have good self-esteem, you know that you’re smart enough to make your own decisions. You value your safety, your feelings, your health — your whole self.

Good self-esteem helps you know that every part of you is worth caring for and protecting.
Handout: How teenagers get self-esteem

1. It all starts when a child is very young. Babies don’t see themselves in a good or bad way. They don’t worry when they dribble or vomit their food up. They don’t think they look weird when they’re dressed in funny clothes.

2. People around a baby usually help him or her develop self-esteem by encouraging him or her to learn to crawl, walk or talk. When a baby is cared for it also helps him or her feel lovable and valuable.

3. Sometimes babies are not cared for in a loving way and this can make them feel unimportant and unloved when they get older. So it is really important that teens who experienced this learn how to improve their self-esteem.

4. As they grow older they can have a bigger role in developing their self-esteem. For example: doing well in a test or being chosen for the soccer team. These are things children and teenagers can be proud of. Having a good sense of humour or being a kind person, or a good friend are also things to be proud of.

5. A teenager’s family and other people in his or her life — like teachers, teammates, and classmates — can also boost his or her self-esteem. They can help a teen work out how to do things or notice his or her good qualities. They can encourage him or her to try again when something doesn’t go right the first time. It’s all part of growing up, learning to see themselves in a positive way, to feel proud of what they’ve done, and to be confident that there’s a lot more they can do.

6. Remember to help and encourage your peers as well.

What forms your self-esteem?

- Childhood experiences: criticism by parents, caregivers, teachers, peers, your environment, the media, your cultural background, or society in general (negative statements, being rejected)
- What you think you look like physically
- How your personality comes across
- What kind of person you think you are
- What you think others think of you
- How much you like yourself or you think others like you
- If you have a poor self-image, your self-esteem will be low.

What is high self-esteem?

If you have high self-esteem you will be confident, happy and sure of yourself. You will be highly motivated and have the right attitude to succeed. Self-esteem is therefore crucial to you and is the cornerstone of a positive attitude.
What is low self-esteem?

Low self-esteem results from you having a poor self-image (not thinking of yourself in a respectful and honouring way).

If you do not value your achievements you will feel like you have no purpose in life.

Maybe you know teens with low self-esteem that don’t think very highly of themselves or seem to criticise themselves too much. Or maybe you have low self-esteem and don’t always feel very good about yourself or think that you’re important.

Sometimes a child or teen will have low self-esteem if his caregiver doesn’t encourage him enough or if there is a lot of fighting at home. At other times, self-esteem can be hurt in the classroom. A teacher may make a teen feel stupid. A bully might say and do hurtful things.

For some teens, classes at school can seem so hard that they can’t keep up or get the marks they’d hoped for. This can make them feel bad about themselves and hurt their self-esteem. Their self-esteem can improve when a teacher, tutor, or counsellor or friend encourages them, is patient, and helps them get back on track with learning. When they start to do well, their self-esteem will grow enormously.

Ask for help from somebody who you can trust!

Some of us have good self-esteem, but then something happens to change that. For example:

If a young person moves to a new school and doesn’t make friends right away, he or she might start to feel bad.

Young people who are orphaned, from single-parent families, whose parents have divorced or live in conflict may find that this can affect self-esteem. They may sometimes feel unlovable or that the situation is their fault.

A young person who believes they are too fat or too thin may start thinking that means he or she isn’t good enough.

A young person who is dealing with an illness (e.g. diabetes, HIV or asthma) might feel different and less confident than before.

Even going through the body changes of puberty — something that everybody goes through — can affect self-esteem.

Increasing your self-esteem

Everybody feels happy at times and sad at times, but having low self-esteem is not OK.

Feeling like you’re not important can make you sad and can keep you from trying new things. It can keep you from making friends or affect your performance at school.

Having good, strong self-esteem is also a very big part of growing up. As you get older and face tough decisions — especially under peer pressure — the more self-esteem you have, the better. It’s important to know you’re worth a lot.

If you think you might have low self-esteem, try talking to an adult you trust about it. He or she may be able to help you come up with some good ideas for building your self-esteem.
1. Make a list of the things you’re good at.

2. It can be anything from drawing or singing to playing a sport or making people laugh. If you’re having trouble with your list, ask your caregiver or people who know you to help you with it.

3. Add a few things to the list that you’d like to be good at. Your caregiver, teacher or people who know you can help you plan a way to work on those skills or talents.

4. Give yourself three compliments every day. (Don’t just say, “I’m so cool.” Be specific about something good about yourself, like, “I was kind to my friend today” or “I did better on that test than I thought I would.”)

5. Before you go to bed every night, list three things in your day that really made you happy. Make a promise that you will do three kind things tomorrow.

6. Remember that your body is your own; no matter what shape, size, or colour it is. If you are worried about your weight or size, check with your doctor. Remember that there are things about yourself you can’t change. You should accept and love these things — your skin colour, your funny toes — because they are part of you.

7. When you hear negative comments in your head, tell yourself to stop. When you do this, you take the power away from the voice inside that discourages you. Change thoughts by focusing on the positive ones. Change negative thoughts to positive thoughts and actions. (For example, instead of thinking about not being chosen for the team, think about ways that you can improve your particular area of talent.)

8. By focusing on the good things you do and all your great qualities, you learn to love and accept yourself — the main ingredients for strong self-esteem! Even if you’ve got room for improvement (and who doesn’t?), realizing that you’re valuable and important helps your self-esteem to shine.
Handout: Things that you can do to increase your self-esteem

What is self-image?
Self-esteem focuses on how you feel about yourself.

How to improve your self-image

- List things you like about yourself, including your appearance, personality, and skills.
- Change negative thoughts to positive thoughts by focusing on the positive ones.
- Start exercising: you will feel better and look better.
- Remember good things people have said about you and note them down if you want.
- Accept things about yourself that are true and learn to think about them in a positive way.
- Take yourself less seriously and lighten up!
- Accept criticism in a constructive way so you can improve and develop.
- Don’t be limited by your self-image. Step outside of it and break free. It doesn’t have to control you or keep you down. Acting differently will change how others see you and will also help to change your own attitude towards yourself and your abilities.
- Take up challenges positively and surprise yourself!
- Read about things that motivate you.
SESSION 16

Activity 16: Moral behaviour, self-esteem and making the right decisions

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

Activity
Group work, role-play.

Outcomes
Participants:
• Learn about their own moral compass – something inside them that can help guide them towards making a good decision
• Gain enhanced awareness about building self-esteem so that they believe they are worthy of respect
• Develop a sense of pride in themselves
• Gain further insight into being empathic – being able to put themselves into the shoes of others
• Realise that self-esteem can be derived from doing something good.

Materials
Handouts:
16a. Compass, 16b. The good and bad meter and 16c. The devil / angel gauge, 16d. Scenarios

120-150 minutes

1. Tell the group this activity is about moral behaviour, self-esteem and making good decisions.
2. Ask a few participants to volunteer to perform a role-play.
3. Take them aside and discuss the following scenario with them. Explain that one of them to is play William the newcomer, and four or five of them to play some old school friends. Ask them to be really nasty to William. Encourage “William” to play his part as a very shy and insecure newcomer.

Scenario: Out-of-town William

Your group are sitting in playground. You have all known each other for a while now. It’s the start of the second term. A person you don’t know slowly and shyly approaches you. He stands quietly for a while watching you all talking, and then clears his throat and haltingly tells your group that his family has moved from the Eastern Cape and this is his first day at this school. You all look at him, ignore him and then carry on talking to each other. William walks away with his shoulders slumped.

4. Ask the rest of the group to act as observers, observe the following and make notes on the flipchart:
   - Encourage participants to identify with the experiences of William and the group.
   - Imagine that you were one of the group members – how did you feel about behaving this way towards William?
   - Does this kind of thing happen?
   - Do you think it was a good or bad way to behave?
- Why?
- Do you think the group realised that they had made William feel sad?
- How do you think William felt when he first approached the group of friends?
- How do you think William felt when the group shunned him?

5. Write up the feelings expressed on the flipchart.

6. Ask the role-players:
   - How did you feel in behaving this way towards William?
   - Do you think it was a good or bad way to behave?
   - Why?

7. Write their feelings on the flipchart. They can refer to the Feelings Chart in Activity 6.

8. Ask “William”:
   - How did you feel when you first approached the group of friends?
   - How did you feel when the group turned their back on you?

9. Write William’s feelings on the flipchart.


11. De-role the role-play group.

Icebreaker

Part B: Getting in touch

1. Now ask the group to close their eyes and think about a time they knew they did something wrong.

2. Explain:
   - You can’t touch it, but it has a major impact on how you react
   - You can’t see it, but it is there somewhere in your heart
   - You can’t hear it, but it gives you funny feelings that you sometimes ignore.

3. Ask them to think of how they felt inside:
   - Could they give it a name?
   - What is this thing?
   - Is it important?
   - Explore their own interpretation of it.

4. Explain that it is their inner sense of right and wrong – their own internal guideline towards being an honest, honourable and moral person with integrity:
5. Ask the group: “What are honesty, integrity and morality? Let’s call them your moral compass. What is a compass? A compass is a thing that shows the direction (of magnetic north).”

6. Put up the drawing of the compass 16a.

Continue: “So a moral compass is a thing inside your heart that points you in the direction of goodness, kindness, what you know is right and wrong.”

![Compass drawing](image)

Ask: “Do you think that a person knows how to feel in their own heart what is good for them and others?”

7. Now ask them to make a drawing of this “feeling” and calling it their compass for the moment. It can be in the shape of a heart, or a circle or a square, whatever they wish. Encourage them to be creative.

8. Ask: “What is north?” They can fill in “good”, “kind”, etc.

“What is south?” They can fill in “nasty”, “unkind”, “wrong”, etc.

9. Once they have completed their drawings, ask them to stick the drawings up on the wall and encourage them to walk around and to look at all of the drawings.
10. Now ask the group to find a word to describe this feeling of what is good and what is bad. Get them to agree on what the word should be. Some suggestions:

- Conscience
- Moral compass
- Good / bad meter
- Heart prickle
- Higher self
- Inner goodness
- Bad spike
- Prodder
- Goodness meter
- The devil / angel meter.

11. Introduce the idea that the qualities of honesty, integrity and morality can become the core of their decision-making.

12. Explain that honesty, integrity and morality can be called our “moral compass”. If a compass is a thing that shows the direction (of magnetic north) then a moral compass is a thing inside your heart that points you in the direction of goodness, kindness, what you know is right and wrong.


Ask them where their own meter or gauge might sit? In their heart, their stomach, their mind?

14. Invite comment about the angel and devil. Say that now that we know there is thing inside each of us, we need to learn how to use it. Let us imagine that this illustration is their “conscience”, sitting somewhere inside each of them.

*If indicated, link this part of the activity to the spiritual part of their lives and encourage discussion about the possible benefits of strong spiritual connection. Ask them to volunteer some of the personal advantages that their faith has provided. Do not equate spirituality with religious belief: some people express spirituality through religion, others do not. Be careful not to introduce any specific belief system or religion into the discussion, remaining respectful of the enormous religious and cultural diversity in this country. Focus on the essence of ubuntu, present in all religions, that shows itself in treating others kindly, showing concern for them and working for the good of the community.*
15. See Trainer’s notes at the end of this session.

Icebreaker

Part C: Big and small decisions

1. Explain that this part of the activity is to look at how to decide what the right and wrong things are. We know that some decisions you make aren’t so important. For example, you might decide to wear a green T-shirt instead of a red one. That’s a small decision with no serious possible consequences.

But other decisions may involve a choice between right and wrong, and sometimes it’s not easy to know what to do.

2. Divide participants into four mixed groups. Give each group one of the following situations to role-play from 16b. Handout: Scenarios. Allow ten minutes to prepare their role-plays. They may make notes if they wish. Tell them that in each role play half the group wants to do the wrong thing and the other half wants to do the right thing. Each half tries to give strong reasons for their side.

3. Allow each group five minutes to perform their role-plays. After each role-play discuss the results in the big group.

4. You can use the following as guidelines for their answers.
   a) What was the right decision?
   b) What were the possible consequences of the “right” decision?
   c) What were the possible consequences of the “wrong” decision?
   d) What steps did you take to reach your decision?
   d) Was it easy to decide what to do?
5. Allow time for discussion, process feelings and encourage questions.

6. Tell participants that there is a golden rule to use when they aren’t sure what is the right thing to do.

They should stop and think and ask themselves the golden rule question, followed by these questions:

- What does my conscience (that “little voice” inside my head) say about it?
- Could it hurt anyone, including me?
- Is it fair?
- Would it violate (go against) the golden rule? (How would I feel if somebody did it to me?)
- Have I ever been told that it’s wrong?
- Deep down, how do I feel about it?
- How will I feel about myself later if I do it?
- What would adults I respect say about it?

7. Stress that if they still can’t decide they should try to talk it over with someone they trust and respect.

Explain to the group that by imagining what it feels like to be another person in a given situation they are “empathising”. Being able to empathise is one of the main roots of moral behaviour.

- The best rule is still do to others what you would like others to do to you.
- This is empathy. Empathy is identifying with how another person feels.
- A good healthy moral compass is internal. A person knows how to feel in their own heart what is good for them and others.
- The best rule is still do to others what you would like others to do to you. This builds empathy.
- Empathy is the ability to see things from another’s point of view.

8. Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and answer any that may arise.

9. Finally, ask them to try and do something kind every day and ask themselves how it makes them feel. Stress again by performing an act of kindness they can feel really good about themselves.
Trainers’ notes

- Culture and belief systems can play an important role in the support group setting.
- Often, culture, tradition and religious beliefs are lumped together under one heading.
- South Africa is an extremely culturally diverse nation and the subject of traditional belief is complex and sensitive. (“Culture” is a loose and often erroneously used term and caution is needed when ascribing a behaviour / belief to a person’s “culture”).
- To a greater or lesser extent, traditional Africa co-exists with modern Africa, with many people upholding Christian or even eastern doctrines alongside their traditional beliefs, maintaining a compound rather than single belief system.
- Culture is diverse and exciting and allows for really working creatively.
- The needs of the group cannot be adequately met without an understanding of culture and ethnicity.
- Be aware of the different cultures and ethnicities within the group:
  - Always be sensitive
  - Avoid offending
  - Choose words carefully
  - Ask yourself how you would like to be treated!

Ideas for the participants to take home:

- Remember to do at least one kind thing every day.
- Write down that thing.
- Think about how doing that kind thing felt.
- Write down those feelings.
- For a week keep daily records of choices you make that involve deciding between right and wrong. How do you feel about the choices you made? How could you do better?
- Ask a family member or someone you trust and respect to tell you about a time when either they did the right thing and are really glad they did, or didn’t do the right thing and are sorry about it. What would have resulted if they had made the opposite choice?
16a. Handout: Compass
Handout: Good/bad meter
Handout: Angel/devil guage
You pass an empty old house. In front of it there’s a “no trespassing” sign. But the front door is open. You really want to go in and see what’s there. No one is around. What do you do?

A group of teens that you think is really cool are picking on another teen. They want you to join them, and they say you’re a baby if you don’t. You don’t want to be left out, but you think picking on the other teen is unfair. What do you do?

You’re walking home from school, and you’re really hungry because you forgot to bring your lunch that day. You pass by a fruit seller. “They’ll never miss just one apple,” you think to yourself. And no one is looking. What do you do?

Your best friend asks you to help him cheat on a test. He’s never done it before and he promises he’ll never do it again. What do you do?
SESSION 17

Activity 17: The taxi game: choices and consequences

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.
8. Tell the group that this is an activity about young people learning about the different sexual standards and their right to choose whether or not to have sex (decision making, resisting peer pressure, identifying right from wrong).
9. Divide them into small same-sex sub-groups. Ask the sub-groups if they know what “abstinence” means. Allow time for interaction. Make notes on the flip chart and then explain that abstinence means not having sex (abstaining from sex).
10. Then ask the sub-groups what they think “sex with love” means? Allow time for interaction. Make notes on the flip chart and then explain that “sex with love” is the belief that it is OK to have sex as long as you are in a relationship and “in love” with that person. Ask them if they aware of this standard. Explore ideas about being “in love”. Refer to Session 9.
11. Finally ask the participants what they think “sex without love” means. Allow time for interaction and then make notes on the flip chart. Explain that “sex without love” is the belief that you can have sex with anyone without being in a relationship or without any love or affection. Ask them if they aware of this standard.

Remind the group that the Bridge over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

Activity
Group activity. Taxi card game (sexual standards), agree/disagree activity, discussion.

Outcomes
Participants gain awareness:

- About being able to make an informed decision about sexual debut
- About some of the consequences of having sex at a young age
- About the fact that sexual feelings are powerful and can override common sense
- That sex can be coercive
- That alcohol and drugs can influence decision-making
- That sex can be transactional and trans-generational
- That people can be involved in multiple and concurrent partnerships
- That gender relationships play an important part in determining sexual and reproductive health outcomes.

Materials
Pencils and crayons
Handouts:
17a Taxi cards
17b Good and bad things about abstinence
12. Divide participants into three groups. Make sure that there are both boys and girls in each of the groups. Tell them to imagine that they are at a taxi rank. There are three different taxis. The taxis represent the different choices that they can make when going into a relationship. Each of the three groups should discuss the good and bad things about the three taxis. After the exercise they can decide for themselves which of the taxis is the best one for them.

13. The taxis are:
   a. The abstinence taxi (no sex)
   b. The sex with love taxi
   c. The hit and run taxi (sex without love)

14. Hand out the three taxi cards to each of the groups.

15. Hand out flipchart paper and pens/pencils. Ask them to pick one person who will write down their answers and another one who will report back to the large group when they have finished discussing their answers. Ask them to brainstorm answers to the questions and to make a list of their answers on flipchart paper.

16. Paste one taxi card (or signs with taxi names) on the wall in three different parts of the room.
   a. Abstinence (no sex) taxi
      • What is good about abstinence (the advantages)?
      • What is bad about abstinence (the disadvantages)?
   b. Sex with love taxi
      • What is good about having sex when with your partner when you are in love?
      • What is bad about having sex when with your partner when you are in love?
   c. Sex without love taxi (Hit and run)
      • What is good about having sex without being in a relationship?
      • What is bad about having sex without being in a relationship?

17. Allow 15-20 minutes for the groups to brainstorm answers to the questions. Allow each group to present their answers to the large group one at a time. Paste their lists up as each group finishes their feedback. Ask them to decide which taxi they pick and tell them to go and stand under that card.

18. Then ask the following questions and talk about the answers with group:
   a. Abstinence (no sex) taxi
      • How do you feel about people who abstain?
      • How do others feel about people who abstain?
      • What do you think would make a person stop being abstinent (abstaining)?
      • Do you think it is difficult to abstain if all of your friends are having sex and you are the only one who isn’t?
      • How do you think you could stop this from happening?
      • Do you think you may feel bad because your body is saying it wants to have sex and you are not allowing it?
• Are there people in your life who you can talk to about your decision to be abstinent?
• Will they be supportive?

b. Sex with love taxi
• How do you feel about people who have sex when they are in love?
• Do girls and boys have the same understanding of love?
• Is love a deep and vital emotion?
• Does love involve caring?
• Love is just bodies responding – if it feel right it is right. Is this true or not?

c. Sex without love taxi
• How do you feel about people who have sex without love?
• Do you think being drunk makes it easier to have sex with someone you don’t know well?
• Does having lots of different partners at the same time mean you are popular?
• Is it OK to take money or presents in exchange for sex?

Icebreaker (5 minutes)

19. Tell the group this is an activity where they have to decide if they agree or disagree.

Draw a line down the middle of the room. Ask the group to stand in a row on the line.

On one side of the line put up a sign saying “yes”. 
On the other side put a sign saying “no”.

Tell them that you are going to read out some questions. If they agree they must jump to the side of the “yes” sign. If they do not agree they must jump to the side of the “no” sign.

20. Ask the questions one at a time:
• The more partners you have, the more chance HIV and STIs will spread.
• Sex makes a person feel important and grown up.
• Having unprotected sex just once is not risky for your partner.
• If someone pays for sex, they have a right to insist on not using condoms.
• It’s cool to have sex with an older person.
• Alcohol can weaken the immune system of an HIV-positive person.
• Alcohol and drugs can make the person forget to take their medication.
• Alcohol and drug-abuse can lead to unsafe sexual practices such as unprotected sex, multiple partners and sex for drugs.
• If a person is HIV positive, drugs like ”meth”, “tik” and “speed” can affect their ability to learn new information, solve problems and concentrate.

21. Ask the group what they have learnt from this activity and summarise.

Trainer’s notes:

- Many young people have sex without thinking carefully about the results.
- Young people often do not make a decision to have sex. It just ‘happens’ to them in an unplanned way.
- Sex is a very powerful feeling and can overcome people’s common sense.
- Some young people are forced into sex against their will.
- It is very important that young people learn to make strong decisions on whether to have sex or not, i.e. to say a real ‘no’ or a real ‘yes’ when it is right for them.
- Young people may decide to have sex for a number of reasons, including love, desire, power, and money, or to belong to a group.

Abstinence

- Abstinence can be difficult for some people.
- It is good to talk to your partner or friend about your decision to abstain.
- Partners need to be honest with each other and make sexual decisions together. These are some of the best ways to keep a relationship happy.
- It may not be easy to do. You may feel awkward or embarrassed.
- It’s best to talk about your feelings before things get out of control.
- Be well prepared to protect yourself against pregnancy or STIs if you decide to stop abstaining.
- Having sex is not the only way two people can get to know each other.
- People get closer as they build trust.
- Trust is built through talking honestly to each other and respecting each other’s thoughts and feelings.
Staying abstinent

- Staying abstinent is a choice you have to make every day.
- There are ways to help yourself with that choice.
- It’s sometimes difficult being one of the few remaining abstinent when everyone else seems to be having sex.
- Be clear about your reasons to stay abstinent.
- Remind yourself why you choose to be abstinent.
- Think about the consequences.
- If you are in a situation where you experience very powerful feelings that could overcome your common sense and your decision to remain abstinent, try to stick with your decision until you can think about it with a clear head.
- There are no harmful effects that come from being abstinent.
- Boys and girls have sex for different reasons, so they need different ways to avoid sex.
- Find a safe place to talk, where you won’t feel like getting romantic.
- Say, ‘I want to talk to you now, before we go too far.’

Ask yourself these questions:

- Am I sure about why I want to be abstinent?
- Am there any things I can think of that could make staying abstinent difficult for me? Can I avoid them?
- Alcohol / drugs can affect my judgment and allow me to take risks. How do I feel about not using them?
- Are there people in my life I can talk to about my decision to be abstinent? Will they be supportive?

If you decide to stop being abstinent ask yourself these questions:

- Do I have information about other methods of birth control and do I have access to them?
- Do I know how to protect myself from HIV and other STIs?
Background information

Risk behaviour in adolescence

Many of the health behaviours that a young person engages in during his or her adolescent years are likely to continue into adulthood.

The exploration of sexual activity in adolescence often involves risk taking. Adolescents do not always use contraception consistently and properly, increasing the risk of HIV transmission, STIs and unwanted pregnancies. This in turn puts their physical and mental health at risk. Once a young person has sex it is more likely that he or she will continue to be sexually active, with a strong possibility that they will engage in multiple and concurrent partnerships. The Second South African National Youth Behaviour Survey (2008) found that a high percentage of young people had one or more sexual partners over a three-month period.

It is particularly important to educate young, HIV-positive adolescents about healthy behaviours.

Multiple and concurrent partnerships (See also Activity 11)

The term multiple and concurrent partnerships (MCP) means that a person has a number of sexual partners over a certain period of time, for example a month or a year or more. These partnerships can follow each other, one after another. A person can also have overlapping sexual partnerships, when he or she has sex with one person in the same time period as having sex with another person (concurrency). There are many different forms involved, for example a person might have a steady partner ‘small house’ or ‘side partner’. He or she might be involved with intergenerational relations (those involving older men or women) or transactional relationships (sexual relationships for money or material possessions). Whatever the form, when an individual is involved in relationships with two or more people a sexual network develops which may allow HIV to spread very quickly.

In 2007 Soul City looked at the reasons for multiple and concurrent partnerships and found that amongst other things they include a poor understanding of the risks involved in having many sexual partners, cultural and social norms that make it acceptable for a man to have more than one sexual partner at the same time, gender inequality which results in male domination, wanting money or material things, and alcohol and drug abuse.

A challenge for health-care providers is to help young people infected with HIV to think about how just one act of unprotected sex can put many others at risk. Early adolescence is a good time to talk to HIV-positive adolescents about behaviours that benefit others, since they are starting to show more tendencies towards caring for, being concerned about, and helping others. This behaviour increases greatly between childhood and adolescence. This means that guidance in the development of attitudes and beliefs becomes especially important between the ages of 10 and 14 years when the stage is being set for future relationships with sexual partners.
**Transactional sex**

Transactional sex (TS) has to do with the provision of goods or money in exchange for sex. Often it occurs between a young teenage girl and a man much older that she is (sugar daddy), but TS can also be between a teenage boy and an older woman (sugar mommy). When a sexual partner is 10 or more years older than the young person, the relationship is called “intergenerational” (IG) or “cross generational”.

Sometimes a girl can be involved in sexual relationships with more than one man. These relationships often provide a means for young girls to meet a variety of needs, for example living expenses, school and university fees, and items that they could otherwise not afford. When these relationships benefit the whole family, parents and caregivers do not always discourage them. This form of relationship is not the same as prostitution because the relationships last for longer.

The problem with transactional sex is that the sexual rights of girls in these relationships are often disregarded. Because they are receiving goods or money, it is not always possible for them to refuse sex or to insist on safe sex.

> For HIV-positive girls there is a strong risk of re-infection or infection with an STI because there is a higher probability that their older partner, who may have been engaged in many such relationships, will have HIV.

The nature of these relationships is such that many girls are at risk of violence. Researchers have found that girls in TS relationships will find it difficult to negotiate condom use, sometimes fearing that they will be accused of being unfaithful to their partner.

Programmes that address the sexual and reproductive health of adolescents need to think about the kind of social and cultural norms that can lead to TS and IG and should empower girls to make decisions that will not put their health at risk.

**Alcohol abuse**

Sexual exploration frequently involves the use of alcohol and drugs. Because alcohol interferes with a person’s ability to make good judgements there is more chance that they will engage in risky sexual behaviour. In South Africa nearly 1 in 8 learners has had an alcoholic drink before the age of 13 years (Second National Youth Risk Behaviour Survey 2008). Drinking and, in particular, binge drinking, or having more than 5 drinks at one time, has been associated with sexual risk behaviour, for example young people who use alcohol and drugs are likely to have more sexual partners.

Alcohol is also a risk for sexual violence and sexual coercion. It has been associated with inconsistent condom use and increased risk of STIs.
In the case of HIV-positive adolescents, alcohol can weaken the immune system, making the effects of HIV much worse. The more a person drinks the more harm he or she does to the immune system, and the more chance there is that the virus will become stronger and able to make more copies of itself. Alcohol use can also affect antiretroviral treatment (ART) by reducing adherence and causing the medication to be less effective or ineffective. Alcohol misuse may also injure the liver by worsening the toxic effects of ARVs on this organ of the body.

Drug abuse

Injection drug use is when a drug is injected into a person’s tissue or vein with a needle. It also puts young people at risk by affecting their ability to make decisions and leading to unsafe sexual practices such as unprotected sex, multiple partners and sex for drugs. The same applies to non-injection drug use such as crack cocaine.

Young HIV-positive adolescents who take drugs may also damage brain functioning by using these drugs. It has been shown that HIV-positive persons who abuse drugs are more vulnerable to cognitive damage and harm to the nerve cells in the brain, than those who are not infected with the virus. HIV infection and the use of methamphetamines (“crystal meth”, “tik” and “speed”) can cause changes in the brain that may affect a person’s ability to learn new information, solve problems and concentrate.
Handout: Taxi cards a

1. What are the good things about abstinence?

2. What are the bad things about abstinence?
Handout: Taxi cards b

1. What are the good things about sex with love?

2. What are the bad things about sex with love?
Handout: Taxi cards c

sex without love taxi

1. What are the good things about sex without love?
2. What are the bad things about sex without love?

hit and run
Handout: Good and bad things about abstinence

Good things about abstinence

Abstinence:
- Is free and safe
- Allows the person to avoid becoming infected with HIV or infecting others
- Has no medical or hormonal side-effects
- Prevents pregnancy
- Prevents STIs and reduces the risk of infertility or cervical cancer.

Abstinence allows you:
- To wait until you’re ready for a sexual relationship
- To wait to find the right partner
- To have fun with romantic partners without sexual involvement
- To focus on school
- To support personal, moral, or religious beliefs and values.

Bad things about abstinence
- There are very few bad things about abstinence.
- You may feel left out if all your friends are having sex and you are not.
- Your friends may insult you.
- Some boys may see girls who refuse sex as a challenge and force them to have sex.
- You may feel bad because your body is saying it wants to have sex and you are not allowing it.
SESSION 18

Activity 18: Youth friendly services, the law, assertiveness

Suggested method:

1. Welcome and ask participants to sign the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome.
6. Ask the participants to perform the club greeting.
7. Ask the group to if they have any questions about the previous session.

Remind the group that the Bridge Over the River Model teaches us to move from just knowing the facts and having the information to behaviour change, by learning life-skills such as communication, decision-making, thinking, managing emotions, assertiveness, self-esteem building, resisting peer pressure, relationship skills, etc. Linked to self-belief, we gain a heightened sense of what is right and wrong – our moral compass.

Part A

1. Tell the group the first part of the activity is about youth friendly services. Ask the group to think about their experiences of health care workers.
2. Provide Handout 18a and ask participants to complete the questionnaire. Allow ten to fifteen minutes for this task.
3. Explore with participants what else they think would help to make youth services more youth friendly and how they believe the attitudes of unfriendly youth service providers could be changed. Allow time for discussion and provide any answers that might be needed.

Activity

Group work, questions and answers, role-play: assertiveness skills, group presentations followed by discussion.

Outcomes

Participants:

- Share experiences of the attitudes of health care workers
- Gain more information about basic sexual and reproductive health rights
- Gain more skills in asserting their rights with health care workers.

Materials

Handouts:
18a. Q & A Attitudes of health care providers, 18b. The National Adolescent Friendly Clinic Initiative (NAFCI) – Adolescent Sexual and Reproductive Health Rights, 18c. Did you know? and 18d. Did you know? (Make sure the participants get both c and d after the activity), 18e. Scenarios 1-4, 18f. Scenarios 5-8, 18g. Tips for assertive communication 18h. Aggressive, passive and assertive behaviour
4. Ask the group: What do we want from health care providers? Give each participant a copy of 18b. Handout: The National Adolescent Friendly Clinic Initiative (NAFCI) – Adolescent Sexual and Reproductive Health Rights Then ask participants to take turns to read out one sentence. Break after each sentence to answer any questions, clarify and discuss if needed.

5. Answer any more questions that arise and allow further time for discussion using the following points to facilitate creative input, interaction and understanding:

**Trainer’s notes: Service providers and their attitudes towards youth**

A number of young people speak of the abusive and judgemental treatment by service-providers when seeking sexual and reproductive services.

Many service providers do not understand the psychosocial context in which adolescents live. It should be a priority for these providers to receive training in communication and counselling skills. They should be empowered with a clearer understanding of the specific health needs of adolescents, including the risks of early pregnancy, susceptibility to HIV and other STIs, and the unique factors that influence decisions about contraceptive measures. This might go a long way towards ensuring they provide a higher quality of care to their young clients.

Furthermore, the quality of care given to youth may increase substantially when providers understand cross-cultural issues of adolescent development.

Most adolescents do not have a clear idea of what their rights are, what the law says, nor do they have the skills to assert their rights.

**Part B: About the law**

1. Divide the participants into two groups.

2. Tell the group that this part of the session will provide a very brief overview of some of laws and rights regarding sexual and reproductive issues, but that the law is complex.

3. Stress to the group that the law is complex as there are contradictions (saying two opposite things) that can make the law very unclear and confusing. For example:
   - One law says children can access sexual health services from age 12 years, but another says sex under age 16 years is illegal.
   - One law says a girl can get an abortion at any age but another law says if she has had sex under the age of 16 years she is breaking the law.

The law might change as well. Participants should always get legal advice if they are unsure about anything to do with the law and to speak to a lawyer to clarify any legal questions.
4. Give sub-group 1 handout 18 c – Statements, and sub-group 2 18d – Statements

5. Tell sub-group 1 to read out their first statement (a). Allow time for questions and discussion after each of the laws and rights have been read out.

6. Tell sub-group 2 to read out their first statement (d). Allow time for questions and discussion after each of the laws and rights have read out.

7. Continue alternating in this manner until all the statements have been read.

8. Now ask the group if they have a basic grasp of some of the legal and rights issues they might need to know.

❄️ Energiser / break

Part C

1. Ask the group which of the life skills they might need to change the attitudes of unfriendly health providers. Prompt if necessary and provide them with the answer – exploring what their understanding of “assertiveness” is.

2. Explain that this part of the session involves a relationship-skills game called “Learning about assertiveness”. Ask the participants to form two lines, facing each other.

3. Each participant touches palms with the participant facing him or her in the other line. Call one side Line One, and the other Line Two.

4. Ask all the participants in Line One to start pushing against the person in Line Two, using only their palms.

5. Participants in Line Two can respond in any way they like.

6. After 30 seconds or so, ask everyone to stop and to change roles.

7. This time Line Two members should push against Line One members, and Line One members can respond as they choose.
8. After another 30 seconds or so, ask everyone to sit down in a big circle. Ask people how they felt doing this exercise:
   - Did they respond by pushing back (aggressive) or by giving in (passive)?
   - How does this relate to their real-life experiences of conflict?
   - Do they back down and accept, or do they push back strongly?
   - Ask them to decide (for this activity) to choose whether they are either a passive or aggressive personality.

9. Tell them to make two groups, red and green. (Red is aggressive and green is passive.)

10. Now ask them to discuss in their groups the difference between passive and aggressive.

*Explain: When some people are criticised or insulted or disrespected, they say nothing or feel intimidated (too shy) to speak up. This is passive behaviour.*

   In other words, a lot of people give in to the criticism or react strongly without focusing on the message. These behaviours do not make the person feel better about themselves or others.

   A loose definition of a passive personality type or response: Not letting people see your emotion or feeling, not responding to something that might cause a reaction. Keeping silent or still, not saying or doing anything in response to something that might be expected to produce a reaction/emotion / feeling.

   In contrast, some people react strongly and emotionally, become angry and loud or even insulting. This is aggressive behaviour.

   A loose definition of an aggressive personality type or response: competitive, wanting to win or succeed, forceful, assertive pushy, not being shy. Attacking, vigorously energetic.

11. Ask the red team (the aggressive team) to demonstrate an aggressive response (using body language and voices) to the following statement: “You must get out of the room now!”

12. Now ask the green team (the passive team) to demonstrate a passive response (using body language and voices) to the following statement: “You must get out of the room now!”

13. Discuss the two different responses.

   If either of the groups is not represented, the facilitator can role-play the two different responses.

14. Now ask the participants what they think ‘assertiveness’ means. List their answers on the flipchart.

15. Explain assertiveness.

   Assertive behaviour is not aggressive or passive. It is somewhere in the middle. Being assertive is not just about expressing your rights; it is also about better communication with others, and helping others to understand you. Assertiveness skills can be used in most situations.

16. Explain that there are quite a few ways they can express themselves to achieve this aim. Take participants out of the red and green groups and split them into four smaller sub-groups.

   38. Read out the starter sentences below, and then demonstrate how assertive sentence formulations can help participants express themselves assertively and assist them in building confidence when dealing with rude, unfriendly or aggressive people:
• “I don’t want you to …”
• “I want to …”
• “Would you …”
• “When you do … I feel …”
• “I have a different opinion. I think that …”
• “When you … I feel … because …”
• “I have decided not to …”
• “I will not …”

17. Hand out one scenario (18e) to each of the sub-groups. Ask them to work together and prepare a response using one of the assertiveness starter sentences. Allow a few minutes for this. Explain that by getting used to using the starter sentences, they will have a better idea of approaching a situation assertively, rather than passively or aggressively.

18. Stress to the sub-groups that ideally they should respond assertively with confidence, calmly and with good reasoning. It is therefore important to stop and think before responding, and to remember that these skills take time and practice to develop. Suggest that the sub-group members practise with each other.

19. Remind them about body language and the messages they give if their body language indicates something different from their words.

Give them each handout 18f. Handout: Tips for assertive behaviour to which to refer.

20. Allow each sub-group to present their response after reading out their scenario.

21. Get the participants to role-play practising assertive responses in same-sex pairs, followed by mixed-sex pairs.

22. If there is sufficient time the Handout 18e: Scenarios 5-8 can be handed out.

• Get the participants to role-play practising assertive responses in same-sex pairs, followed by mixed-sex pairs.
• Get the participants to role-play practising assertive responses in same-sex pairs, using the legal statement followed by mixed-sex pairs.
• Ask the group what they have learnt from this activity. Make notes on the flipchart. Allow questions and clarify.

**Trainer’s notes (Part C)**

**Examples of possible assertive responses:**

1. “I don’t want you to feel let down, but I really have to leave now – I’ve promised to help my friend organise his party and it’s important to him that I help him. I certainly will be available to assist you next time.”

2. “Would you call Dr Smith please? I have an appointment and I am entitled to see him. It is four o’clock, the practice only closes at 5, and I have been waiting for two hours with bad tooth-ache.”

3. “When you leave the door open I feel shy that people will see me in my underwear, so please close it.”

4. “I have decided not to go in the car with you because I’m scared about driving with you when you have been drinking.”
What the law says

A. Condoms

The law says: “No person may refuse to sell condoms to a child over the age of 12 or provide a child over the age of 12 with condoms on request where (such) condoms are provided or distributed free of charge.”

B. Abortion (termination of pregnancy)

The law says: Abortion is legal in South Africa and regulated in the same way as all other medical procedures.

It is law in South Africa that a girl can request a TOP up until the 12th week of pregnancy without parental consent. From 12 to 20 weeks there are other criteria that need to be in place for TOP to take place.

At present a girl of any age may request an abortion, but the law may change.

C. Rape and HIV/PEP

The law says: A victim of rape is entitled to receive free post-exposure prophylaxis (PEP) to protect him or her from the risk of HIV infection.

The law says: A victim of rape can apply to court to force (compel) the rapist (perpetrator) to undergo a HIV test and to be told (informed) of the result of such a test, whether the rapist tested negative or positive.

Always remember the window period.
Note PEP should be take as soon as possible after the rape for maximum effectiveness – within 72 hours.

D. Sexual offences and children

The law says: In terms of section 54 of the Act, knowledge of a sexual offence that has been committed against a child must be reported to the police immediately and failure to do so constitutes an offence and a fine or imprisonment for a period not exceeding 5 years may be imposed upon conviction of such a person.

The National Register for Sex Offenders aims to prohibit persons who have previously been convicted of a sexual offence against a child, from working with children again.

E. The child social grant

Adolescents need to be 16 years of age or over to apply for a child grant for their own child or younger sister or brother.

The Social Assistance Act 13 of 2004 defines a ‘primary caregiver’ as a person 16 years or older.

F. Sex

The law says: Currently, it is an offence to have sex below the age of 16 years, even when sex is consensual. This means that if one or both of the persons engaged in consensual sex are below the age of 16 years, they are committing a criminal offence.
1. What is your experience of the attitudes of health care providers?

2. Tick the statement if you agree. All health care workers:

<table>
<thead>
<tr>
<th>Statement</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Should always communicate openly and in a friendly manner</td>
<td></td>
</tr>
<tr>
<td>Should always welcome everybody regardless of age, marital status, gender and sexual orientation</td>
<td></td>
</tr>
<tr>
<td>Should always be trained in adolescent issues</td>
<td></td>
</tr>
<tr>
<td>Should always give you enough time during your appointment</td>
<td></td>
</tr>
<tr>
<td>Should always show respect to young people (and others too)</td>
<td></td>
</tr>
<tr>
<td>Should always maintain your privacy</td>
<td></td>
</tr>
<tr>
<td>Should always maintain confidentiality</td>
<td></td>
</tr>
</tbody>
</table>
3. **Tick again if you agree.** All health care workers when asked:

| Should provide information on reproductive health |
| Should answer your questions about your body |
| Should answer your questions about anything you ask |
| Should explain about conception and pregnancy |
| Should explain about termination of pregnancy |
| Should refer you for counselling if needed |
| Should explain about contraception |
| Should explain about STIs/HIV/ARVs |

4. What else do you think would help to make youth services more youth friendly?

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5. How could the attitudes of unfriendly youth service providers be changed?

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A young person irrespective of age, sex, race, religion, culture, social status, mental and physical ability has basic health rights. These include:

1. The right to information on health
2. The right to a full range of affordable health services
3. The right to privacy when receiving health care
4. The right to be treated with dignity and respect when receiving health care
5. The right to be assured that personal information will remain confidential
6. The right to be given an explanation of the processes that the young person goes through when receiving health care. (In other words, an explanation of what their treatment or procedures might involve)
7. The right to be treated by people who are trained and knowledgeable about what they do
8. The right to continuity of services (that their service will be continued)
9. The right to be treated by a named provider (ensuring that the health care provider is part of the health system)
10. The right to express views on the services provided and to complain about unsatisfactory health services
11. The right to gender equality
12. The right to a healthy and safe environment
13. The right to make free informed choices in matters relating to sexual expression, sexual pleasure and sexual orientation.
Handout: Did you know?

A. Condoms

Anybody aged 12 years or above may get (access) condoms without consent.

B. Abortion (termination of pregnancy)

A girl of any age who has fallen pregnant can request an abortion.

C. Rape and HIV / PEP

A survivor of rape is entitled to receive free post-exposure prophylaxis (PEP) to protect him or her from the risk of HIV infection.

A survivor of rape can apply to court to force (compel) the rapist (perpetrator) to undergo a HIV test and to be told (informed) of the result of such a test, whether the rapist tested negative or positive.
D. Sexual offences and children
All sexual offences committed against children must be reported to the police. If you are aware of an offence committed against any child, you must report this to the police immediately. If you do not report such an offence you could be imprisoned or pay a fine.

E. The child social grant
Adolescents need to be 16 years of age or over to apply for a child grant for their own child, or a younger sister or brother.
1. You have made plans to go to your best friend’s birthday party. Your teacher asks you to stay late to help her with marking. You usually accept these requests as you want to be on good terms with your teacher, but today you really want to go early to help your friend prepare. You decide to be assertive and refuse for once.

2. The person at the desk tells you that the dentist has left – you have bad tooth-ache and been waiting for two hours. The consulting hours end at 5.00. It is 4.00 and you overheard her telling her friend she is going to go home early. You decide to be assertive and refuse to leave.

3. You have developed an itchy red bump at the top of your leg. You go to the clinic to find out what it is. The nurse insists you take off your jeans and show her the bump and the door to the passage is open. You are embarrassed that someone will see you. You decide to be assertive and say no.

4. Your uncle is supposed to take you home after the soccer game. It is obvious he has been drinking. He is slurring his words and falling over. He tries to make you get into the car but you don’t feel it is safe to drive with him. You decide to be assertive and say no.
5. A person of the opposite sex asks you to go to a party with him or her. You don’t know anyone who is going, which makes you feel a little uncomfortable. You have also heard that this person uses drugs and does not have a very good reputation at school. You decide to be assertive and say no.

6. You are talking to a number of your friends. Most of them have had sex and are teasing you about the fact that you have not. One member of the group hurts your feelings by saying something inappropriate. You decide to make an assertive reply.

7. You decide to get your ears pierced. Your friend tells you that you can get it done at a place in town. You go to the place, but it does not look very clean. You have heard about infections and getting HIV/AIDS from unclean needles. You decide to ask the person if the needles are clean and to see the equipment used for cleaning. The person won’t show you, but insists that the shop is very clean and safe. The person urges you to get the procedure done. You decide to say no assertively.

8. A friend of your family asks if you want a lift home after school. You do not feel very good about this person, and you feel uncomfortable about the situation. You decide to be assertive and refuse the lift.
Use “I statements” to focus the conversation on you and not on blaming others.

Examples:

- “I feel hurt” rather than “You hurt me”.
- “I don’t agree” rather than “You are wrong”.
- “I feel ignored” rather than “You don’t care”.
- “I am treated unfairly” rather than “You are so unfair”.

Say “No” when you want to mean it. The word “No” is quite powerful, so use it.

Deliver your message to the person that matters, not to everyone else but the person.

If you don’t understand the other person, ask them to explain. Don’t assume or interpret what they said. A wrong interpretation can make you upset and you may then react strongly, while the other person is probably going to react to as well. This is because they really didn’t say what you thought they said and this can easily lead to a whole new conflict.

If you want to say “No”, you can make it seem less harsh by offering alternatives if the situation lends itself. This suggests that you are at least sincere.

When a person interrupts you whilst you are being assertive you might use the following sentences to continue getting your point across:

1. “Please let me finish what I am saying.”
2. “Please don’t stop me until I’m finished.”
3. “That’s fine, but please listen to what I have to say.”
4. “I know you think … but let me finish what I was saying.”
5. “Thank you, but …”

When a person tries to persuade you to change your mind, there are three possible ways to deal with this:

1. Refuse
2. Delay
3. Bargain
Some examples of what to say when someone tries to persuade you:

1. Refuse
Say no clearly and firmly, and if necessary, leave.
- “No, no, I really mean no.”
- “No, thank you.”
- “No, no — I am leaving.”

2. Delay
Put off a decision until you can think about it.
- “I am not ready yet.”
- “Maybe we can talk later.”
- “I’d like to talk to a friend first.”

3. Bargain
Try to make a decision that both people can accept.
- “Let’s do … instead.”
- “I won’t do that, but maybe we could do … ”
- “What would work for both of us?”
Aggressive behaviour

- Expressing your feelings, opinions, or desires in a way that threatens or punishes the other person
- Standing up for your own rights with no thought for the other person
- Putting yourself first at the expense of others
- Overpowering others
- Reaching your own goals, but at the sake of others
- Dominating behaviours – for example: shouting, demanding, not listening to others; saying others are wrong; leaning forward; looking down on others; wagging or pointing finger at others; threatening; fighting, using body language that shows a fighting attitude.

Passive behaviour

- Giving in to the will of others; hoping to get what you want without actually having to say it; leaving it to others to guess or letting them decide for you
- Taking no action to assert your own rights
- Putting others first at your expense
- Giving in to what others want
- Remaining silent when something bothers you
- Apologizing a lot
- Acting submissively — for example: talking quietly, laughing nervously, sagging shoulders, avoiding disagreement, hiding face with hands, using body language that shows submissiveness.

Assertive behaviour

- Telling someone exactly what you want in a way that does not seem rude or threatening to them
- Standing up for your own rights without putting down the rights of others
- Respecting yourself as well as the other person
- Listening and talking
- Expressing positive and negative feelings
- Being confident, but not “pushy”
- Staying balanced — knowing what you want to say; saying “I feel” not “I think”; being specific
- Acting assertively – for example: using “I” statements; talking face-to-face with the person; no whining or sarcasm; using body language that shows you are standing your ground, and staying centred.
## Evaluation Form 1

Name of group:  

Name of member:  

Date:  

At first I did / did not want to join this group because ....

The thing I liked most about the group was ....

The thing/s I did not like about the group was/ were ....

Should every HIV-positive adolescent join a group like this?

Why?

If I could change something about this group it would be ....

I learned new things about ....

The best thing I leaned about myself was ....

The most important thing I learned in this group was ....

I would have liked to learn more about ....
Evaluation form 2

Name of group: ...........................................................................................................................................................................................

Name of member: ....................................................................................................................................................................................

Date: ...................................................................................................................................................................................................................

Read out the following questions and ask group members to put their X in the agree, disagree or not sure column.

<table>
<thead>
<tr>
<th></th>
<th>AGREE</th>
<th>DISAGREE</th>
<th>NOT SURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I joined the group I was happy</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I liked being with other boys and girls who were HIV infected</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I learnt a lot about myself in the group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I learnt a lot about sexual and reproductive health</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I will be able to make good decisions as a result of being in this group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I enjoyed being part of a group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The questions that I had have been answered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The person/people who ran the group helped me to learn about my body and many other things</td>
<td></td>
<td></td>
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</tbody>
</table>
The pre- post-course evaluation

In order to gauge the extent to which the objectives of the sexual and reproductive health club have been met (i.e. helping HIV positive adolescents to build knowledge and understanding of sexual and reproductive health), facilitators may want to develop an evaluation tool. Alternatively they can use a simple questionnaire, such as the one below. This can be administered at the club’s first meeting to assess baseline knowledge and again at the closing, to assess if knowledge about SRH has increased.

**Answer True or False**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. HIV positive girls can infect others more easily if they have sex when they are having their period</td>
<td></td>
</tr>
<tr>
<td>2. Masturbation is a safe alternative to sex</td>
<td></td>
</tr>
<tr>
<td>3. The law says that children can only have sex if they are 16 years or older</td>
<td></td>
</tr>
<tr>
<td>4. A girl can get pregnant before she has her first period</td>
<td></td>
</tr>
<tr>
<td>5. A person can have more than one sexually transmitted infection at the same time</td>
<td></td>
</tr>
<tr>
<td>6. A person will always know straight away if they have a sexually transmitted infection</td>
<td></td>
</tr>
<tr>
<td>7. STIs can cause girls and boys never to be able to have children of their own.</td>
<td></td>
</tr>
<tr>
<td>8. Boys are the ones who should make decisions about having sex</td>
<td></td>
</tr>
<tr>
<td>9. Teenage pregnancy can put the life of the mother and her baby at risk</td>
<td></td>
</tr>
<tr>
<td>10. Gender based violence is about violence by a boy towards a girl</td>
<td></td>
</tr>
<tr>
<td>11. Violence in relationships can have many health consequences</td>
<td></td>
</tr>
<tr>
<td>12. Puberty when your body begins to change happens at the same for everyone</td>
<td></td>
</tr>
<tr>
<td>13. It is more important to look after your own sexual health that to worry about infecting others with HIV</td>
<td></td>
</tr>
<tr>
<td></td>
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### Model answers

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<td>HIV positive girls can infect others more easily if they have sex when they are having their period.</td>
<td>T. Menstrual blood contains the HIV virus</td>
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<td>2.</td>
<td>Masturbation is a safe alternative to sex</td>
<td>T. Masturbation is a completely normal and very safe alternative to sexual intercourse</td>
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<td>3.</td>
<td>The law says that children can only have sex if they are 16 years or older</td>
<td>T. 16 is the age at which a child is considered by law to be capable and mature enough to consent to sex</td>
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<td>4.</td>
<td>A girl can get pregnant before she has her first period</td>
<td>T. Although not common, some girls ovulate before their first menstruation</td>
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<td>5.</td>
<td>A person can have more than one sexually transmitted infection at the same time.</td>
<td>T.</td>
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<td>6.</td>
<td>A person will always know straight away if they have a sexually transmitted infection.</td>
<td>F. People can have no signs of an STI at first, especially girls. If you suspect you might have an STI you should see your doctor, get a diagnosis and treatment and tell your partner</td>
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<td>7.</td>
<td>STIs can cause girls and boys never to be able to have children of their own.</td>
<td>T. There are many complications associated with untreated STIs including infertility in males and females</td>
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<td>8.</td>
<td>Boys are the ones who should make decisions about having sex</td>
<td>F. This should be decision that is made jointly. A girl’s decision not to have sex should always be respected.</td>
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<td>9.</td>
<td>Teenage pregnancy can put the life of the mother and her baby at risk</td>
<td>T. The risk of dying from pregnancy-related factors is 5 times higher for a girl 10-14 years old than for a young woman in her twenties. The babies of very young adolescents often have low birth weight and are born prematurely</td>
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<td>10.</td>
<td>Gender based violence is about violence by a boy towards a girl.</td>
<td>T. The most common form is intimate partner violence, such as dating violence, when girls are forced or coerced into sex.</td>
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<td>11.</td>
<td>Violence in relationships can have many health consequences.</td>
<td>T. Physical injury and emotional problems like depression are just some of the consequences of violence in relationships.</td>
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<td>12.</td>
<td>Puberty when your body begins to change happens at the same for everyone.</td>
<td>F. When changes begin and how quickly they happen varies from person to person</td>
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<td>13.</td>
<td>It is more important to look after your own sexual health that to worry about infecting others with HIV.</td>
<td>F. It is important to safeguard your sexual health, but you also to think about the risk of infected a sexual partner with HIV.</td>
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<td></td>
<td>T. Just like anyone else, HIV positive adolescents should be able to enjoy safe and satisfying sexual relationships, knowing that should they want to start a family one day, they can do so under the guidance of healthcare professionals.</td>
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<td>It is OK for an HIV positive adolescent to have unprotected sex with an HIV positive person because both people are infected with the virus.</td>
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<td></td>
<td>F. There is a danger of re-infection with a different strain of the virus. This can cause the disease to get worse very quickly and may also lead to drug resistance.</td>
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<td></td>
<td>F. These strong feelings are normal, but acting on them before a person is physically, emotionally or socially ready can have many consequences. For example, when sexual intercourse &quot;just happens&quot; it can result in hurt, rejection and shame.</td>
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<td></td>
<td>F. A person has AIDS, rather than being HIV positive, when their CD4 count drops below a certain level or when they develop one of a particular group of opportunistic infections.</td>
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<td>18.</td>
<td>Self-esteem has to do with what a person thinks of him or herself.</td>
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<td></td>
<td>T. A person with low self-esteem tends to think negative thoughts like &quot;I am no good,&quot; a person with high self-esteem feels that he or she has value and worth.</td>
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<td>19.</td>
<td>Sexual abuse can mean that a person touches you without your permission in a sexual way.</td>
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<td></td>
<td>T. Sexual abuse is the violation of a boy or girl without his or her consent. There are many forms of sexual abuse, such as rape, touching in a sexual way, or showing a child pornographic material.</td>
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<td>20.</td>
<td>Drinking too much liquor can harm the immune system and make the effects of HIV much worse.</td>
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<td></td>
<td>T. The more a person drinks the more she or he damages the immune system and the more chance there is that the virus will get stronger. It can also impair judgement resulting in a risky behaviour decision.</td>
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<td>Safe sex means that young HIV positive adolescent take responsibility for avoiding the spread of HIV and other STIs.</td>
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<td>T. It means making sure that contact with the bodily fluids of your partner is avoided. This means wearing a condom during vaginal, oral or anal sex.</td>
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<td>22.</td>
<td>It doesn't matter if you miss taking your antiretroviral therapy a few times.</td>
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<td></td>
<td>F. You need to take your treatment as prescribed if you want to stay strong and healthy. The medication is necessary to stop the virus reproducing and to bring it down to levels where it cannot be picked up in blood tests. HAART also preserves the immune system. When doses are missed the virus replicates again and the viral load increases.</td>
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<td><strong>23.</strong> If infected with STI's both partners need to be treated.</td>
<td><strong>T.</strong> If only one partner gets treatment, he or she will be re-infected if unsafe sex occurs.</td>
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<td><strong>24.</strong> Empathy (a skill we develop during adolescence) is the ability to put ones' self in the shoes of another person and try and feel what they are feeling.</td>
<td><strong>T.</strong> Empathy is the ability to put ones' self in the shoes of another person and try and feel what they are feeling. A person who is highly aware can identify how another person feels. This is called empathy and is the cornerstone of truly understanding others.</td>
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<td><strong>25.</strong> Any girl can choose to have an abortion.</td>
<td><strong>T.</strong> It is law in South Africa that a girl can request TOP up until the twelfth week of pregnancy without parental consent. From twelve to twenty weeks there are other criteria that need to be in place for TOP to take place.</td>
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<td><strong>26.</strong> It is good for a boy and a girl in a relationship to talk to each other freely about their feelings, thoughts and what they would like.</td>
<td><strong>T.</strong> Friendships and love between boys and girls would be happier and safer if they were able to talk to each other more freely about their feelings and thoughts and what they would like.</td>
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<td><strong>27.</strong> MCP stands for Member of the Cape Parliament.</td>
<td><strong>F.</strong> Multiple concurrent (sexual) partners.</td>
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<td>- Simplified:</td>
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<td>- Multiple: many</td>
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<td>- Concurrent: within the same time period or overlapping</td>
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<td>- Partners: people you are having sex with</td>
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<td><strong>28.</strong> If someone makes sexual remarks in your company, this could be called sexual harassment.</td>
<td><strong>T.</strong> Sexual harassment may include any unwanted physical, verbal or non-verbal conduct - from unwanted comments and unwanted touching to sexual assault and rape. Because there are so many subtleties (as in the case of coercion), many young people don't realise that they are being sexually harassed, nor do they realise they have any rights.</td>
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<td><strong>29.</strong> Performing a kind act towards another person can make you feel good about yourself.</td>
<td><strong>T.</strong> Try it and see.</td>
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<td><strong>30.</strong> When you feel uncomfortable inside that your behaviour is hurting someone, you should still carry on behaving in that way.</td>
<td><strong>F.</strong> The best rule is still do to others what you would like others to do to you. Ask yourself how you would feel if someone was doing it to you.</td>
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Rachel Jewkes, Mzikazi Nduna and Nwabisa Jama.Stepping Stones - Adapted from the original Stepping Stones manual by Alice Welbourn. Edition III


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