



WGNRR Africa Youth SRHR Academy

Youth Sexual and Reproductive Health and Rights (SRHR) Training Toolkit
**BUILDING CHAMPIONS' SKILLS ON GENDER,
SEXUALITY, SRHR AND HUMAN RIGHTS**



AMPLIFYCHANGE



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ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
AYFS	Adolescent and Youth-friendly Services
CSE	Comprehensive Sexuality Education
ECs	Emergency Contraceptive Pills
FAM	Fertility Awareness Method
FGDs	Focus Group Discussions
GBV	Gender Based Violence
HF	Health Facility
HIV	Human Immune Virus
IUD	Intrauterine Device
JMP	Join Monitoring Programme
KIVIDEA	Kigoma Vijana Development Alliance
MHM	Menstrual Hygiene Management
MM	Maternal Mortality
RUT	Reaching the Unreached Tanzania
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health Rights
STIs	Sexual Transmitted Infections
TAWEA	Tanzania Women Empowerment Association
TDHS	Tanzania Demographic Health Survey
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNCRPD	United Nations Convention on the Rights of Persons with Dis-abilities
WGNRR	Women's Global Network for Reproductive Rights
WHO	World Health Organization
YFS	Youth-Friendly Services

ACKNOWLEDGEMENT

WGNRR Africa is implementing the Youth SRHR Academy in Tanzania, a training program aimed at building the basic understanding of young people¹ on issues related to gender, sexuality, sexual and reproductive rights, and human rights and their interconnections. Through funding from Amplify Change, WGNRR Africa has developed this toolkit to respond to the capacity needs expressed by young people aged 15 -21 years on the above-mentioned issues and equip them with knowledge and skills that will increase their ability to advocate for their SRHR and counter associated stigma and misconceptions.

WGNRR Africa acknowledges with much appreciation the efforts invested in this work by the “Reaching the Unreached Organization (RUT)” in leading the whole process of assessing the capacity needs of adolescents in four provinces² of Tanzania and tailoring this toolkit to the needs expressed by the young people. We also acknowledge the substantive inputs and contributions of local partners, namely Salama foundation, Wadada Solutions on Gender Based Violence, Kigoma Vijana Development Alliance (KIVIDEA), Haki Zetu Tanzania, Tanzania Women Empowerment Association (TAWEA), Binti Salha and Salama Foundation. Their invaluable support in mobilizing youth and coordinating the Focus Group Discussions (FGDs) process was of great importance.

Our heartfelt appreciations are also extended to the WGNRR Africa program team which coordinated the draft and review of this toolkit until its completion.

Our appreciations would not be complete without mentioning and thanking AmplifyChange fund that enabled the accomplishment of this important work.



¹ Young people in this document is used interchangeably to refer adolescent and youth aged 15 – 21 years old

² The four provinces include Dar-es-salaam, Dodoma, Mwanza and Kigoma

ABOUT THIS TOOLKIT

One of the most difficult aspects in implementing SRHR programmes in Tanzania is being explicit about sexuality and related topics as such concepts are taboos. This means that the programme materials and facilitators need to be sensitive in addressing openly issues such as sex before marriage, menstruation, abortion, condom use, taboos and abuse in a positive and non-judgmental way. The information should be factual and not value based. All information should be tailored to the target group, taking into account age, literacy level, ethnic background, gender and the country context.

A situational analysis on the SRHR of young people aged 15 – 21 in four regions of Tanzania, i.e. Mwanza, Kigoma, Dodoma and Dar es Salaam concluded that there is a huge gap among young people in terms of knowledge, attitudes and practices around their SRHR. The Focus Group discussion with young people in 6 districts of Tanzania, namely Kigamboni and Temeke (Dar-es-salaam), Dodoma Municipal council (Dodoma), Magu and Ilemela (Mwanza) and Kigoma Municipal and Kasulu Town Council (Kigoma) revealed that – misconception around contraceptives, HIV/AIDs and Abortion is rampant among young people; sexuality and abortion are taboo topics in their communities and surrounded by stigma; - it's difficult for young people to access SRH services and information due to existing inadequate youth friendly services; young people lack advocacy skills to influence policies, norms and practices that affect their SRHR; and that – caregivers invest inadequate efforts to educate young people on sexual and reproductive health matters.

It is against this background that WGNRR - Africa developed this training toolkit that draws on the national manual for health service providers on adolescent and youth friendly reproductive health and adds targeted advocacy skills modules to empower young people in the process of fostering their leadership in advancing their SRHR in Tanzania.

Objective of the Toolkit

This toolkit has been designed with a double objective of:

1. Equipping adolescents and youth with basic knowledge and skills on issues related to SRHR, human right, sexuality and gender and their interconnections in order to advocate for full access to youth friendly SRHR information and services., and
2. Serving as a guide for young people when influencing their SRHR agenda to caregivers (parents, guardians), service providers, and teachers.

Expected Outcomes

It is expected that young people who participate in the full training using this toolkit will:

1. Have understood the concept of gender, sexuality, reproductive rights, and human rights and their interconnections.
2. Have developed positive attitude that promotes respect for human rights, including SRHR of young people and have demonstrated increased empathy for young people seeking SRH services and information.
3. Be able to describe the different barriers young people encounter when seeking for SRH services and advocate for young people's full access to SRHR.

4. Have prepared a personal action plan for advancing SRHR of young people in their own communities.

Audiences

While the primary audiences for this toolkit are youth advocates, trainers, administrators, program managers, health and technical advisors of young people's SRHR training programmes, some materials can also be used to engage a variety of stakeholders, including community groups, grassroots advocates and women's groups involved in youth SRHR programmes in Tanzania. Because this was developed based on the needs expressed by young people aged 15 – 21 years old in Tanzania, content and activities were also tailored to Tanzania specific context and to meet the needs of young people with no or little experience in the field of SRHR. However, the content can also be adapted to fit other countries' context and to meet the specific needs of young people of the same age in those countries.

How to Use the Manual

This toolkit is based on a training philosophy that emphasizes principles of participatory learning and prioritizes active participation. The training activities and their accompanying materials were designed according to adult learning principles to facilitate active engagement, knowledge and skills acquisition for a range of learning styles. In order to be effective in achieving specific session's objectives. However, facilitators should be able to adapt the sessions to suit various target groups and situations as they see fit.

Module objectives and any recommended preparatory work are detailed at the beginning of each module as a guide for facilitators. Each session includes a brief overview, the objectives, the time and materials required and detailed instructions, questions for reflection and key message This encourages participatory learning and builds confidence amongst participants.

Toolkit Structure

The toolkit is divided into five modules that covers following topics:

Module One Creates a safe and supportive learning environment including expectations, check ground rules, pre-assessment and values clarification exercises; and introduces the concepts of puberty and adolescence, physical and emotional changes, and menstruation.

Module Two focuses on basics of SRHR, sexuality, Gender and, Human Rights concepts and their interconnections.

Module Three addresses barriers to young people's access to SRHR i.e. lack of information, myths, misconception and attitudes around SRHR of young people.

Module Four introduces the concept of Advocacy for SRHR of young people including generalities, why advocacy is important, who can be advocate, what can we advocate for and advocacy action planning.

Participant and Workshop Considerations

Number of participants and room layout: These activities were designed with a time frame

that is based on an average number of 24 participants per workshop. Because many of the activities are designed for small group work, an ideal physical layout for the room is clusters of 6-8 people per table.

Training methods and materials: Facilitators will need to read the toolkit in advance to familiarize themselves with the content and references. Facilitators can cover the content using PowerPoint slides, participant handouts and materials and activities that are facilitated according to the included instructions. The PowerPoint slides are not sufficient when used alone because they do not cover all of the content. In addition, using only the lecture method is strongly discouraged as it significantly decreases participants' learning and retention. Instructions for flip charts are included for facilitators who prefer them to PowerPoint slides.

Evaluation and follow-up: Sample pre- and post-workshop surveys are included and can be used to assess initial knowledge, comfort levels and attitudes on SRH care for young people and discern changes from the beginning to the end of the workshop. Facilitators should review the surveys in advance and make any changes to reflect the content that will be covered in that workshop. A sample workshop evaluation form is also included to measure participant satisfaction against the objectives and suggestions for improvement.

Agenda: Facilitators should create a tailored agenda that meets the time and specific objectives for each session of the workshop. The Agenda shall however include Values Clarification activities adapted specifically to address values and attitudes of young people around abortion and sexuality.





MODULE 1
YOUNG PEOPLE
AND PUBERTY

MODULE 1 YOUNG PEOPLE AND PUBERTY

(5 hours, 45 minutes)



KEYWORDS: *Values Clarification and Attitude Transformation, Puberty, Menstruation, Menarche, Menstrual Hygiene Management, Menstrual Cycle, Fertility, Taboo, Social Norms, Stigma*

MODULE OBJECTIVES

This Module introduces the process undergone by growing girls and boys toward sexual maturation. It addresses biological or physical transformations; psychological and emotional development of adolescents that lead to the achievement of fertility and the development of sex characteristics. However, in facilitating potentially sensitive SRHR content, it is essential to foster a safe and confidential atmosphere and supportive learning environment amongst the participants.

Specifically, the module covers the topics of key elements to consider in setting up a safe and supportive learning environment, puberty, physical and emotional change, menstruation and risk behavior for young people during puberty.

By the end of this module, participants will be able to:

1. Understand the necessity of fostering a safe and supportive learning environment and agree to monitor themselves according to agreed group norms. Understand the biological, physical and emotional changes that occur during their development; menstruation and fertility.
2. Identify factors influencing adolescent sexual behavior.
3. Outline consequences of unsafe sexual activity among young people.
4. Understand the menstrual cycle and its management
5. Challenge taboos, social norms, and stigma around fertility and menstruation.

Materials Needed

- PowerPoint presentation
- Exercise handouts

SESSION 1.1.

CREATING SAFE AND SUPPORTING LEARNING ENVIRONMENT

(2 hours, 30 minutes)

Session overview

This session addresses the key elements to consider in setting up an environment that is inclusive, challenging, caring, engaging, and interactive; one that enables participants to feel comfortable sharing ideas and opinions, and participating in activities and discussions on sensitive topics such as condoms, menstruation, sexuality and abortion. Also, it will help to

establish ground rules that provide a safe and supportive learning environment and helps prevent uncomfortable or embarrassing situations for the facilitators and participants.

SESSION OBJECTIVES

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

1. Articulate their expectations for the workshop.
2. Describe the workshop goal, objectives and agenda.
3. Identify facilitators' and participants' role and responsibilities.
4. Foster a safe and supportive learning environment and agree to monitor themselves according to agreed group norms.

Materials Needed

- Flipchart and sticky notes
- Markers
- Prepared flipcharts with workshop goal and objectives, workshop agenda, facilitator roles, participant roles and group norms
- Labeled flipchart with workshop expectations and parking lot
- List of group norms
- Evaluation materials, such as pre- and post-workshop surveys, workshop evaluation forms, daily evaluations and suggestion box
- Icebreaker materials

Activity 1.1. Workshop Introduction (60 minutes)

A. Welcoming and Setting the Ground (20 minutes)

Welcome participants to the workshop and solicit their expectations; orient them to the workshop goal, objectives and agenda, facilitator, participant roles and group norms; and invite them to provide ongoing evaluation of the workshop. The aim is to create a safe and supportive learning environment that enables facilitators and participants to achieve the workshop objectives.

Objectives

1. To welcome and introduce participants and facilitators
2. To provide the general overview of the workshop

Materials Needed

- An opening remark (if any)
- Flipcharts
- Marker Pen
- Handouts

Procedures

1. Welcome participants and introduce the workshop. Thank them for their attendance.
2. Introduce yourself and provide some information about your facilitation experience and background in the youth SRHR field.

3. Ask participants to introduce themselves by their names and which partner organization they come from.
4. Post the prepared flipchart labeled Workshop Goals and Objectives, review and discuss with participants.
5. Post the flip chart labeled Workshop Expectations and solicit participants' expectations for the workshop. Write them down exactly as they express them on the flipchart.
6. Post the flip chart labeled "Workshop Agenda" and review the main agenda items with participants. Discuss possible changes that can accommodate participants' expectations.
7. Identify which of their expectations are likely to be met during the workshop and which are not likely to be met. For those that fall outside of the scope of the workshop, plan to provide additional resources or other means for participants to meet those needs.
8. Post the flipchart labeled Parking Lot and discuss it. Explain that when topics arise during a training session that the group doesn't have time to address at that moment, or that would be better addressed at a later time, facilitators write them on the Parking Lot flipchart, which means they are set aside to be discussed later in the course.
9. Discuss facilitators' roles and responsibilities.
10. Post the flipchart labeled Facilitators' Roles and share expectations about your roles, including:
 - Providing information and feedback to participants
 - Asking and answering questions
 - Facilitating discussions and activities
 - Making sure the group stays on task and on time
 - Modeling effective training techniques
 - Maintaining a safe and productive learning environment
11. Ask participants to share other roles that facilitators should play during the workshop and add them to the flipchart. Remind participants that you welcome feedback about your facilitation.
12. Remind participants that you will not have answers to all the questions that arise. Emphasize that you will facilitate the group working together to find answers to most questions. Participants have valuable skills and experience to share, and they will learn much from each other during the workshop.
13. Discuss participants' roles and responsibilities.
14. Post the flipchart labeled Participants' Roles and share your expectations about their roles, including:
 - Participating fully according to one's comfort level
 - Taking responsibility to ensure personal learning goals are met
 - Sharing knowledge and experiences with facilitators and other participants
 - Giving constructive feedback to facilitators and other participants
15. Ask participants to share other roles that they should play during the workshop and add them to the flipchart.



TIPS FOR FACILITATOR

- Please ensure that resources are made available or easily accessible to participants, taking into account the need for confidentiality and/or anonymity.

- Respect confidentiality, except where it is required by law to disclose information (e.g., child abuse, protection issues, sexual abuse and dangerous situations). This needs to be made clear to the participants.
- Be prepared for varied responses from participants in reaction to sexual material (e.g., interest, sarcasm, uncontrollable giggling, embarrassment, shyness, bragging, making fun of others)
- Show an understanding for participants who come from varied backgrounds (cultural, religious, moral) and sexual experiences (e.g. dealing with STIs, survivors or offenders of sexual acts, teenage parents).
- Tell the participants that they might have questions during the session that they are afraid to raise in front of their peers and friends. Let them know that they can write questions anonymously and place these in a Question Box that has been set up especially for the session. Questions can be answered after each session, or when appropriate.

B. Knowing Each Other Well (Diversity Bingo) (20 minutes)

Objectives

1. To get to know the individual participants.
2. To introduce the concept of diversity and recognize the diversity present in the group.

Materials Needed

- Bingo card
- Pen
- Flipchart

Procedure:

Individual Exploration (10 mins)

1. Pass out bingo cards one to each participant.
2. Explain to the group that this is a fun way of getting to know each other.
3. To complete their bingo card, they need to move around the room, speak to other participants and get them to sign their name against a square on the bingo card that applies to them.
4. Explain that each square must be signed by a different individual.
5. The first person to get signatures on all the boxes on their bingo card should shout "BINGO"!

Group Sharing (10 mins)

1. Bring the group back together and ask volunteers to share answers to the following questions:
 - How did you decide which square to sign on someone else's paper?
 - Did anyone feel that they could have signed all or most of the squares?
 - Which squares did you find hardest to fill?

2. Ask the participants to reflect on:
 - What did they learn about themselves doing this activity?
 - What did they learn about other participants doing this activity?



TIPS FOR FACILITATOR

1. Ask participants to brainstorm a list of rules and values they think will make the training programme more successful.
2. Explain that group norms are mutually agreed upon and they serve to:
 - Set guidelines for how the group will work together
 - Create a safe, respectful and productive learning environment
 - Enable tasks to be accomplished efficiently
3. Write these rules on a flip chart or chalkboard. Feel free to add any important rules that participants may have omitted. These rules should be kept visible during all sessions and referred to as needed throughout the programme.
4. Establish Ground Rules, such as:
 - Participants have the right to “pass” on activities/questions that feel uncomfortable
 - It is all right to feel embarrassed or not to know answers to everything
 - Everyone’s opinions are to be respected
 - All questions will be addressed appropriately
 - Be discreet about group discussions (i.e., no gossiping)
 - Speak for yourself. Use “I statement” to state opinions or feelings
 - Respect others’ differences
 - Questions are encouraged and may be asked at any time. There is no such thing as a stupid question.
 - Things shared will be kept strictly confidential. They will not be discussed outside the group
5. Ask participants to add more ground rules.

C. Expectations and Hesitations Check (20 minutes)

This is an introductory activity that can be completed as an icebreaker at the beginning of a workshop or day’s sessions and then revisited at the end as one form of evaluation. This activity helps participants identify their expectations (or hopes) and hesitations (or concerns and discomforts) for the workshop and whether there is a change in these feelings as a result of the training they have undergone. The activity allows facilitators to identify additional expectations participants have and address any concerns about the workshop topic and contents.

Procedure

1. Introduce the activity as an opportunity to discuss what participants expect to gain from the workshop or day’s sessions and what concerns or discomforts they may have about the workshop and

2. On a flipchart, write the following statements:
 - *My overall expectation for this workshop is ...*
 - *Right now, I feel hesitant about ...*
 - *I am concerned about being asked ...*
 - *I feel uncomfortable discussing ...*
 - *During the workshop, I hope that I will be able to ...*
 - *At the end of this workshop, I hope that I ...*
3. On another flipchart, write the headings “Expectation” and “Hesitations” in separate columns.
4. Give each participant a stick card. Post the flipchart with the statements. Ask participants to take five minutes to silently read the statements and write their responses on their stick card.
5. Instruct participants to pair with the person sitting next to them and discuss for five minutes the responses they feel comfortable sharing with their partner. Remind them that they do not have to discuss any responses they do not feel comfortable sharing.
6. Ask participants to share with the large group one expectation or hesitation and record these on the flipchart labeled Expectations and Hesitations as each person speaks. Write the responses exactly as they are stated. Remind participants that they may decline to share a response if they do not feel comfortable.
7. Remind participants to refrain from commenting on or evaluating anyone’s response.
8. After everyone who wants to has contributed, add your expectations for the workshop that were not mentioned by participants. Ask for one or two overall comments about the entire list of expectations and hesitations (not any one person’s response).
9. Acknowledge that you will do your best to meet the group’s expectations. Generally, explain which agenda items should meet certain expectations and which may be beyond the scope of the workshop. Record the latter items on the Parking Lot flipchart, if appropriate.
10. Reassure participants that you will discuss how they might meet these expectations in other ways outside of the workshop.



TIPS FOR FACILITATOR

Close this session by asking participants to write down the reasons for their motivation to be part of the YAS Academy project as SRHR champions, and to reflect on their personal capacity to undertake peer education and community advocacy activities over the course of the year (to help ensure proposed activities are within their capacities etc.). These reflections and motivations will be re-visited at the end of the workshop.

Activity 1.2. SRHR & Values Clarification Activities (90 minutes)

The purpose of this session is to help participants be speaking from a personal point of view, identifying their own beliefs on sensitive and most tabooed SRHR topics as well as understanding the issues from another point of view.

Overview

Often, our beliefs about SRHR and specifically abortion and sexuality are so ingrained that we are not fully aware of them until we are confronted with situations and compelling arguments that challenge them. This activity helps participants to:

- Articulate personal beliefs, identify the values that influence their current beliefs and attitudes about SRHR sensitive issues, specifically abortion and be able to describe alternative values and their consequences
- Distinguish between assumptions, myths and realities surrounding SRHR and explain the correct information on SRHR
- Explore how values are formed, how personal beliefs affects societal stigma and vice versa and how the sociocultural context surrounding unwanted pregnancy and abortion and the tragic outcomes that can result from restricting access to safe abortion.

The session is composed of 4 activities which are not compulsory. However, the facilitator has to choose those compatible and adapt to her/his audience and context.

Objectives

1. To achieve greater self-awareness of one's own feelings, values and beliefs about SRHR, specifically on abortion, and greater clarity in areas of contradiction, uncertainty and commitment.
2. To achieve greater understanding of empathy with those whose views on SRH differ from one's own and discover new ways to be heard by those with whom we differ.

Exercise A. Agree/Disagree/Unsure (60 minutes)

Activity Objectives

1. Articulate their beliefs about sexual and reproductive health and rights and abortion
2. Defend and respectfully explain other, sometimes conflicting, points of view
3. Explain different values underlying a range of beliefs on SRHR and abortion
4. Discuss how personal beliefs affect societal stigma or acceptance of abortion

Materials Needed

- Signage: Agree, Disagree, Unsure
- Value Statements (refer to annex # 3)

Procedure

1. Explain to participants: this is an activity where we'll be speaking from a personal point of view; in order to get the most out of the activity, encourage participants to be completely honest.
2. Explain activity to participants, emphasizing that if at any time they don't feel comfortable expressing their opinion, they don't have to.
3. Read out loud the various value statements, giving time for participants to go to the side of the room that reflects their answer.
4. If time allows, give interested participants a chance to explain why they chose the side they did (and/or for other participants to respond).

5. Following the exercise, debrief with the following discussion questions:
 - Any particular statements you want to discuss? Or response to a certain statement?
 - What observations do you have about your own responses to the statements?
 - All of the statements (except for one) were framed in general terms. But what do you think would have happened if we framed the questions more personally? How would that have changed answers (e.g. Some people believe that women in general should not be allowed to freely access abortion services, but change their opinion about to access abortion services if they personally or a family member need them).
6. Wrap up activity by emphasizing
 - Abortion is indeed often a very personal and sensitive issue; personal views about it differ from person to person sometimes we ourselves can have uncertain feelings about it, or even contradictory feelings or double standards about it, and it's important to acknowledge that.
 - BUT the reality is that women worldwide, regardless of whether it is legal in their country or not, have abortions, for many different reasons.
 - Approximately 44 million pregnancies worldwide end in voluntary termination each year, occurring even in restrictive or illegal settings
 - Next activity will further explore these various reasons.

Exercise B. Values as a social construct (15 minutes)

Activity Objective

1. To know how values are formed

Materials Needed

- Manila Paper
- Pen
- Colored Paper

Procedure

1. Write an example of a "value" related to sexuality and reproductive health that was said by your: 1 – Family; 2 – Peers; 3 – School; 4 – Religion; 5 – Mass Media.
2. Draw a box and –
 - Place it inside the box if you hold dear to it
 - Place it outside the box if you don't believe in it
 - Place it at the edge of the box if you're confused
3. Discuss how values are formed

SESSION 1.2.**YOUNG PEOPLE AND PUBERTY**

(3 hours, 15 minutes)

SESSION OVERVIEW

This session introduces the process undergone by growing girls and boys toward sexual maturation. It addresses biological or physical transformations; psychological and emotional development of adolescents that lead to the achievement of fertility and the development of sex characteristics. Specifically, the module covers the topics of puberty, physical and emotional change, menstruation and risk behavior for young people during puberty.

SESSION OBJECTIVES

By the end of this module, participant will be able to:

1. Understand the biological, physical and emotional changes that occur during their development; menstruation and fertility.
2. Identify factors influencing adolescent sexual behavior.
3. Outline consequences of unsafe sexual activity among young people.
4. Understand the menstrual cycle and its management
5. Challenge taboos, social norms, and stigma around fertility and menstruation.

Materials Needed

- PowerPoint presentation
- Exercise handouts

Activity 1.2: Puberty (60 minutes)**Introduction and Purpose of the activity**

The purpose of this activity is to build young people's understanding of the biological, physical and emotional changes that occur in their bodies during their growth and development. Through this session, young people will be aware of the concept of puberty, its stages, factors influencing puberty, Adolescents' Sexual behaviors and challenges and how to develop positive sexual behaviors.

**TALKING POINTS**

- Puberty as a period of body and emotional changes during human development
- When puberty starts
- Factors influencing puberty
- Stages of puberty
- Adolescent sexual behaviors
- Outcomes of risky behavior and how to overcome them

A. Basic Facts

Definition

Puberty refers to the physiological changes that occur in early adolescence (sometimes beginning in late childhood) which result in the development of sexual and reproductive capacity. It is the period during which growing boys or girls undergo the process of sexual maturation. Puberty involves a series of physical stages or steps that lead to the achievement of fertility and the development of the so-called secondary sex characteristics, the physical features associated with adult males and females (such as the growth of pubic hair). While puberty involves a series of biological or physical transformations, the process can also have an effect on the psychosocial and emotional development of the adolescent³. Physical growth and development manifest in a growth spurt during which there are marked changes in the size and shape of the body.

When Puberty starts (Global and National trends)

There are big individual differences in the onset and progression of puberty, or the physical changes associated with adolescence. There are also gender differences.

Globally, the onset of puberty varies among individuals. Puberty usually occurs in girls between the ages of 10 and 14, while in boys it generally occurs later, between the ages of 12 and 16.

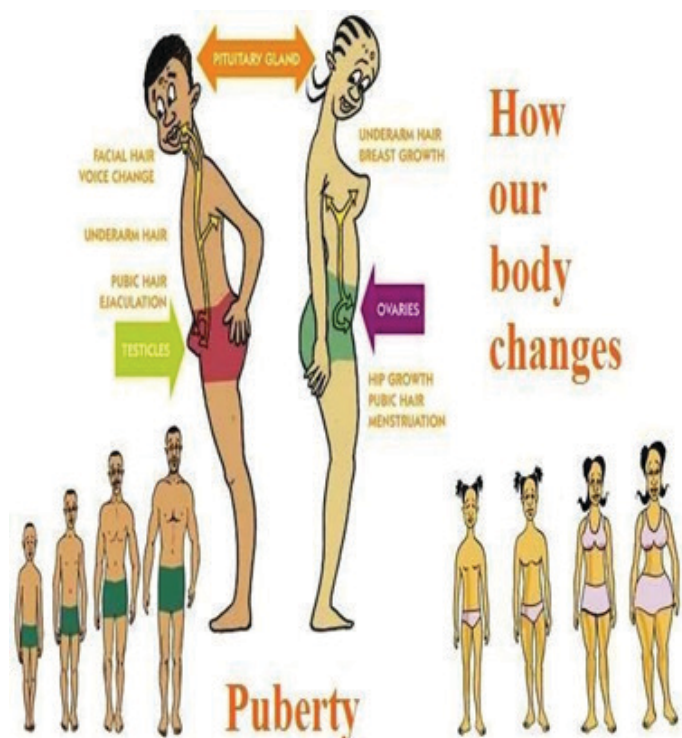
Adolescent girls reach puberty today at earlier ages than were ever recorded previously. Nutritional and other environmental influences may be responsible for this change. For example, the average age of the onset of menstrual periods in girls was 15 in 1900. By the 1990s, this average had dropped to 12 and a half years of age.

In Tanzania, puberty begins earlier, at about age 9, meaning that puberty occurs from ages 9 to 14.

While the onset of puberty in males takes place between 9-14 years of age; females experience the initial pubertal changes between 8-13 years of age.

Sexual and other physical maturation is a result of hormonal changes. In boys, it is difficult to know exactly when puberty is coming.

Girls also experience puberty as a sequence of events, but their pubertal changes usually begin before boys of the same age. Each girl is different and may progress through these changes differently.



³ <http://www.healthofchildren.com/P/Puberty.html#ixzz6JsItLRdW>

B. Factors Influencing Puberty



TALKING POINT

The age at which puberty begins can vary widely between individuals and populations. Age of puberty is affected by both genetic factors and environmental factors such as nutritional state or social circumstances.

Stages of Puberty

The body changes that happen during the process of puberty have a typical pattern in both boys and girls, with a generally predictable sequence of events. These sequences of changes in puberty have been characterized by physicians and is referred to as sexual maturity rating (SMR) or Tanner stages. These changes are both physical and emotional.

Group work: Own Pubertal Changes (OPC) Exercise

Procedure:

1. Divide participants into groups of 5 young people each (boys only and girls only).
2. Ask them to describe the noticeable changes that occurred on their bodies and emotions during the period between 9 to 20 years of age. If possible let them try to classify the changes according to number of ages (i.e from 9 -11, around 12, 13, 14 and 15 years).
3. Ask participants to discuss the changes that occurred at a specific age and agree on key changes at each stage.
4. Convene them in a plenary and ask each group to present starting by male groups
5. Fill the Tanner stages tables on the flipchart when groups are presenting.
6. Allow clarification adds on from group peers and allow questions, comments and feedback from other participants.
7. Conclude the activity by stressing the following talking points:

Physical Changes:

For girls:

- In most girls, the first sign of puberty is the beginning of breast development (breast buds), which occurs at an average age of approximately 11 years.
- In girls, the growth of pubic hair typically begins after breast development, followed by the growth of hair in the armpits.
- A minority of girls, however, begin to develop pubic hair prior to breast development.
- The onset of menstruation (having periods) usually happens later than the other physical changes and usually occurs around two and a half years after the onset of puberty.
- A regular pattern of ovulation, corresponding to achievement of fertility, usually develops rapidly once a girl begins having menstrual periods (the onset of menstruation or first period is known as menarche). However, girls who have a later onset of menstruation (after age 13) tend to have lower rates of regular ovulation in the years following the onset of menstruation. Studies have shown that one-half of adolescent girls who first begin to menstruate after age 13 will not ovulate regularly over the next four and a half years.

For boys:

- In boys, an increase in the size of the testicles is the first change observed at the onset of puberty.
- Enlargement of the testicles begins at an approximate average age of 11 and a half years in boys and lasts for about six months.
- After enlargement of the testicles, the penis also increases in size.
- Enlargement of the testicles and penis almost always occurs before the development of pubic hair.
- The next stage is the growth of pubic area hair and hair in the armpits.
- Next, the voice becomes deeper and muscles increase in size.
- The last step is usually the development of facial hair.
- Fertility is achieved in males near the onset of puberty, when a surge in testosterone triggers the production of sperm.

Emotional Changes:

Both boys and girls can experience emotional changes that accompany the myriad physical changes of puberty. These changes are not the same for all adolescents. Changes can occur in the way a teen responds to family or friends and views him- or her. Many adolescents are self-conscious and may experience mood swings, anxiety, confusion, and sensitivity. On the other hand, not all emotional changes of puberty are related to negative thoughts or feeling upset. Puberty is also a time in which the young person learns about his or her own interests and goals and learns to relate to others in a more mature way. While some emotional changes are a normal part of puberty, it is important to seek medical help if these emotional changes are unusually severe, affect day-to-day functioning, or result in thoughts of harming oneself or others.

Refer annex number 1 for Tanner Stage

Activity 2.2: Sexual Behavior of Young People During Puberty (60 Minutes)

Introduction and Aim of the activity

This session explores the development of sexual behavior among young people, identifies factors influencing sexual behaviors of young people, and addresses the risks and consequences associated with irresponsible sexual behaviors. At the end of this session participants will be able to: - describe how sexual behavior is influenced during puberty, outline the risky sexual behaviors and their outcomes and; lay down the possible ways to develop responsible and positive sexual behavior.

A. Exploring Sexual Activity Among Young People

Group work : Cross the Line Exercise (30 minutes)

This activity adapted from the Ipas Abortion VCAT toolkit is often used as an icebreaker to bring participants' different views and experiences on sexual activity to the surface and address the connection between sexuality and stigma. It helps participants understand how sexual behaviors develop and how stigma affects people's diverse views and experience with sexuality, as well as broader public dialogue on sexuality.

Objectives

By the end of this activity, participants will be able to:

1. Articulate their feelings, views and experiences on sexuality
2. Identify diverse views and experiences among participants;
3. Describe how stigma affects individual and societal views and reactions to sexuality of young people.

Materials Needed

- Masking tape or string, approximately 2-3 meters long, to mark a line on the floor. If neither tape nor string is available, ask participants to pretend that there is an imaginary line across the floor.

Advance Preparation

Clear a large area of the room to allow participants to move around, and place the line in the middle of this area.

Review and adapt statements, if needed. Select in advance the statements you will read that most apply to that group of participants. It is advisable to end with a statement upon which you think all participants can agree, such as the last one in the handout.



TIPS FOR FACILITATOR

1. Ask all participants to stand on one side of the line.
2. Explain that you will read a series of statements and that participants should step entirely across the line when a statement applies to their beliefs or experiences.
3. Remind participants that there is no "in between," which means they must stand on one side of the line or the other, and there are no right or wrong answers.
4. Ask participants not to talk to each other during the exercise unless they need clarification or do not understand the statement that is read.
5. Stand at one end of the line and give an easy practice statement, such as: Cross the line if you had fruit for breakfast this morning.
6. Once some people have crossed the line, give participants an opportunity to observe who crossed the line and who did not. Invite participants to notice how it feels to be where they are.
7. Ask someone who crossed the line and then someone who did not to briefly explain their response to the statement. If someone is the only person who did or did not cross the line, ask them what that feels like.
8. Invite participants to all move back to one side of the line.
9. Repeat this for several of the statements about sexuality.
10. After the statements are read, ask participants to take their seats.
11. Discuss the experience. Some discussion questions may include:
 - How did you feel about the activity?
 - What did you learn about your own and others' views and experiences on sexuality?
 - Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel

- What did you learn from this activity
 - What does this activity teach us about the stigma surrounding sexual activity?
 - How might stigma affect young people's emotional experience with sexuality? How would it affect young people's family members?
 - How might stigma impact the experience of health workers and providers working in youth SRH care?
12. Debrief in particular the last statement. If everyone in the group crossed the line, discuss this commonality. If everyone did not cross the line, discuss how these different views affect people's work on SRH care for young people and the broader social climate for sexuality in that setting.
 13. Solicit and discuss any outstanding questions, comments or concerns with the participants.
 14. Thank the group for their participation.

Refer Annex number 2 for cross the line statements

B. Development of Sexual Behavior During Puberty



TALKING POINTS

- In Tanzania, traditional cultures that allow early marriage is a factor in influencing sexual behavior.
- The reach of mass and social media (including television, WhatsApp, YouTube, Instagram) and the growing reach of the internet can influence sexual behavior of young people.
- Adolescent and youth are coerced into having sex (Trafficking, sexual exploitation, etc.).
- In many cultures, girls lack the power, confidence, and skills to negotiate safe and protected sex.

During adolescence, the physical growth, psychological as well as cognitive development reaches its peak. During adolescence, an individual's need for intimacy and love making with opposite gender increases. Adolescents explore different appropriate ways to express love and intimacy. However, this natural need becomes a behavior when influenced by different factors.

Factors Influencing Young People Sexual Behavior

Adolescent sexuality development can be better explained with the bio-psycho-social model. Biological factors, psychological factors, as well as social factors have equal importance in determining the development of sexuality in adolescents.

1. Biological factors include the genetic factors and those related to nervous and endocrine systems, which determine the biological sex and also having an influence on the psychological sex. During adolescence hormones such as progesterone, testosterone and

many other hormones play a role in causing the onset of puberty. The secondary sexual characters are expressed due to this neuro-endocrinol influence.

2. Psychological factors include an individual's personality or temperament, which also decides the attitude toward sexuality. Introvert adolescents face difficulty in approaching and responding sexually.
3. Social factors or environmental factors also play a significant role in the development of adolescent sexuality. The attitude of the parents toward sexuality, parenting style, peer relationship, cultural influences are the important social factors which facilitates the sexual learning and decides the sexual attitude of the adolescent.

Other than the biological, psychological, and social factors, many more factors such as political, legal, philosophical, spiritual, ethical, and moral values and media significantly influence sexuality development. In recent decades, there is an exponential growth in media coverage worldwide. Tanzanian Adolescents access literature related to sexuality, sexual crimes, and violence through media which affects their perception and attitude toward sexuality. Similarly, television, internet also exposes the adolescents to literature and movies with sexuality content, influencing their perception about sexuality.

C. Risky Sexual Practices and Related Outcomes to Young People

Adolescence, the period in particular between 10 and 24 years involves sexual experimentation that may lead to negative health outcomes such as acquisition of sexually transmitted infections (STIs) and unplanned pregnancies.

The risky sexual practices in this age group may include:

- Early sexual debut
- Having multiple sexual partners
- Engaging in unprotected sexual intercourse
- Engaging in sex with older partners and
- Consumption of alcohol and illicit drugs

Several studies done in sub Saharan Africa, including Tanzania, have shown a high prevalence of STIs including HIV among young people, with females having higher prevalence compared to males. Reasons for higher susceptibility of females have been found to be multifactorial and include biological, economic and social demographic factors; mixing patterns among sexual partners, the age difference between male and female sexual partners, with males seeking sexual gratification from younger females and peer pressure. In contrast, most studies have indicated that male youth have a higher number of sexual partners than females.

Outcomes of risky sexual behaviors include but not limited to

- STIs and HIV contamination
- Early pregnancies that mostly end up in unsafe abortions
- School drop out
- Early marriage
- Early motherhood and single parenting
- High rate of adolescent maternal mortality and morbidity

D. Supporting the Development of Positive Sexual Behavior Among Young People

- ★ Provide adolescents and Youth Opportunities to Build Social and Emotional Competence: Adolescents and youth with strong social and emotional competence are less likely to engage in risky behaviors related to aggression, substance use, and sexual risk taking. Skills related to social and emotional competence include communication skills, emotional awareness, peer-refusal skills and emotional regulation. These skills promote positive social development in multiple ways. They assist youth in developing close friendships, having positive peer relations, engaging in positive social behaviors (and selecting and attracting friends with positive behaviors), and avoiding negative social influences.
- ★ Making our communities Safe and Supportive for young people's SRHR: Adolescents and youth who live in safe, supportive communities are less likely to use drugs, exhibit aggressive behavior, commit crimes, and drop out of school.
- ★ Promote the Development of Sustained Relationships with Caring Adults: Adolescents and youth who report that they have positive relationships with adults and those who receive mentoring in the context of a long-term supportive relationship are more likely to succeed on multiple fronts.



TALKING POINTS

Talking with adolescents and young people about positive principles for sex helps them to:

- Reject sexual activities, habits, conversations etc. that could harm themselves or others.
- Choose sexual activities that are positive and safe for themselves and the other person.
- Come to you if something is bothering them
- Develop positive sexual self-esteem

Avoiding discussion on sexual behaviors increases the chances that they will:

- Hide things from you that are hurting them
- Develop harmful ideas, behavior and practices about sex
- Give in to pressure to behave in ways which harm themselves or others

Activity 2.3: Introduction to Menstruation (75 minutes)

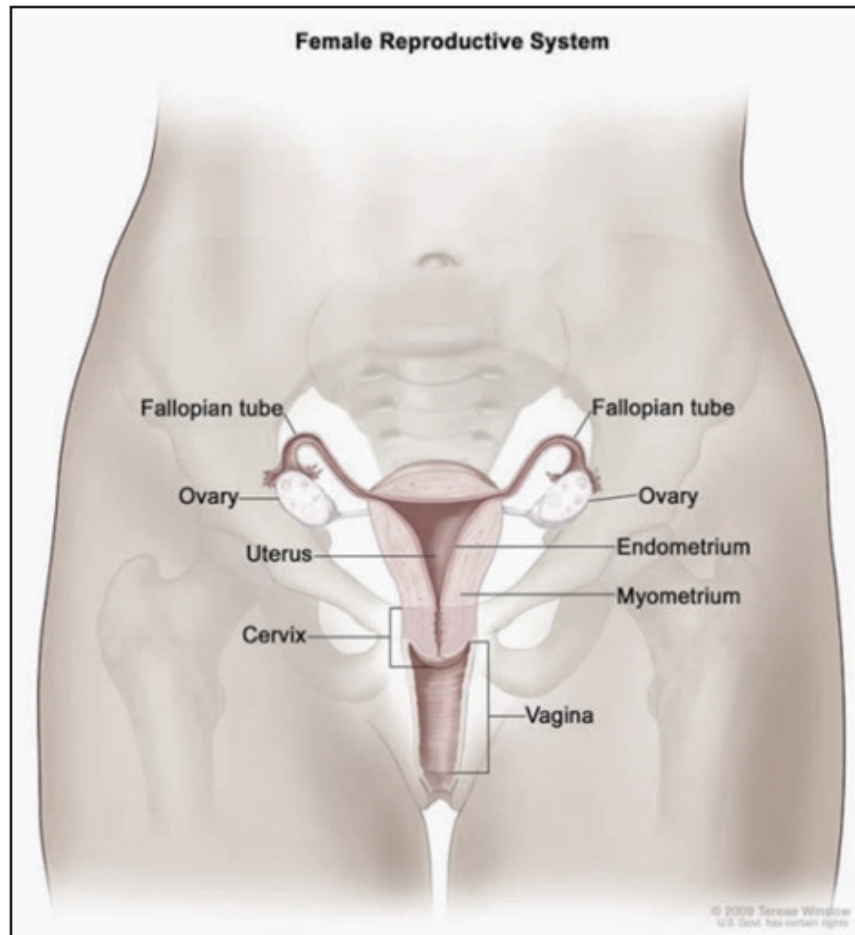
Activity Overview

Menstruation is a natural and regular occurrence that nearly all young girls of reproductive age experience. On average, a woman will have 450 menstrual cycles over approximately 38 years of her life. In addition, despite this being part of the natural reproductive cycle, cultural beliefs, taboos and social norms restrict the participation of young girls and women in society during menstruation or other types of vaginal bleeding. In addition, limited access to clean water, proper sanitation facilities and menstrual products make it difficult for young girls to manage their vaginal bleeding hygienically. As a result, many young girls and women face considerable physical and social challenges during their menstruation period. This session aims to help young people understand the general concept of menstruation and menstrual

hygiene management. It addresses key definitions, describes menstrual cycle and challenges associated with menstruation, and challenges social norms and stigma associated with menstruation.

Activity Objectives

By the end of this session, participants will have a good understanding of menstruation and related challenges; will be able to describe menstrual cycle, manage her menstruation and challenge social norms and stigma around it.



TALKING POINTS

- Emphasize that menstruation should not prevent adolescents from attending school and other daily activities
- Emphasize that during menstruation period which may takes 2-7 days, a girl should take precaution on personal hygiene i.e. bathing often at least twice a day, use of sanitary pads/towels (to change accordingly, ironing or drying under the sun)
- Effective menstrual hygiene is vital to the health, well-being, dignity, empowerment, mobility and productivity of women and girls. Schools should provide privacy for girls to enable personal hygiene.

A. Breaking the Silence (20 minutes)

Materials Needed:

- Paper sheets
- Markers



TIPS FOR FACILITATOR

1. Sit in a circle.
2. Give each of the participants a marker and a paper sheet.
3. Ask them to write a personal statement about menstruation. This can be an experience, a thought or a question – both negative and positive statements are allowed.
4. Then ask each of the participants to show their sheet and explain their statement.
5. Remember: There are no right or wrongs, this is an activity to start the conversation.

Definition of Key Terms:

Menstruation or Menses: is the natural monthly flow of blood from the uterus through the vagina in girls and women from puberty to menopause. It is a normal process for women and girls, and it starts at puberty or adolescence. Girls tend to start their menstrual periods between the ages of 10 and 14, and this continues until they reach menopause usually between their late forties to mid-fifties. Menstruation is also sometimes known as menses or a menstrual period. During adolescence, a girl's body starts to change. Along with physical changes (such as growing breasts, wider hips, and body hair) the girl will also experience emotional changes due to hormones.

Menarche: Also known as female puberty, this is the onset of menstruation, the time when a girl has her first menstrual period. During the menarche period, menstruation may be irregular and unpredictable.

Menopause: This is the end of a woman's menstrual cycles. The term can describe any of the change's women go through just before or after they stop having periods, marking the end of reproductive age.

Menstrual hygiene management (MHM) refers to management of hygiene associated with the menstrual process. WHO and UNICEF Joint Monitoring Programme (JMP) for drinking water, sanitation, and hygiene has used the following definition of MHM: Women and adolescent girls are using a clean menstrual management material to absorb or collect menstrual blood, that can be changed in privacy as often as necessary for the duration of a menstrual period, using soap and water for washing the body as required, and having access to safe and convenient facilities to dispose of used menstrual management materials. They understand the basic facts linked to the menstrual cycle and how to manage it with dignity and without discomfort or fear⁴.

⁴WHO/UNICEF (2012) Consultation on draft long list of goal, target and indicator options for future global monitoring of water, sanitation and hygiene. Available at <https://washdata.org/sites/default/files/documents/reports/2017-06/JMP-2012-post2015-consultation.pdf>

Menstrual health and hygiene (MHH) encompass both MHM and the broader systemic factors that link menstruation with health, well-being, gender equality, education, equity, empowerment, and rights. These systematic factors have been summarized by UNESCO as accurate and timely knowledge, available, safe, and affordable materials, informed and comfortable professionals, referral and access to health services, sanitation and washing facilities, positive social norms, safe and hygienic disposal and advocacy and policy.

Menstrual hygiene materials are the products used to catch menstrual flow, such as pads, cloths, tampons or cups.

Menstrual supplies are other supportive items needed for MHH, such as body and laundry soap, underwear and pain relief items.

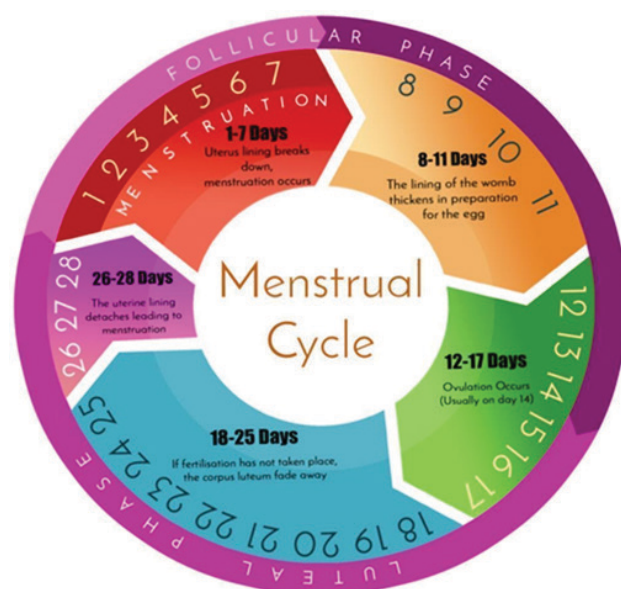
Menstrual facilities are those facilities most associated with a safe and dignified menstruation, such as toilets and water infrastructure.

What is the Menstruation Cycle? The menstrual cycle is the hormonal process a woman's body goes through each month to prepare for a possible pregnancy. The cycle for menses is usually around 28 days but can vary from 21 to 35 days. Each cycle involves the release of an egg (ovulation), which moves into the uterus through the fallopian tubes. The body's tissues and blood start to line the walls of the girl's uterus for fertilization. If the egg is not fertilized, the lining of a girl's or woman's uterus is shed through the vagina along with blood.

The bleeding usually lasts between two to seven days each month, with some lighter flow and some heavier flow days. The menstrual cycle for girls during their first year or two is often irregular.⁵

B. When does the menstruation cycle begin and end?

The cycle for menses is usually around 28 days but can vary from 21 to 35 days. Each cycle involves the release of an egg (ovulation), which moves into the uterus through the fallopian tubes. The body's tissues and blood start to line the walls of the girl's uterus for fertilization. If the egg is not fertilized, the lining of a girl's or woman's uterus is shed through the vagina along with blood. The bleeding usually lasts between two to seven days each month, with some lighter flow and some heavier flow days. The menstrual cycle for girls during their first year or two is often irregular.⁶



The menstrual cycle is the hormonal driven cycle; Day 1 is the first day of your period (bleeding) while day 14 is the approximate day

⁵ House, Cavill, and Mahon. 2012. Menstrual Hygiene Matters. UK: WaterAid

⁶ Ibid.

you ovulate and if an egg is not fertilized, hormone levels eventually drop and at about day 25; the egg begins to dissolve and the cycle begins again with the period at about day 30. Menstruation begins day 1 and normally ends days 3-5 of the menstrual cycle but can go up to 7 days.

Signs and Symptoms of Menstruation

Besides the bleeding, other signs and symptoms of menstruation may include headache, acne, bloating, and pains in the low abdomen, tiredness, mood changes, food cravings, breast soreness, and diarrhea.

C. Menstrual Hygiene Management (MHM):

Menstrual Hygiene Products

Lay out a selection of menstrual hygiene products on the table. You could include a disposable pad, a reusable pad, a tampon, a menstrual cup and some cloth. Ask the girls which ones they have used or heard of. Then go through each item and explain how and where it is commonly used. Many of the girls we have worked with have never seen a tampon before and you may wish to demonstrate how it works using a glass of water. It may also be useful to demonstrate how the disposable and reusable pads fit into underwear.

MHM is gaining recognition globally as a critical human rights and development problem, one that influences poverty levels and even a country's GDP. Menstruation has critical implications for a girl's educational and health outcomes.

Therefore, there is a great need to provide skills and means to manage their menstruation in order to expect positive health and education outcomes. They need to be empowered to use clean menstrual management material to absorb or collect menstrual blood, change these materials in privacy as often as necessary for the duration of a menstrual period, and have access to safe and convenient facilities to dispose of the used menstrual management materials. Menstrual hygiene materials must be made available; linkages to health services must be formed; and safe facilities with water and soap, adequate sanitation and disposal mechanisms must be provided.

Failure to meet these needs puts girls at risk of not having a high-quality educational experience and poor health outcomes.

MHM materials include the facilities, products, education, training, and support necessary for girls to manage their menstrual periods away from home.

Recommended Self-Care during Menstruation:

- Use menstrual products such as sanitary napkins/ pads, tampons, menstrual cups etc:
- Always wash your hands before you put in a new change pad or tampons to prevent infection. Wash your hands after you change pads or tampons.
- Wash the vagina regularly to prevent bacteria clinging to your body after you have removed your sanitary pad. Do it in a proper way of using your hands in motion from the vagina to the anus, not vice-versa. Motioning your hand from the anus to the vagina can lead to the transmission of the bacteria from the anus into the vagina or urethra opening leading to infections.

- Change your sanitary pad or tampon about every 3 to 4 hours to keep the blood from soaking through your clothes. a tampon in for a long time.
- Wrap toilet paper around the pad or tampon and throw it in the trash or any safe or environmentally friendly disposal method. Do not flush the pad or tampon down the toilet. It can block up sewer lines.
- Rest, exercise, and eat healthy foods: These are some ways to help control symptoms of periods.

D. Some Challenges Associated with Menstruation

1. **Menstrual symptoms:** Menstruation is accompanied with some pains including abdominal pain, bloating, back-ache, headache, tiredness, feeling emotional, breast tenderness, increased/decreased sexual desire or libido. RELAX, these are all normal. They are not signs of illness or disease and not every woman will experience the same premenstrual symptoms.
2. **Premenstrual syndrome:** Some women report feeling the symptoms of premenstrual syndrome (PMS). This very common condition can include symptoms such as: rapid changes in mood, insomnia, dizziness, bloating, social withdrawal, difficulty concentrating, breast tenderness and tiredness. These symptoms can vary in severity. Other symptoms may include joint or muscle pain, headaches, fluid retention, constipation, and diarrhea.
3. **Premenstrual dysphoric disorder (PMS):** People can experience depression, irritability, and mood swings while menstruating. Some women experience a severe form of PMS known as premenstrual dysphoric disorder (PMDD). It can lead to the following symptoms: depression, mood swings, anger, anxiety, feelings of being overwhelmed, concentration difficulties, irritability and tension.
4. **Irregularities:** 'Every woman is different and what is normal for me may be different for you, and that doesn't mean one of us is wrong. Being different is a good thing – some people are fast runners; some people are good cooks; some people are tall and some people are short. What matters is knowing and accepting yourself, including your menstrual cycle'.

There are so many reasons for a woman to go through some irregularities or missing her period. These may include: stress, inadequate food intake, the first 2 years after starting her periods, lots of exercise, pregnancy, nearing the menopause and medicines. However, scientists do not fully understand the female reproductive tract and sometimes things happen which we can't explain. For example, 'We don't know any scientific reason why a change of climate would affect the menstrual cycle, because the female reproductive system is controlled by hormones from inside the body, not conditions outside of the body.'



TIPS FOR FACILITATOR

Explain that the symptoms women and girls experience can be split into two groups, those caused by muscles and those caused by hormones. Explain these mechanisms and the symptoms they cause: "We have already discussed how menstruation happens because an egg has not been fertilized and needs to be pushed out of the uterus along with the thick

lining that has been built up. The muscles in the uterus contract in order to push all this out. This contraction causes stomach pain and back pain. You can relax the muscles by massaging them or applying a warm compress. Ibuprofen is a medicine that works really well for muscle pain. We have also already talked about how hormones or chemical messengers control menstruation. Changes in these chemicals can cause unpleasant symptoms and unfortunately around menstruation there are naturally lots of changes to a woman's hormones. This causes headaches, bloating and breast tenderness. It can also make you you tired, emotional and affect your level of sexual desire or libido."

E. Cultural Challenges to Menstrual Health

Group Work (15 minutes)

Procedure

Step 1: Divide participants into two groups. Give out a piece of flip chart paper, colored markers. Ask them to write down the cultural challenges faced during menstruation.

Step 2: Ask the group how they would overcome the cultural challenges facing them to ensure the menstrual hygiene management.

Step 3: Review the cultural challenges outlined in the Key Information section at the end of the session to ensure that these cultural challenges are addressed.

Step 4: Allow time for participants to ask questions.

Menstrual hygiene practices are affected by cultural norms, parental influence, personal preferences, economic status, and socioeconomic pressures. Menstrual beliefs refer to misconceptions and attitudes towards menstruation within a given culture or religion. Menstrual beliefs, knowledge, and practices were all interrelated to menstrual hygiene management.

One of the main reasons why menstruation is a taboo and menstruation hygiene is neglected is gender inequality. Unequal rights given to men and women result in women's voices being ignored within households and communities and in development programmes.

Due to cultural norms and stigma in some communities, menstruating women are denied some social and economic opportunities as menstruation is perceived as dirty or impure.

Most men do not know about the menstruation and physiological changes in women during menstruation and menstrual cycle, so it is difficult to change their perception regarding menstruation and menstrual hygiene. Due to unwillingness, myths, prejudices, and misconceptions, it is difficult to talk about menstruation with men and boys. But by engaging them into group discussions and regular community meetings, we can change their perception and make them aware about their role regarding menstrual hygiene management.

Involvement of Men/Boys supporting girls' Menstrual Hygiene Management

Men can support and influence women and girls in managing menstruation in households, schools, work, and community through many roles as husbands, fathers, brothers, students,

teachers, colleagues, leaders, and policymakers. Do not give money to buy menstrual products such as commercial sanitary pads, tampons, and menstrual cups as they consider it money wastage.

Men who are in decision making positions can support menstrual hygiene management by introducing girls/women friendly policies, providing sanitary materials free of cost or at affordable prices, providing water and sanitation in their areas as well as conducting seminars and workshops in rural areas.

Key Myths and Misconceptions Around Menstruation

Myths	Facts
Menstruating women and girls (and other menstruators) are unclean	Menstruation is a sign of health and normal development. Menstrual blood is the same as blood from anywhere else in the body and is usually sterile
Taking a bath/shower/washing the body during menstruation causes infection or infertility	Girls should always maintain good hygiene throughout their menstruation. Taking a bath/shower/washing the body during menstruation is necessary, as it prevents a woman from getting infections. However, the practice of 'douching' (forcing water inside the vagina in order to clean it) can make pelvic infections more likely.
Starting menstruation means a girl is ready to marry.	A girl's body is still developing after she has started menstruation. Getting married and having a baby before the age of 18 can lead to health problems for the mother and child.
Burning or burying used menstrual materials leads to infertility	Burning or burying of used menstrual products are safe and hygienic disposal methods and have no link to a body's fertility/infertility. To keep the environment clean, used menstrual products are best disposed of in a rubbish bin whenever possible.
Menstruating women and girls should not eat certain foods (e.g. yoghurt, vegetables, cold water, sour food).	Menstruating girls need to eat foods that contain iron to replace iron losses during bleeding, such as beans and dark green vegetables. Also, eating fresh fruit and foods high in calcium can help keep women healthy and alleviate some symptoms of premenstrual syndrome. Calcium rich foods include almonds, and dark green vegetables like spinach leaves. Drinking plenty of clean water during menstruation is also important, in order to keep the body hydrated as usual.



TALKING POINT

Key Message: Menstruation is Normal

Menstruation is a normal and healthy part of the female reproductive system. It is important to openly talk about menstruation, to ensure that women and girls have sufficient knowledge and feel comfortable to ask questions.



MODULE 2

**SRHR, GENDER, SEXUALITY
AND HUMAN RIGHTS**

MODULE 2 SRHR, GENDER, SEXUALITY AND HUMAN RIGHTS

(3 hours)



KEYWORDS: Sex, Sexual Health, Reproductive Health, Sexual Rights, Reproductive Rights, Safe Sex, Unsafe Sex

MODULE OVERVIEW

This module addresses generalities of the concepts of SRHR, Gender, sexuality, and Human Rights of young people and their connection; and the SRHR concerns of young people. In order to promote effective and sustainable peer education, support and meaningful advocacy around SRHR of young people, the last must first have a broad understanding of what sexuality, gender, human rights and SRHR are all about and how they are interconnected.

MODULE OBJECTIVES

By the end of this module, participant will be able to:

1. Understand and describe SRHR, sexuality, gender and human rights concepts
2. Understand SRHR as a human rights concern
3. Understand the importance of including gender in SRHR of young people
4. Address barriers that hinder young people's access to SRH services and information

Session 2.1.

INTRODUCTION TO THE CONCEPTS OF SRHR, SEXUALITY, GENDER AND HUMAN RIGHTS

(90 Minutes)

"When young people realize their sexual and reproductive health and reproductive rights, they are on a path to realizing their full potential as individuals and as actively engaged members of their communities and nations."

- *The State of the World's Population 2014, UNFPA*

Introduction and Aim of the Session

Young people – specifically young women – face significant barriers to accessing information about sexual and reproductive health (SRH) and realizing their rights. Gender inequality and harmful traditional practices and norms have a disproportionate impact on girls and women, and diminish their autonomy and compromise their access to resources, services, and education. Throughout their entire life, they suffer and survive violations to their sexual and reproductive rights (SRR). These rights violations cannot be tolerated any longer, and it's up to young people and their peers to make a difference.

The purpose of this session is to impart young people with some background information on what SRHR is; what sexuality, gender and human rights mean, and how young people rights must be respected, protected, and fulfilled. Young people will also have the opportunity to

explore the links and resources provided to learn more about some of the different treaties and instruments that serve to protect young people's rights to SRH and gender equality.

A. Understanding Essential Concepts and their Intersection

1. Sexual and Reproductive Health

Let's understand the key components of SRHR

- ★ Reproductive health: is defined as a state of complete physical, mental, and social well-being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the freedom to decide if, when, and how often to reproduce. Implicit in this is the right of men and women to be informed about and to have access to safe, effective, affordable, and acceptable methods of family planning of their choice. This also includes the rights to be informed and have access to health-care services that will enable women to go safely through pregnancy and childbirth. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations.⁷
- ★ Sexual health: is defined as a state of physical, emotional, mental, and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction, or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination, and violence.⁸

2. Gender concepts:

Sex and Gender

The term "sex" is defined to mean the biological differences between women and men. These sets of biological characteristics are not mutually exclusive as there are individuals who possess both, but they tend to differentiate humans as males and females. In general use in many languages, the term sex is often used to mean "sexual activity," but for technical purposes in the context of sexuality and sexual health discussions, the above definition is preferred.



"Gender" refers to the social relationships between women, men, girls and boys that vary from one society to another and at different points in history.

Gender roles

Gender roles are learned from the time of birth and are reinforced by parents, teachers, peers and society. These gender roles are based on the way a society is organized and vary by age, class and ethnic group.



⁷International Conference on Population and Development (ICPD). 1994. Programme of Action. Chapter 7, A. Reproductive rights and reproductive health, paragraph 7.2., (<http://www.un.org/popin/icpd/conference/offeng/poa.html>).

⁸WHO. 2002. Sexual and reproductive health: gender and human rights (sexual health working definition, which does not represent an official WHO position or definition), (http://www.who.int/reproductivehealth/topics/gender_rights/sexual_health/en/).

Gender norms

Gender norms are the accepted attributes and characteristics of male and female gendered identity at a particular point in time for a specific society or community. They are the standards and expectations to which gender identity generally conforms, within a range that defines a particular society, culture and community at that point in time. Gender norms are ideas about how women, men, girls and boys should be and act. Internalized early in life, gender norms can establish a life cycle of gender socialization and stereotyping.



Gender relations

Gender relations have to do with the ways in which a culture or society defines rights, responsibilities and the identities of women, men, girls and boys in relation to one another. Gender relations refer to the balance of power between women and men or girls and boys.



Gender equality

Gender equality is a transformational development goal. It is understood to mean that women (girls) and men (boys) enjoy the same status on political, social, economic and cultural levels. It exists when women (girls) and men (boys) have equal rights, opportunities and status. It exists when women (girls) and men (boys) have equal rights, opportunities and status.



Gender equity

Gender equity is the process of being fair to both women (girls) and men (boys) in distribution of resources and benefits. This involves recognition of inequality and requires measures to work towards equality of women (girls) and men (boys). Gender equity is the process that leads to gender equality.



Gender parity

Gender parity is a numerical concept. Gender parity concerns relative equality in terms of numbers and proportions of women and men, girls and boys. For example, the ratio of girls and boys enrolled in school.



Empowerment

Empowerment is about women, men, girls and boys taking control over their lives: setting their own agendas, developing skills (including life skills), building self-confidence, solving problems and developing self-reliance. The process of empowerment enables women, men, girls and boys to question existing inequalities as well as act for change.





Gender analysis

Gender analysis is an organized approach for considering gender issues through the entire process of programme or organizational development. This requires sex-disaggregated data and ensures that development projects and programmes incorporate roles, needs and participation of women, men, girls and boys.



Gender mainstreaming

Gender mainstreaming is the process of assessing implications for women, men, girls and boys of any planned action including legislation, policies or programmes at all levels. It refers to a strategy for making women's, men's, girls' and boys' concerns and experiences an integral dimension of design and implementation, monitoring and evaluating policies and programmes in all political, economic and societal spheres so that women and girls can benefit equally and inequality is not perpetuated. The ultimate goal is to achieve gender equality.



Practical needs

Practical needs are immediate perceived needs such as water, shelter, clothing, basic health care and food. They are based on women's and girls' existing roles (within the gender division of labour) and do not challenge their subordinate position. These needs arise from and reinforce women's and girls' reproductive and productive roles.



Strategic needs

Strategic needs are long-term in nature and often related to structural changes in society. These are identified based on an analysis of women's and girls' subordination in society, and when addressed, should lead to the transformation of the gender division of labour and challenge the power relations between women and men, girls and boys.

3. Gender-Based Violence

An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e. gender) differences between males and females. It encompasses different types of violence including:

- a. **Domestic violence (DV) and intimate partner violence (IPV):** 'Domestic violence' is a term used to describe violence that takes place within the home or family between intimate partners as well as between other family members. 'Intimate partner violence' applies specifically to violence occurring between intimate partners (boyfriends/ girlfriends, married, cohabiting or other close relationships).
- b. **Economic abuse / violence:** An aspect of abuse where abusers control victims' finances to prevent them from accessing resources, working or maintaining control of earnings, achieving self-sufficiency and gaining financial independence.

- c. **Emotional abuse (also referred to as psychological abuse):** Infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, social exclusion, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.
- d. **Forced marriage and child (also referred to as early) marriage:** Forced marriage is the marriage of an individual against her or his will. Child marriage is a formal marriage or informal union before age

Root Causes of GBV

The root cause of all GBV is gender inequality. Neither GBV nor gender inequality are natural. Gender inequality is created and sustained in most human societies today. Education can play a role in promoting gender inequality by giving more or different opportunities to boys than girls, and by teaching boys and girls that they have different roles to play in the home and workplace. The law can support gender inequality by granting more power or rights to men than women. GBV can be used to ensure gender inequality continues in all spheres of daily life (e.g., health, education, employment, laws, policies). The perpetrators of GBV are mostly men. The sufferers are mostly women. Men use GBV to maintain power over women. This is how they protect their dominance and uphold a patriarchal structure. Sometimes, men also use GBV against other men to correct or discipline behaviors they believe are not masculine enough.



KEY MESSAGE

Understanding and recognizing the root cause of GBV is central to GBV prevention and response work. Most think other factors are the causes of GBV. They argue, for example, that alcohol, poverty, drugs, boredom, testosterone and/or bad parenting are causes. They also argue that men are naturally violent and can't help the way they behave. These arguments confuse contributing factors with root cause. It's important to stress the difference between contributing factors and root cause so the violence is not excused as something that only occurs in unusual circumstances. Equally, it's important to acknowledge that the majority of the violence is perpetrated by men against women, and so there is a gender element to the violence.

Challenges for this key message in Tanzania: GBV is deeply embedded in the social structure of the Tanzanian society. It is highly normalized because gender inequality is also highly normalized. Men who do not control their wives are often viewed as weak. They are seen to be failed men. Women who do not agree to be subservient to men are often seen as bad women who deserve to be punished/corrected.

Some myths and misconceptions supporting and sustaining GBV

Myth	Fact
<i>Men are naturally violent. They have high levels of testosterone.</i>	Testosterone levels are not constant in a man throughout his lifetime. The level of testosterone a man has at any particular time depends on his situation. Testosterone does not cause violent behavior. High levels of

Myth	Fact
	testosterone in a man in a risky situation can in fact motivate the man to run away and not fight. The violence is a choice. Women have testosterone too, but we don't see equally high rates of violence being perpetrated by women.
<i>Men and women are different. They have always been different. It's natural that they have different roles.</i>	It may be true that men and women are different biologically. Women have the capacity to get pregnant and give birth, but men do not. These biological differences do not mean there should be differences in status or power or opportunity. In many societies, the biological differences—and particularly reproduction—have been used to force women into a lower position, by insisting they must remain in the home to take care of children. This allows men to occupy the public space, to control the political and legal system, and to hold the economic power. This means that biological differences are actually being used to create and excuse gender inequality. Biological differences don't cause this inequality.
<i>Women like looking after children. They are naturally more nurturing and caring than men.</i>	Many women may like looking after children. This does not mean they should not be treated equally because this is what they do. Looking after children is actually a very important role in all societies. It is how we create future generations who can contribute to and manage a society in productive ways. When a man shows he cares, he can be accused of being weak, not a real man, and more like a woman. This practice of gender socialization makes it difficult for men to show they care. And so, many men do not show they care. Because many men don't show they care, we read this as a natural state of being for men. However, it is actually a result of gender socialization. For example, we raise boys to not show emotion when they are sad or upset. We tell them that men don't cry and that they should therefore stop crying if they want to be seen as a real man.

4. Sexuality Concepts

Sexuality is a central aspect of being human throughout life and encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, ethical, legal, historical and religious and spiritual factors .

Comprehensive Sexuality Education (CSE)

In alignment with the 1994 International Conference on Population and Development (ICPD) Programme of Action, “comprehensive sexuality education (CSE)” is defined as a right-based and gender-focused approach to sexuality education, whether in school or out of school. CSE is curriculum-based education that aims to equip children and young people with the age appropriate knowledge, skills, attitudes and values that will enable them to develop a positive view of their sexuality, in the context of their emotional and social development.

By embracing a holistic vision of sexuality and sexual behaviour, which goes beyond a focus on prevention of pregnancy and sexually transmitted infections (STIs), CSE enables children and young people to:

- **Acquire accurate information** about human sexuality, sexual and reproductive health, and human rights, including about: sexual anatomy and physiology; reproduction,

contraception, pregnancy and childbirth; sexually transmitted infections and HIV/AIDS; family life and interpersonal relationships; culture and sexuality; human rights empowerment, nondiscrimination, equality and gender roles; sexual behaviour and sexual abuse, gender-based violence and harmful practices.

- **Explore and nurture positive values and attitudes** towards their sexual and reproductive health, and develop self-esteem, respect for human rights and gender equality. CSE empowers young people to take control of their own behaviour and, in turn, treat others with respect, acceptance, tolerance and empathy, regardless of their gender, ethnicity, race or sexual relations.
- **Develop life skills** that encourage critical thinking, communication and negotiation, decision-making and assertiveness. These skills can contribute to better and more productive relationships with family members, peers, friends, and romantic or sexual partners.

When CSE is started early, provided over time and involves all of the elements listed above, young people are more empowered to make informed decisions about their sexuality, including their sexual and reproductive health, and can develop the life skills necessary to protect themselves while respecting the rights of others.

Quality CSE education provides students with opportunities for learning sexual health information, exploring attitudes and values about sexuality and relationships, and developing critical interpersonal skills. It encourages students to talk with their parents about sex and teaches students communication, negotiation and refusal skills they can use to form healthy relationships. Hundreds of studies have shown that well-designed and well-implemented CSE programs can reduce sexual risk and support positive sexual health outcomes among teens, including:

- Delaying the age of first sexual intercourse
- Reducing the overall number of sexual partners
- Reducing unprotected sex and increasing use of condoms and contraception
- Reducing unintended teen pregnancy
- Reducing rates of teen HIV and other sexually transmitted infections (STIs)

Core principles of CSE

- Comprehensive Sexuality Education programmes and curricula must adhere to the following core principles:
- Respect for human rights and diversity, with sexuality education affirmed as a right
- Critical thinking skills, promotion of young people's participation in decision-making, and strengthening of their capacities for citizenship
- Fostering of norms and attitudes that promote gender equality and inclusion
- Addressing vulnerabilities and exclusion
- Local ownership and cultural relevance
- A positive life-cycle approach to sexuality.

5. Human Rights Concepts

Universal Declaration of Human Rights (UDHR)

In 1948, The Universal Declaration of Human Rights (UDHR) was adopted by the United

Nations (UN) General Assembly. This milestone document sets forth a common standard of achievement for all people and all nations. It set out, for the first time, fundamental human rights to be universally protected.⁹ According to UDHR, human rights are rights inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, color, religion, language, age or any other status. By virtue of being human, we are all entitled to our human rights equally, and without discrimination. These rights are all interrelated, interdependent, and indivisible.

With this in mind, the human rights of young people include, among others:

- ◇ The right to life, liberty and security of person.
- ◇ The right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
- ◇ The right to education.
- ◇ The right to freedom of opinion and expression.
- ◇ The right to freedom of peaceful assembly and association.
- ◇ All are equal before the law and are entitled without any discrimination to equal protection of the law.
- ◇ No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
- ◇ Marriage shall be entered into only with the free and full consent of the intending spouses.

Reproductive Rights

Details and specifications surrounding reproductive rights emerged in 1994, at the International Conference on Population and Development (ICPD) in Cairo. ICPD was a milestone in the history of population and development, as well as women's rights. At the conference, the world agreed that population is not just about counting people, but about making sure that every person counts.¹⁰ A total of 179 governments adopted the 20-year ICPD Programme of Action, which set out to:

- Provide universal access to family planning and SRH services and reproductive rights;
- Deliver gender equality, empowerment of women, and equal access to education for girls;
- Address the individual, social, and economic impact of urbanization and migration; and
- Support sustainable development and address environmental issues associated with population changes.

ICPD's Programme of Action was a landmark agreement in history because it adopted a rights-based approach, placing women front and center, and explicitly recognizing that reproductive rights also belong to young people. It states that reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other relevant UN consensus documents. It was a movement away from problematic "population control" policies and rhetoric to one that acknowledged the primacy of human rights to achieving sustainable development. These basic rights rest on the capacity of all individuals (boys, girls, men and women) to live a satisfying and safe sex life and to decide

⁹ United Nations Human Rights. Universal Declaration of Human Rights. Official UN Universal Declaration of Human Rights Home Page, (<http://www.ohchr.org/en/udhr/pages/introduction.aspx>).

¹⁰ UNFPA. International Conference on Population and Development. (<http://www.unfpa.org/icpd>).

whether to reproduce and attain the highest standards of reproductive health including, right to:

- Decide freely from coercion and violence and responsibly the number, spacing, and timing of their children – and to have the information and means to do so;
- Plan family, use family planning methods, access to reproductive health education so as to understand sexual functioning of his or her body.
- Attain the highest standard of SRH; and
- Make decisions concerning reproduction free of discrimination, coercion, and violence.

In addition, it highlights that full attention should be given to promoting mutually respectful and equitable gender relations as well as meeting adolescents' educational and service needs to enable them to make informed, positive, and responsible decisions about their sexuality.

Sexual rights

Unlike human and reproductive rights, there is currently no official internationally agreed definition of sexual rights, but sexual rights are protected through other human rights. Global advocates are leading an effort to clarify this definition at the UN right now and have proposed the following working definition of sexual rights in the meantime:

Sexual rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. They rest on the recognition that all individuals have the right, free of coercion, violence, and discrimination of any kind, to:

- Achieve the highest attainable standard of sexual health;
- Pursue a satisfying, safe, and pleasurable sexual life;
- Have control over and decide freely, and with due regard for the rights of others, on matters related to their sexuality, reproduction, sexual orientation, bodily integrity, choice of partner, and gender identity; and
- Access the services, education, and information, including comprehensive sexuality education, necessary to do so.



TALKING POINTS

This exercise explores what it means to be male or female in the participants' culture. It also challenges participants to think of gender as something that is constantly changing and that can improve over time.

Often, 'gender' and 'sex' are understood to be the one and the same. In reality, they are quite different. There is a difference between what our bodies are physically able to do, such as producing sperm or giving birth, and what our society expects us to do.

Sex is determined by our bodies: a person is either male or female from before the moment he or she is born. Gender, on the other hand, is socially defined. Gender depends on historic, economic and cultural forces, and by definition is constantly changing. This means that people

have different understandings of what gender is, depending on their context. People learn about what it means to be male or female from many places, including from their families, communities, social institutions, schools, religion and media.

The result of traditional gender roles is often that people are not able to reach their full potential. Both men and women would benefit from a perspective that does not limit what people can and cannot do.

To stereotype is to categorize individuals or groups according to an oversimplified standardized image or idea. For example, in many cultures, education for girls and women is given a lower priority than for boys and men. However, according to UNICEF, girls denied an education is more vulnerable to poverty, violence, abuse, dying in childbirth and at risk of diseases including HIV/AIDS (State of the World's Children 2004, press release).

As another example, in many cultures, men are expected to display traditional traits of masculinity. This can often result in sexual promiscuity, heavy alcohol consumption, or violence, all of which are unhealthy behaviors, both for men and their families.

Gender is hierarchical; in most societies, it gives more power to men than to women. Also, it preserves the existing power structure. Work that women do revolves around the physical, emotional and social wellbeing of other people, especially their husbands/partners and children. Work that men do is related to their role as breadwinners/providers for their families, which leads them to seek out paid work. For example, many women love to cook, and many women cook better than men. Then why is it that mostly men are cooks at hotels and restaurants while women cook at home, unpaid?

It works well to emphasize improving women's agency and autonomy, but not to the exclusion of men. Working with men has shown that if we work together to promote a wider definition of gender for both men and women – thus reducing discrimination and stereotypes for men and women who don't exactly fit the "norm" – everyone can be empowered. We need to keep working hard to find ways to reduce discrimination and allow more people equal choices and chances.

Often, society defines what is right for men and women. It is not our fault that the system is that way. However, when we recognize that there is injustice, we can do something to change it. Society is made up of people, and people are capable of change. This is a very personal process. First, we have to recognize what is happening in our own lives, and then we can begin to make changes.

Most of us feel that culture, religion, tradition, and social norms dictate gender roles.

But where does change happen if not in our individual circumstances? How does a fashion trend start if not by one or two people one day starting to wear or do a certain thing? Ideas about gender affect us both privately and publicly; that means we have the opportunity to make changes at both the personal level, as well as in society.

*Session 2.2.***CONNECTING GENDER, SEXUALITY AND SRHR**

(90 Minutes)

Introduction and Aim of the Session

Understanding that society's expectations for us as boys/men and girls/women are not necessarily related to our biological differences is a good first step to understanding how culture influence gender and how gender-based discrimination affects our perceptions, beliefs and lives. This session will take participants through a series of exercises that will help them understand the connection between gender and sexuality and how gender affects SRHR of young people.

Activity 2.1: Exploring Gender and Culture (1 hour)

This is an exercise aimed at enabling participants to understand how gender discrimination affects young people lives.

Activity Objectives

1. To distinguish 'gender' and 'sex'
2. To explore the idea of socially-defined gender roles
3. To recognize gender stereotypes

Materials Needed:

- Flip chart paper
- Colored pens or markers

Ideal workspace: All participants must be able to see the flip chart. For Part B, enough table or floor space is needed for groups of 4-5 people to draw large pictures.

Number of participants: 10-25; preferably similar numbers of men and women.

STEP 1: Discussion**Part A:**

1. Ask participants to think about the first words that come to mind when they hear the words 'man' and 'woman'.
2. Write down responses from the group in two columns on flipchart paper: 'MAN' and 'WOMAN.'

This is an example of the kind of list that participants might come up with:

MAN: Police, Father, Power, Strength, Freedom, Businessman, Penis, Testicles, Generous, Selfish Dominant, Loud, Noble, Beer, wine, Bread-winner, Decision-maker, Violence, Unfaithful, Husband, Moustache, Beard, Lazy, Brave, Adam's apple, Humorous.

WOMAN: Cooking, Talkative, Shopping, Mother, Wife, Breasts, Gossip, Sexy, Beautiful Tidy, Jealous, Uterus, Gentle, Passive, Kind-hearted, Menstruation, Pregnancy, Childbirth, Housekeeper, Passive, Obedient, Vagina, Tolerant, doesn't drink heavily or smoke.

Make sure that, at a minimum, some words describing biological traits (such as 'penis' for man and 'breast' or 'menstruation' for woman) come up on the list. Biological components are bolded in the list above.

3. When the lists are complete, ask participants if any of the roles can be reversed. Can any of the 'man' words also describe women? Can any of the 'woman' words also describe men? What are the things that women or men can do exclusively?

Can a woman be a police officer? A husband? A parent? Powerful? Free? Strong? Humorous? Generous? Bread-winner? Noble? Unfaithful? Can women drink? Can a woman have a penis? If women are capable of being a police officer (for example), why aren't there more women who are police officers? Can a man cook? Do shopping? Be gentle? Submissive? Beautiful? Have breasts? Gossip? Be warm, kind-hearted? Menstruate? Be sexy? Be a wife? Can a man be fair? Be passive? Tolerant? Obedient? If men are capable of cooking and shopping, why don't more men do the cooking and shopping for their households? Why do some men who have jobs as cooks not do the cooking for their families?

Explain that these lists illustrate the difference between sex and gender. Refer to the World Health Organization's (WHO) working definitions for sex and gender: Sex refers to the biological characteristics that define humans as female or male. Gender refers to the economic, social and cultural attributes and opportunities associated with being male or female at a particular point in time.

Part B

1. Divide participants into single-sex groups of 4-5 people.
2. Ask the groups to work together to illustrate what they understand to be an ideal man and an ideal woman, using large sheets of paper and markers.
3. Alternatively, if supplies are available, participants can use modeling clay, or cloth, or balloons, wires, pencils, and other materials to build a sculpture.
4. Depending on time available and the number of participants, you can ask each group to draw two pictures (one man and one woman), or only one picture.
5. When they have finished, ask each group to present and explain their drawing(s) and share some of their reactions to the group.

These are some sample reactions that may come out after completing this activity:

"By drawing an image of the ideal man, we realized that men also endure pressure and bear a different kind of discrimination by reinforcing gender inequalities."

"We men feel a burden to impress girls, earn an adequate salary and develop a muscular body."

"It is so difficult to live up to the expectations of the ideal woman". (woman)

"I feel enormous pressure to support my family financially. My dream was to return to school to get an advanced degree, but I had to give it up in order to fulfill my obligations." (man)

STEP 2: Discussion

- Initiate a discussion with the group using some or all of these questions as a starting point; ask additional probing questions as appropriate. Encourage debate within the group, and be ready to spend some time discussing the issues that arise.
- Some sample answers are included beneath some of the questions, to give you an idea of where the questions are headed. These are participant responses from a similar exercise that was done in other countries.

What did you learn about being a boy or girl when you were growing up? How did you learn? From whom?

"A newborn baby's sex is acknowledged when it is born when its genitals are recognized. Penis and testicles mean it is a boy; vagina means it is a girl. On identifying the biological sex of the child, the family knows how to bring her/him up".

"There are differences in the colors used for boys and girls (blue/pink), types of clothes (trousers/dresses), types of toys etc. Social norms are set by each culture.

"A person's biological sex dictates the way they will be brought up. Boys are brought up to be independent, aggressive, tough, courageous, physically strong; girls are brought up to be dependent, emotional, sensitive, delicate".

How are images of the ideal man and woman created? Where do they come from? Who affirms them? Would you like to change the images you describe?

"The attitudes, values and behavior that as men we consider appropriate for us (our gender identity or masculinity) are learned in society".

"Men can also be dependent and sensitive; women can be strong and independent. Society puts different values on these attributes for men and women".

"More social value is placed on a newly born boy child than a girl child"

What are the things that women or men can do exclusively? (This question is deliberately open ended. Participants may come up with answers that reflect biological or cultural differences).

What is a gender stereotype? Are gender stereotypes positive, negative, or neutral? Why do gender stereotypes persist? What is the purpose of challenging gender stereotypes? Why do some people resist challenging the status quo?

How easy or difficult is it to consider gender roles that are different from the ones we are accustomed to? What does this mean in the context of our development? What happens if we challenge these roles? What happens if we do not challenge these roles?

STEP 3:***Closing***

Congratulate participants on their contributions, and encourage them to become more aware of gender roles and expectations in their daily lives.

Ask participants: How do the concepts in this exercise help you understand how culture influences gender and sexuality? How will your perception and attitudes change as a result of your new knowledge? Provide pieces of paper to each participant and invite them to write how their understanding of gender has changed after this exercise. Also ask them to write one action or change in their life they will take this week as a result of participating in this exercise. No one is asked to write their name on the paper, so it is anonymous.

Anyone can volunteer their thoughts on what they wrote out loud with the group, after everyone is finished.

Activity 2.2: Gender and Sexuality (30 minutes)**Activity Objectives**

1. To explore how gender and sexuality intersect

Materials Needed

- Flipchart paper
- Pens or markers
- Prepared flipchart pages with WHO's working definition of sexual rights
- Prepared flipchart pages with WHO's working definition of sexuality

Ideal workspace: All participants must be able to see the flip chart

Number of participants: 10-25; preferably equal numbers of men and women

STEP 1. Brainstorming

1. Ask the group to brainstorm all the words that they can think of associated with sexuality.
2. Have 2 people write down the words on large sheets of paper as the facilitator probes for more words. This should be done quickly.
3. Probe for missing words: Any positive associations?
4. What are some negative consequences of actions related to sexuality? Here are some examples from previous workshops (in no particular order): Kissing, Massage, Caring, Infertility, HIV, Touching, Fantasy, Sharing, Child spacing, Rape, Hugging, Sexual harassment. Loving/liking, Abortion, Date aggression, Masturbation, Passion, STIs, Ovaries, FGM, Contraception, need to be touched, Pornography, Sperm, Self-esteem, Orgasm, Sexual attraction, Getting pregnant, Body image, Petting, Communication, Emotional vulnerability, Incest, Unwanted pregnancy.

5. Then, ask them how some of the words they have come up with relate to sexual and reproductive rights.
6. When the group has run out of ideas, share with participants the World Health Organization's working definition for what constitutes sexual rights: Sexual rights embrace human rights that are already recognized in national laws, international human rights documents and other consensus statements. They include the right of all persons, free of coercion, discrimination and violence, to:
 - The highest attainable standard of sexual health, including access to Sexual and reproductive health care services;
 - Seek, receive and impart information related to sexuality;
 - Sexuality education;
 - Respect for bodily integrity;
 - Choose their partner;
 - Decide to be sexually active or not;
 - Consensual sexual relations;
 - Consensual marriage;
 - Decide whether or not, and when, to have children; and
 - Pursue a satisfying, safe and pleasurable sexual life;

STEP 2: Discussion

1. Initiate a discussion with the group using some or all of these questions as a starting point; ask additional probing questions as appropriate. Encourage debate within the group, and be ready to spend some time discussing the issues that arise.
 - What do you think of the WHO definition of sexuality, now that you have just worked through the exercise to define sexuality for yourselves?
 - When did you first become aware of your own sexuality? How did you generally express your sexuality? How is this changing as you're maturing?

Note: Some participants in this exercise may say the first time they understood themselves to be a sexual person – for example, when they caught sight of a “sexy” picture. Others may say they think that even babies clearly experience erections, so it's hard to say when a person “becomes” a sexual person – perhaps it's from birth! There does not seem to be an upper age limit to sexuality – people of all ages consider themselves to be sexual beings.

How is sexuality associated with power?

Many participants may say that both men and women have a lot of power in relation to sexuality. In fact, this question generates a lot of debate on who has more “sexuality” power! Using your sexuality as power can include flirting, dressing in a certain way, offering sex in exchange for money or gifts, sexual harassment, sexual coercion, and even rape. “Power” is not necessarily a positive or negative thing – it is just power – but it can be used to influence, coerce, or force others into doing something. In our programs, we want to be aware of the power that sexuality can have, and provide opportunities for more choices, respect and dignity for everyone.

- In what ways are gender and sexuality similar? In what ways are they different?
- Whose responsibility is it to define and uphold sexual rights?

- If people are not aware of their rights, do the rights still apply? How?
- Why is there a gap between stated rights and real life of young people? What can we do as young people to close this gap? What can we do as champions?
- Who defines responsible sexual behavior?
- What do sexual rights mean in the context of our communities?
- A common argument is that our culture, religion, or society won't tolerate open talk about sexuality. This is a powerful argument. Is it valid? What can we do to change it?

STEP 3: Closing

Congratulate participants on their contributions. Encourage them to become more aware of how they and others express their sexuality, and how it may change in different situations. Provide pieces of paper to each participant and invite them to write how their understanding of sexuality has changed after this exercise. Also ask them to write one action or change in their life they will take this week as a result of participating in this exercise. No one is asked to write their name on the paper, so it is anonymous.

Anyone can volunteer their thoughts on what they wrote out loud with the group, after everyone is finished.



TALKING POINTS

Sexuality can have a different meaning for people in various stages of life, and there are differences with regard to age, gender, culture and sexual orientation. Often when people see the words 'sex' or 'sexuality,' they think of sexual intercourse or other sexual activity.

Sexuality is much more than sexual feelings or sexual intercourse. It is an important part of who every person is. It includes all the feelings, thoughts, and behaviors of being female or male, being attracted and attractive to others, and being in love, as well as being in relationships that include sexual intimacy. It also includes enjoyment of the world as we know it through the five senses: taste, touch, smell, hearing, and sight.

Gender and sexuality are both closely linked to identity and self-expression. The way we express our sexuality is often determined by our gender; often men are expected to be sexually promiscuous, while women are expected to protect their virginity and reputation for chastity, and deny that they feel sexual pleasure.

In many places, there is an assumption that a woman's or a man's sexuality is uncontrollable. For example, if a man rapes a woman, it is assumed he could not control his sexual urges.

Sexuality is part of life. Whether for physical, emotional and psychological well-being, livelihoods or reproduction, sexuality is central to human existence. Choices available to men and women with regard to sexuality are often related to giving and taking power.

Sexuality is a human right. Everyone has the right and the responsibility to allow others to meet their sexual desires in the way they want. Sexual rights include your right to express and satisfy yourself, while not discriminating against others or having fear of discrimination against you. Sexual rights guarantee that people can express their sexuality free of coercion, discrimination and violence, and encompass mutual.

Sexuality is very important to achieving personal, community or even national economic development goals. Our cultural understanding and norms related to sexuality influence age of marriage, whether people are allowed to leave their homes freely, a nation's policies on access to information about contraception and family size, and whether certain kinds of people experience work-related discrimination, such as people who work in sex work, or who are living with HIV. Sexuality has far broader impacts on people's well-being and ill-being. The need to respond to HIV/AIDS and the adoption of human rights approaches have created openings for a franker debate on sexuality and more resources in this area. Social and legal norms and economic structures based on sexuality have a huge impact on people's physical security, bodily integrity, health education, mobility and economic status. In turn, these factors impact on their opportunities to live out happier, healthier sexualities."

As with gender, young people need to explore and comprehend their values, attitudes and beliefs relating to sexuality as well as their understanding of its placement within conceptual frameworks and models of behavior change.

Activity 2.3: Rebuilding the World (1 hour)

Introduction

This exercise explores notions of power and social status. By giving participants the 'power' to assign value to different members of society, this exercise is meant to cause some discomfort among participants; it should not be an easy task to decide who gets to live and who must die!

Activity Objectives

1. To challenge participants' thinking around power, social status, and discrimination.
2. To expose ways in which social status and power play into our attitudes and expectations about certain people or groups of people.

Materials Needed

- Paper and pens
- Prepared flipchart page with list of 10 people

Ideal Workspace: Enough space for people to have small group discussions

Number of Participants: 10-25; preferably similar numbers of boys and girls, and preferably young people of diverse social status.

STEP 1

1. Divide participants into groups of 4-5 people, and explain the following scenario:
 “Within a few moments a powerful bomb will explode. There is room for only six people to be saved in an atomic shelter before the bomb goes off, but there are ten people who want to come inside. Your task is to choose the six who – in your opinion – should be allowed in. These six people will be responsible for rebuilding the world after the bomb”

2. Groups should carefully study the characteristics of the ten candidates, then choose the six that they think should be allowed into the shelter and explain why.
 - Police officer with a gun
 - 16-year-old mentally disabled girl
 - Olympic athlete, 19 years old, homosexual
 - Female pop singer, 21 years old, very beautiful
 - 50-year-old black woman, religious leader
 - Peasant woman, pregnant for the first time
 - Philosopher, 70-year-old grandfather
 - Biochemist (male) 35 years old, in a wheelchair
 - Communist (male), specialist in medical sciences
 - ‘Retired’ prostitute, 40 years old

3. After each group has chosen six people, bring everyone back to the large group and discuss the different lists:
 - Did the small groups choose the same people or different people?
 - Were their reasons for choosing a particular person similar or different?

STEP 2: Discussion

Initiate a discussion with the group using some or all of these questions as a starting point; ask additional probing questions as appropriate. Encourage debate within the group, and be ready to spend some time discussing the issues that arise.

- What does this exercise reveal about status? Discrimination? Stereotypes? The relative value to society of certain people? Power? Privilege?
- How did considerations about reproduction (fertility, suitability for reproduction, etc.) affect choices?
- Do we have enough information to make assumptions and judgments about the ten candidates?
- What are some qualities of women that give some women more status or power over other women? What are some qualities of men that give some men more status or power over other men?
- If the retired sex worker could choose the six people, who do you think she would choose?
- Which forms of power do we manipulate in our own lives?
- How did it feel to have the power to decide who was important enough to survive and who should die?
- How are social status and power connected? Is low status a result of little power, or is little power a result of low status? Where does social power come from?
- Why do groups of lower social status often remain ‘invisible’?

- How does power affect your relationships? Do men and women share equal power in sexual relationships? How does power affect the way men and women search for a life partner? The way men and women communicate?
- How do you negotiate power in your relationships? Is it something you are conscious of?
- In general, men have greater decision-making power and control in sexual interactions. How does this translate in terms of attitudes and behavior? What does this mean for safer sex? Sexual violence? Sexual pleasure?

STEP 3: Closing

Congratulate participants on their honesty and hard work. Encourage them to be more aware of the dynamics of social status and power in their daily lives. Ask participants: How can we incorporate notions of social status and power in your life? To what extent can we question and challenge stereotypes that undermine certain groups of people such as young people, PWDs, and ultimately change mindsets?



TALKING POINTS

In our communities, people are in different positions of power. Often, society dictates how we behave in certain circumstances. For example, individually we may decide not to discriminate against a certain group of people, but we discriminate anyway because of the culture we live in.

Patriarchy, for instance, plays out in all our lives. The position of a daughter, wife, or mother is determined in relation to the man in the family. Unequal power balance in gender relations that favors men translates into unequal power balance in interactions between men and women. Power is fundamental to both sexuality and gender.

We assume that power is something outside of us, that someone else controls us. But the fact is that we all have power at different moments in our lives. Thus, power is shifting, and is relative to those around us. We may have more power in our families, but less power in our workplaces.

We need to ask ourselves when and how power balances change, and who changes them. Some forms of power will be used in very empowering ways, some in disempowering ways.

Some sources of personal power:

- Formal positioning (caste, culture, religion, family)
- Charisma (personal charm and personality)
- Influence (who you know and how you can use your relationships)
- Knowledge or intellectual credentials
- Skills, experience or applied knowledge
- Persuasion or leadership qualities
- Victim status ('poor me')
- Gender (male vs female)

Groups that are marginalized in some way (such as the disabled, the elderly, sex workers, etc.) tend to be feared and de-valued; they are not taken seriously. Often, they feel powerless. When this happens, they lose some of their humanity; they are denied their individuality and their sexuality.

When inequities are identified, it is common to try to assign blame. However, more is gained by working together than by taking sides. When we recognize injustice, we have a responsibility to do something to change it.



MODULE 3

**ADDRESSING BARRIERS
TO YOUNG PEOPLE'S
ACCESS TO SRHR SERVICES**

MODULE 3 ADDRESSING BARRIERS TO YOUNG PEOPLE'S ACCESS TO SRH SERVICES

(3 hours)

KEYWORDS: Cultural beliefs, Sexual Exploitation, Stigma, Abortion, Family planning, Infertility



KEY MESSAGE: Everyone has equal rights and should have equal opportunities to access SRH services and information despite their gender, age, culture or religion. This means young people have the same rights as adults.

MODULE OVERVIEW

This module addresses key challenges/barriers faced by young people in accessing SRHR information and services as expressed by young people in Tanzania. The key barriers addressed in this toolkit are incomplete or incorrect knowledge of SRH, including myths and misconceptions around contraception; HIV/AIDS and abortion and associated stigma and discrimination. This module will increase knowledge, ability and agency of young people to challenge and dismantle myths and misconceptions around the 3 SRHR issues above mentioned in order to increase their access to SRHR services.

MODULE OBJECTIVES

By the end of this module, participants will be able to:

1. Understand the individual and sociocultural barriers that affect young people's access to SRHR and their impact on young people health and life.
2. Correct the misconception and misinformation around contraception, HIV/AIDS and abortion.
3. Demonstrate capacity to challenge stigma and negative attitudes fueled by myths and misconceptions around SRHR of young people.

Materials Needed

- Male and female condoms
- Penis and vagina anatomical models. If models are not available, you can use other related objects.
- If possible, have samples of the various contraceptive /contraceptive pictures

Session 3.1.

PUTTING INTO CONTEXT

(30 Minutes)

Fast Facts:

- Tanzania is home to 10 million adolescents in the age group of 10-19 years, accounting for 23% of the country's population.
- Adolescents between ages 10-14 and ages 15-19 make up 13% and 10% of the total population respectively.

- Adolescents represent a huge opportunity to transform the social and economic fortunes of the country if they are healthy, educated and empowered.
- The combination of socio-cultural and economic factors such as low education levels, high poverty rates, discriminatory social norms and extreme religious practices have adverse effects on adolescent health outcomes in Tanzania.
- There is low level of knowledge on SRH and STI/HIV among young people, high prevalence of child marriage, correspondingly high levels of adolescent fertility and limited access to quality and age appropriate information¹¹
- There is lower knowledge on family planning among youth in the country while among adolescents aged 15 to 19 years, and 27% of them have begun child bearing (21% have given birth and 6% are pregnant with their first child). While it's apparent that pregnant women who are younger than 18 years of age face increased risks of complications for both mother and the new born compared to women between 20-24 years old.¹²
- HIV/AIDS is a big risk factor for male and female ages 15-19 with 43% of new HIV infections in Tanzania occurring among youth below 24 years and with 70% of new adolescent infections occurring in girls¹³.

Session 3.2.

BARRIERS TO YOUNG PEOPLE'S SRHR

(30 Minutes)

Although young people face so many barriers in accessing SRHR services and information, this section will address only individual and socio-cultural barriers.

SESSION OBJECTIVE

Increasing young people's knowledge and agency by correcting myths and misconception around contraception, HIV and abortion.

Individual barriers

Since most SRHR issues are tabooed topics in most cultures of the surveyed districts, young people in those areas face barriers such as incomplete or incorrect knowledge, myths, and misconceptions around youth SRHR topics. Young people's access to contraceptives, HIV and safe abortion services is obstructed by the feelings of shame, fear or anxiety, the lack of awareness about the services available, poor health or advice-seeking behaviors and the perception that services will not be confidential. All these constraints young people's ability to navigate internalized social and gender norms and limit not only their full access to these services but also their self-efficacy and individual agency in demanding access to SRHR services which result in negative health outcomes.

Socio-cultural barriers

Young people's behaviors are strongly affected by the attitudes, norms and beliefs of the adults who have power and authority over them. Young people often lack the autonomy and life skills of adults to make informed decisions about their own SRH and adopt behaviors that

¹¹ TDHS-MIS, Tanzania Demographic and Health Survey and Malaria Indicator Survey, 2015-2016

¹² Ibid.

¹³UNAIDS estimate, 2017

are endorsed by society, either explicitly or implicitly. The key socio-cultural barriers faced by young people include but not limited to:

- Strong traditional and cultural beliefs: Reliance on traditional structures and support for young women within rural communities acts as a barrier to young people accessing modern forms of contraceptives and Maternal and Child Health (MCH) care. This includes the high regard for Traditional Birth Attendants (TBAs) and reliance on traditional forms of contraception.
- Parental neglect, abuse and complicity in the sexual exploitation of children and young people: Parental and community tolerance for early marriage and/or transactional sex and abuse of children and young people act as barrier to access SRHR services for young people. Parents in some communities turn a blind eye to transactional sex where older men in particular exploit the poverty and ignorance of young women and girls, creating thus a culture where abuse is accepted until the young girl are coerced to marry their abusers, falls pregnant and then ostracized and marginalized for their transgression.
- Stigma and discrimination related to HIV/AIDS, youth use of contraceptives and abortion: Stigma and discrimination are widespread among Tanzanian adults and adolescents and create challenges for young people to seek contraceptives and safe abortion services, and to adhere ARV treatment for those living with HIV as they want to avoid the stigma that comes with such services and or being on ARV drugs.

Session 3.3.

ADDRESSING MYTHS AND MISCONCEPTIONS AROUND CONTRACEPTION, HIV AND ABORTION

(2 hours)

INTRODUCTION AND AIM OF THE SESSION

The main barriers to access modern contraceptive uptake, HIV/AIDS and safe abortion services among young people, especially young women are myths and misconceptions. Myths and misconceptions around the above mentioned SRHR topics can have significant impact on unplanned pregnancies, new HIV infection and increasing number of unsafe abortion practices. This session provides an overview of the key concepts and address key myths and misconceptions around contraceptives, HIV/AIDS and abortion.

Understanding Key Concepts

1. Myth: is a usually traditional story or a popular belief or tradition that has grown up around something or someone that serves to explain a practice, belief, or natural phenomenon. As most of SRHR issues are taboo topics, knowledge of young people on these issues is mostly built on traditional stories or popular beliefs which are not necessarily true. For example, I don't need contraception because we only have sex during the "safe" time. You're only fertile one day a month. Myths such as these most likely arise from traditional stories around a lack of understanding of the menstrual cycle.

2. Misconception: A misconception is a conclusion that's wrong because it results from incorrect thinking or facts that are wrong or a flawed understanding. Because they don't know

the facts, many young people have a misconception about how HIV is transmitted. It's a common misconception that "HIV can be spread through casual contact with an HIV infected individual" while, in fact, it's not.

3. Attitude: is manner, disposition, feeling, position, or opinion of someone about something or someone, or a way of behaving that is caused by this. It's a tendency or orientation, especially of the mind with regard to a person or thing. Example: Parents take the attitude that young people should not be allowed to use modern contraceptive methods. It's often very difficult to change people's attitudes but it's not impossible. It takes time and courage!

Contraception Versus Family Planning

Definition:

Contraception and Family planning are two terminologies used interchangeably to refer to the process of preventing pregnancy by interfering with the normal process of ovulation, fertilization and implantation¹⁴. However, in this manual we will use Contraception than Family planning for the simple reason Contraception is centered on empowerment and choice of a range of methods to avoid pregnancy before you are ready while Family planning are the same efforts centered on the need for married couples or sexual partners to space apart children and limit family size.¹⁵ Family planning involves preparations and knowledge around your family future while a girl aged 16 years is not necessarily concerned about planning a family, but she does not want to get pregnant.

The different kinds of birth control that act at different points in these processes are commonly called contraceptive or family planning methods. To ensure equitable and high-quality sexual and reproductive health care, programmes and policies must focus on support for individuals' choice in accessing a full range of contraceptive methods in order to fulfill their reproductive goals.

Types of Contraception

There are many different types of contraception, but not all types are appropriate for all situations. The most appropriate method of birth control depends on an individual's overall health, age, frequency of sexual activity, number of sexual partners, desire to have children in the future, and family history of certain diseases.

Types of Key Contraceptive Methods

Category of methods	Description of method	Remark
Long-Acting Reversible Contraceptives LARC	<p>Implants: These birth control methods release the hormone progestin to stop one from getting pregnant. These may be good choices for many young women because:</p> <ul style="list-style-type: none"> • Are very effective—fewer than 1 pregnancy per 100 women in the first year of use. 	Implants are really good at preventing pregnancy, but they won't protect you from sexually transmitted infections and HIV/AIDS.

¹⁴ <http://www.healthofchildren.com/C/Contraception.html#ixzz6LRLRkOfv>

¹⁵ Sinding SW. The great population debates: how relevant are they for the 21st century? *Am J Public Health* 2000; 90: 1841-45.

continued

Category of methods	Description of method	Remark
Long-Acting Reversible Contraceptives LARC	<ul style="list-style-type: none"> Do not require any action by the user Work for a number of years. Are quickly reversible. Once the implant is removed, a woman can again become pregnant. It is not obvious that the woman is using a contraceptive method. 	
	Intra-Uterine Device (IUD): This is a small piece of flexible plastic shaped like a T that's put into the uterus to prevent pregnancy. Sometimes it's called an IUC — intrauterine contraception. This may be a good choice for many young people because it's long-term, reversible, and one of the most effective birth control methods out there.	IUDs are more likely to come out among women who have not given birth because their uteruses are small. They do not protect against STIs and HIV.
Permanent Contraception	Sterilization: Also known as Tubal ligation is a surgical procedure that permanently closes or blocks the fallopian tubes. When the fallopian tubes are blocked after a tubal ligation, sperm can't get to an egg and cause pregnancy.	These are permanent, safe and effective methods of preventing pregnancy but are not good choices for young people as they will likely want to get pregnant and have children in the future. Young people and people with few or no children are among those most likely to regret sterilization and vasectomy.
	Vasectomy: Also known as male sterilization is a simple surgery done by a doctor in an office, hospital, or clinic. The small tubes in your scrotum that carry sperm are cut or blocked off, so sperm can't leave your body and cause pregnancy.	
Short-Acting Contraceptives	Depo-provera (Depo shot or DMPA) is an injectable contraceptive that contains the hormone progestin to stop one from getting pregnant by preventing ovulation. When there's no egg in the tube, pregnancy	The shot is really good at preventing pregnancy, but it won't protect you from sexually transmitted infections.

continued

Category of methods	Description of method	Remark
Short-Acting Contraceptives	<p>can't happen. This may also be a good choice for because:</p> <ul style="list-style-type: none"> • is an injection you get once every 3 months. • It's a safe, convenient, and private (can be used without others knowing) birth control method that works really well if you always get it on time. 	<p>This method of birth control can cause a temporary loss of bone density, particularly in adolescents. However, this bone loss is generally regained after discontinuing use of DMPA. Most clients using injectable birth control should eat a diet rich in calcium and vitamin D or take vitamin supplements while using this medication.</p>
	<p>Pill (Progesting Only Pill - POP): It works by stopping sperm from joining with an egg (which is called fertilization). The hormones in the pill stop ovulation. No ovulation means there's no egg hanging around for sperm to fertilize, so pregnancy can't happen.</p> <p>Oral contraceptives. A woman takes one pill daily, preferably at the same time each day. The pill is safe, affordable, and effective if you always take your pill on time. Besides preventing pregnancy, the pill has lots of other health benefits, too.</p>	<p>The pill is really good at preventing pregnancy, but it won't protect you from sexually transmitted infections.</p> <p>Some young women find taking a pill every day particularly difficult.</p>
	<p>Male & Female Condoms: Condoms are small, thin pouches made of latex (rubber) or plastic that cover the penis during sex or put inside the vagina to create a barrier that stops sperm from reaching an egg. and cause pregnancy. Condoms also prevent STDs and HIV by covering the penis and vagina, which prevents contact with semen and vaginal fluids, and limits skin-to-skin contact that can spread sexually transmitted infections and HIV. These are best options for young people</p>	<p>Condom is the best way to reduce your chances of getting pregnant and spreading sexually transmitted infections and HIV. It protects you and your partners from unplanned pregnancy STIs and HIV.</p>

continued

Category of methods	Description of method	Remark
Short-Acting Contraceptives	because they have dual potentials of protecting against STIs as well as pregnancy and many young people need protection against both; they are readily available, affordable and convenient for occasional sex.	
Emergency Contraceptives	Emergency contraceptive pills (ECPs): These are pills used to prevent pregnancy after unprotected sexual intercourse or in case of contraceptive failure, incorrect use of contraceptives or in case of sexual assault if without contraceptive coverage. These are recommended for use within 5 days but are more effective the sooner they are used after the act of intercourse. It is safe to use ECPs multiple times between monthly bleedings. Emergency contraceptive pills prevent pregnancy by preventing or delaying ovulation and they do not induce an abortion.	Young women may have less control than older women over having sex and using contraception. They may need ECPs more often. Does not prevent STIs and HIV
Natural Contraceptives	Fertility awareness methods (FAM): These help the tracking of menstrual cycle to know when the ovaries release an egg every month (this is called ovulation). The days near ovulation are fertile days — when one is most likely to get pregnant. So people use FAM to prevent pregnancy by avoiding sex or using another birth control	Until a young woman has regular menstrual cycles, fertility awareness methods should be used with caution. A backup method or ECPs should be on hand in case abstinence fails. Does not prevent STIs nor HIV

continued

Category of methods	Description of method	Remark
Natural Contraceptives	method (like condoms) on those “unsafe,” fertile days.	
	Withdrawal (or Pulling Out Method): Pulling out is exactly what it sounds like: pulling the penis out of the vagina before ejaculation. If semen gets in the vagina, one can get pregnant. So, ejaculating away from vagina prevents pregnancy.	While withdrawal can prevent pregnancy, it requires the man to know when he is about to ejaculate so he can withdraw in time. This may be difficult for some young men. Also, it doesn’t protect against STDs and HIV. It is one of the least effective methods of pregnancy prevention, but it may be the only method available—and always available—for some young people.

Myths and Facts Around Contraceptives

Myths	Facts
Family planning methods are harmful to health.	All family planning methods are safe, and effective if properly used. Couples can choose the method that is best suited for them depending on their needs and health condition. See the examples below as proved scientifically; <ol style="list-style-type: none"> Using injectable will not increase risk for other diseases or harm the next child (FHI 360) Using Copper-T Can cause common side effects (longer, heavier bleeding and more cramping). These side effects may be unpleasant, but they are not harmful (FHI 360) For the contraceptive pills use, bleeding changes are normal and not harmful. If a woman finds them bothersome, counseling and support can help (WHO, 2018).
Condoms reduce sexual pleasure Some couples incorrectly believe that condom use decreases a man’s libido and can cause impotence or that condoms reduce or interfere with sexual pleasure	Some couples become frustrated and lose some of their sexual excitement when they stop to put on a condom. Some men and women complain that the condom dulls sensation. However, many couples learn to enjoy using condoms as part of their

continued

Myths	Facts
	<p>sexual foreplay. In fact, many women and men often say they have better sex when they use condoms, because they can focus on their sexual pleasure without the worry about unintended pregnancy and sexually transmitted infections (STIs).</p> <p>Pleasure may also be increased by lubricating the inside and outside of the condom with water-based lubricants. A drop or two of lubricant on the inside of the condom before it is unrolled can help increase the sensation of sex for some men (IPPF, 2019).</p>
<p>You won't get pregnant if your partner pulls out before ejaculating.</p>	<p>Unfortunately, this is not a guaranteed birth control option. This approach, called the withdrawal method, requires that the man takes his erect penis out of the woman's vagina before he has an orgasm.</p> <p>The fact is that, even before a man ejaculates, a small amount of semen and sperm are released and can cause a pregnancy (USAID)</p>
<p>Birth control also protects against sexually transmitted diseases (STDs).</p>	<p>When planning protection for sexual activity, you have two issues to consider: pregnancy prevention and infectious disease protection. The only forms of birth control that will protect against STDs are abstaining from vaginal (and anal) sex or using condoms while having sex. Other methods of birth control offer protection against unplanned pregnancy, but do not protect against HIV or other sexually transmitted diseases (University of California, San Francisco).</p>
<p>Contraceptives use is eligible for certain groups (those who are e who are in marriage.)</p>	<p>According to WHO 2015, any person of reproductive age is eligible to use contraceptives.</p>
<p>If a woman takes birth-control pills for several years, she may not be able to get pregnant later.</p>	<p>Although a woman who has taken birth-control pills for several years may experience a delay in becoming pregnant, using birth-control pills will not affect a woman's ability to become pregnant later (USAID).</p>
<p>Birth-control pills prevent the spread of STIs.</p>	<p>Birth-control pills only prevent pregnancy. They do not prevent STIs including HIV /AIDS (USAID).</p>

Source: World Health Organization: 2015

HIV Versus AIDS

Fast Facts

- HIV is a virus that attacks the immune system, our body's natural defence against illness.
- If HIV is left untreated, a person's immune system will get weaker and weaker until it can no longer fight off life-threatening infections and diseases.
- Testing regularly for HIV means you can get antiretroviral treatment if you need it and stay healthy.
- AIDS describes a set of symptoms and illnesses that happen at the final stage of HIV infection, if left untreated.

What is HIV?

HIV is a virus that attacks cells in the immune system, which is our body's natural defence against illness. The virus destroys a type of white blood cell in the immune system called a T-helper cell, and makes copies of itself inside these cells. T-helper cells are also referred to as CD4 cells.

As HIV destroys more CD4 cells and makes more copies of itself, it gradually weakens a person's immune system. This means that someone who has HIV, and isn't taking antiretroviral treatment, will find it harder and harder to fight off infections and diseases.

If HIV is left untreated, it may take up to 10 or 15 years for the immune system to be so severely damaged that it can no longer defend itself at all. However, the rate at which HIV progresses varies depending on age, general health and background.

Basic Facts About HIV

- HIV stands for Human Immunodeficiency Virus.
- People with HIV can enjoy a long and healthy life by taking antiretroviral treatment which is effective and available to all.
- Once a person has HIV, the earlier they are diagnosed, the sooner they can start treatment which means they will enjoy better health in the long term.
- It's possible for antiretroviral treatment to reduce the level of HIV in the body to such low levels that blood tests cannot detect it. People living with HIV whose viral load is confirmed as undetectable cannot pass on HIV.
- Regular testing for HIV is important to know your status.
- HIV is found in semen, blood, vaginal and anal fluids, and breast milk.
- HIV can't be transmitted through sweat, saliva or urine.
- Using external (or male) condoms or internal (or female) condoms during sex is the best way to prevent HIV and other sexually transmitted infections.
- If you inject drugs, always use a clean needle and syringe, and never share equipment.
- If you're pregnant and living with HIV, the virus in your blood could pass into your baby's body, during birth or afterwards through breastfeeding.
- Taking HIV treatment and becoming undetectable eliminates this risk.

What is AIDS?

AIDS is a set of symptoms (or syndrome as opposed to a virus) caused by HIV. A person is said to have AIDS when their immune system is too weak to fight off infection, and they develop certain defining symptoms and illnesses. This is the last stage of HIV, when the infection is very advanced, and if left untreated will lead to death.

Basic Facts About AIDS

- AIDS stands for Acquired Immune Deficiency Syndrome; it's also called advanced HIV infection or late-stage HIV.
- AIDS is a set of symptoms and illnesses that develop as a result of advanced HIV infection which has destroyed the immune system.
- Fewer people develop AIDS now because treatment for HIV means that more people are staying well.

Although there is no cure for HIV, with the right treatment and support, people living with HIV can enjoy long and healthy lives. To do this, it's especially important to commit to taking treatment correctly

Key Myths and Misconceptions Around HIV and AIDS

Myths	Facts
I can get HIV by being around people who are HIV-positive.	HIV isn't spread through touch, tears, sweat, saliva, or pee. You can't catch it by: <ul style="list-style-type: none"> • Breathing the same air • Touching a toilet seat or door knob or handle • Drinking from a water fountain • Hugging, kissing, or shaking hands • Sharing eating utensils. • You can get it from infected blood, semen, vaginal fluid, or breast milk.
I could tell if my partner was HIV-positive.	You can be HIV-positive and not have any symptoms for years. The only way for you or your partner to know if you're positive is to get tested.
If I'm getting treatment, I can't spread the virus.	When HIV treatments work well, they can lower the amount of virus in your blood to a level that doesn't show up in blood tests. This is called an undetectable viral load. However, this doesn't mean zero viral load, and there can be intermittent increases in the virus level. So while you are less contagious with an undetectable viral load, the risk of spreading HIV is not zero.
You don't need to use protection if you have had a sexually transmitted infection (STI) because you can only have one STI at a time/ you are immune.	You can have more than one sexually transmitted infection (STI) at the same time. Each infection requires its own treatment. You cannot become immune to STIs. You can catch the same infection over and over again.

continued

Myths	Facts
You don't need to use protection if you have had a sexually transmitted infection (STI) because you can only have one STI at a time/ you are immune.	Many men and women do not see or feel any early symptoms when they first become infected with an STI, but they can still infect their sexual partner.
HIV always leads to AIDS.	HIV is the infection that causes AIDS. But this doesn't mean all HIV-positive individuals will develop AIDS. AIDS is a syndrome of immune system deficiency that is the result of HIV attacking the immune system over time and is associated with weakened immune response and opportunistic infections. AIDS is prevented by early treatment of HIV infection.

Source: UNAIDS (2002). "HIV/AIDS and Education. A Strategic approach"; The Global Content Bank, an International Clearinghouse on Curriculum for HIV/AIDS Prevention: www.unesco.org/education/ibe/ichae/; HIV/AIDS: Key Facts: Fact Sheet. World Health Organization. 2018.

Abortion

Facts Facts

- 1 in 5 women (including young girls) in Tanzania have an unmet need for contraception.
- Each year 1 million Tanzanian women have an unintended pregnancy of which 39% end in abortion.
- Each year 405,000 Tanzanian women have abortion, almost all clandestine, of which 40% result in complications that require medical treatment.
- 60% of Tanzanian women with abortion complications do not receive needed medical attention.
- The provision of abortion services in Tanzania is restricted by the law and only provided legally to save the life of the mother.

Introduction

An abortion is the spontaneous or induced expulsion of the pregnancy before 28 weeks. When abortion occurs spontaneously, it's usually called miscarriage or spontaneous abortion, and this happens in approximately one out of every four pregnancies. If a pregnancy is terminated intentionally or on request, this called Induced abortion. However, this process of terminating a pregnancy can be safe or unsafe.

Safe abortion: An abortion is considered to be safe if it is performed by a skilled person in an approved premise (Health facility) with safe and adequate equipment or products.

Unsafe abortion: An abortion is considered to be unsafe if it is performed by either an unskilled person or in unapproved premises or both with unsafe and risky methods.

The safety of abortion depends heavily on the legal, socio-cultural and hygienic service context before, during and after the medical procedure. In situations where abortion is

restricted by law and/or unavailable, and heavily culturally stigmatized, women may be forced to go to untrained providers or attempt to self-abort using unsafe methods (like using poison or inserting attributes in their vagina). Often these women are also unable to seek counselling or post-abortion care.

Unsafe Abortion Cause of Maternal Mortality:

Unsafe abortion has a great and significant cause of ill-health among women in the developing world. Estimates for 2016 in Tanzania indicate that:

- Maternal Mortality (MM) is amongst the leading public health concern nationally and unsafe abortion is 2nd leading direct cause of maternal mortality in Tanzania
- 405,000 women perform abortion every year mostly unsafe and 40% of these women experience complications from unsafe procedures and there 60% of the women who undergo abortion do not receive the care they need.

Health Impact of Unsafe Abortions:

Unsafe abortion leads to the estimated 47,000 deaths a year. In addition, women can face a variety of severe complications including sepsis, hemorrhage, genital and abdominal trauma, perforated uterus or poisoning that may be fatal if left untreated. Permanent disability can result from unsafe abortion. Long-term consequences of unsafe abortion may include chronic pelvic pain, infertility, a high incidence of premature delivery, and increased risks of spontaneous abortion. An estimated 2% of women of reproductive age are infertile as a result of unsafe abortion, and 5% have chronic infections (www.womenonwaves.org).

Abortion & Young People

Young people under the age of 25 face even more barriers, especially unmarried young women who are assumed to be not sexually active are also more vulnerable to maternal mortality and morbidity¹⁶, and have restrictions placed on their freedoms and choices relating to their lives, marriage and children. They often have no access to any form of Comprehensive Sexuality Education. In addition, they do not have the economic and social power to protect themselves against unintended consequences of sexual relations.

As a result, adolescent girls aged 10-19 account for at least 2.2-4 million unsafe abortions in developing countries¹⁷. Young women under the age of 25 account for almost half of all abortion deaths¹⁸ and this group is seriously affected by the consequences of unsafe abortion. Most of these young women live in developing countries where the grounds on which abortion is permitted are not very liberal. Even where there is a liberal law, adolescents often face another barrier, the requirement that they need parental or spousal consent¹⁹ to obtain an abortion or the law has age mandatory notification.

Despite of the different legal contexts, access to safe abortion services especially for adolescents and young girls remains a challenge. Evidence points out that adolescents and young girls are more susceptible to delay seeking an abortion, and resort to unsafe abortion providers due to fear, lack of knowledge and financial resources. Unmarried, pregnant young

¹⁶ Young Women, Unwanted Pregnancy and Unsafe Abortion: Are We Achieving Global Goals? <http://www.medicalabortionconsortium.org/news/young-women-unwanted-pregnancy-and-abortion-are-we-achieving-global-goals--1064.html>

¹⁷ <http://www.ipas.org/en/What-We-Do/Youth.aspx>

¹⁸ <http://www.dfid.gov.uk/Documents/publications1/pol-2010-safe-unsafe-abort-dev-cntries.pdf>

¹⁹ This law obliges young girls to receive parental consent for the procedure prior to performing it.

women face stringent barriers to abortion and are forced to seek out unsafe abortions and often fear stigmatization should their families and societies become aware of their pregnancies. As a result, this group is more like to suffer from abortion-related complications, including immediate and long-term disability and death²⁰.

Myths and Facts About Abortion

Myths	Facts
Women who have abortions have emotional problems afterwards	The most reliable indicator of whether a woman will experience feelings of distress after an abortion is her emotional stability before the abortion. Women indicate that the most common feeling after the completion of an abortion is relief. While some women also experience a sense of loss, sadness, or grief, having an abortion is not associated with long-term psychological distress.
If I have an abortion I won't be able to get pregnant again.	Having an abortion will not prevent you having a healthy pregnancy when you are ready.
Minors should have their parents' consent before having an abortion.	<p>Parents should ideally be involved in their daughter's pregnancy and should support her in her choices, keeping her best interest in mind. But we must recognize that in some circumstances (for example incest or when children don't live with their parents) this is not feasible or appropriate.</p> <p>Parental or spousal consent requirements also infringe young women's right to bodily autonomy and privacy. Requirements for parental or spousal consent often make it harder for young women to access abortion services quickly. Sometimes, this results in young women trying to access second or third trimester abortions, which present more risks for the young woman.</p>
I cannot get pregnant immediately after having an abortion	It is possible to get pregnant right after an abortion, even before you have had a period. To prevent a pregnancy, talk to your provider about birth control methods that you can use immediately after an abortion.

Source: Price N, Ezekiel M and Hawkins K, *Addressing the Reproductive Health Needs and Rights of Young People Since ICPD: The Contribution of UNFPA and IPPF, Tanzania Country Evaluation Report, 2003, Heidelberg, Germany: Euro Health Group, University of Heidelberg.*

²⁰ <http://www.pathfinder.org/publications-tools/pdfs/Technical-Guidance-on-Youth-Friendly-Postabortion-Care.pdf>
Post abortion care consortium

Stigma & Discrimination

Stigma is a powerful social process of devaluing people or groups based on a real or perceived difference—such as gender, age, behavior, or ethnicity.

Discrimination follows stigma and is the unfair and unjust treatment of an individual based on that socially identified status.

Stigma and discrimination are formidable barriers to effective and equitable healthcare. They keep young people from seeking out services that can improve their health, or, in some cases, save their lives. Yet, stigma and discrimination remain seriously neglected issues, in part because of a lack of agreed upon measurement tools to quantify the extent and impacts of stigma and discrimination and gauge the effectiveness of stigma-reduction efforts.

Certain groups, such as young people, people with disabilities (PWDs), people living with HIV/AIDS (PLWHAS), sex workers are highly stigmatized, restricting their access to SRH services. In general, women experience more stigma and discrimination than men. Stigma surrounding young people's sexual behavior and sexuality reduces the availability of HIV, contraception and abortion services among many other reproductive health services for youth and makes young people—who may seek to conceal their sexual activity to avoid stigma—reluctant to access services.

Consequences of Stigma and Discrimination

- Evidence shows that stigma reduction is crucial to the success of HIV prevention, care, and treatment efforts. Stigma and fear of stigma discourage people from getting tested for HIV, disclosing their HIV status, seeking contraceptive, abortion and post abortion care.
- Stigma hinders prevention efforts, as prevention methods such as condom use are often seen as indications of HIV infection, immoral behavior, or lack of trust. A recent modeling study suggests one-third to one-half of all vertical transmissions can be directly attributed to stigma. Family members and friends of people living with HIV and healthcare providers who work with people affected by HIV also experience stigma and discrimination.

What Can We Do?

Addressing stigma and discrimination could play an important role in increasing access to and uptake of family planning and other reproductive health services related to HIV and abortion. For example, in many places, seeking or using family planning may itself be a stigmatized behavior; discrimination restricts indigenous women's access to maternal and reproductive health services; and stigma can affect whether women seek facility-based childbirth, thereby affecting prospects for maternal and child health.

Activity 3.1: Brainstorming

Ask the participants to brainstorm on groups of people which are highly stigmatized on access to SRH services in their communities.



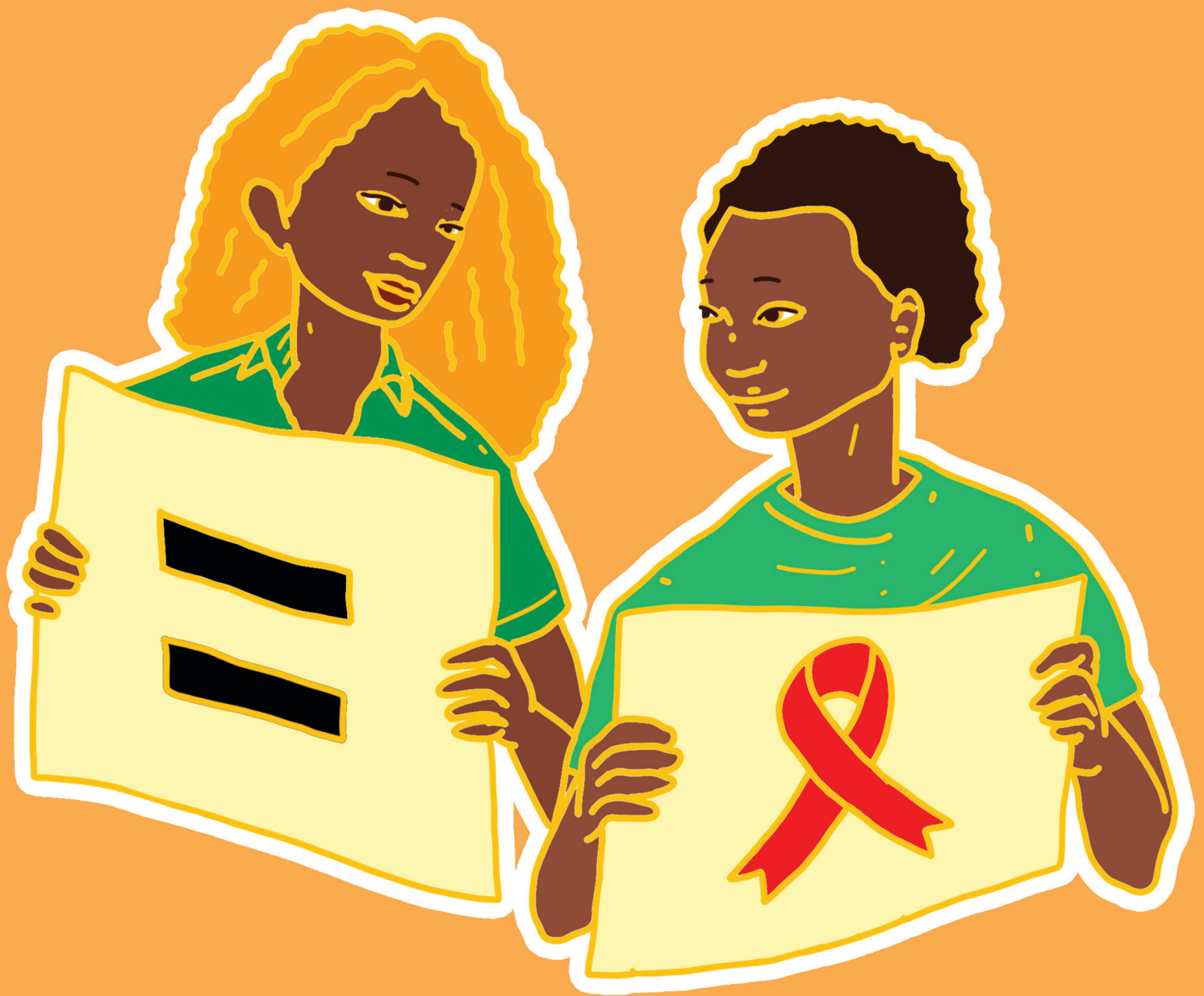
TIPS FOR FACILITATOR

Conclude by suggesting a few actions below that can be adapted by young people to fit their specific context:

- Build the evidence base on stigma and discrimination to inform HIV, unwanted pregnancy and unsafe abortion prevention, care, and treatment.
- Create and apply tools, methodologies, and metrics to reduce stigma and improve the quality and use of services. Take participants through the SABAS tool in Annex...
- Strengthen measures for scale-up of interventions for stigma reduction in healthcare settings
- Foster partnerships among government institutions, National youth officers and key stakeholders to devise and implement policies and strategies that curb HIV, contraceptive and abortion-related stigma and discrimination
- Address misconceptions and negative perceptions surrounding SRHR of young people by working with service providers, local government, parents/guardians, teachers and women's associations to advocate for increased youth friendly service and engagement of young people in open debates around their SRHR.



KEY MESSAGE: Youth need to avoid SRHR misconception. Youths must stop having myths especially those related to SRH matters instead they need to have a right information rather than believing what they hear in the streets without a scientific proof.



MODULE 4
ADVOCACY SKILLS
AND BECOMING
A SRHR CHAMPION

MODULE 4 ADVOCACY SKILLS AND BECOMING AN SRHR CHAMPION

(5 hours)



KEYWORDS: *Human Rights, Advocacy, Sexual Education, Safe Abortion, Reproductive Health, Sexual Violence, Youth Participation*

MODULE OVERVIEW

This module offers a step-by-step guide to help plan, implement or improve advocacy initiatives on young people's sexual and reproductive health and rights in order to promote youth leadership for their SRHR. It provides a WGNRR perspective on youth-led advocacy.

The module addresses generalities of advocacy, who advocate to whom, opportunities for advocacy, development of advocacy strategies, and action planning.

MODULE OBJECTIVES

By the end of this module, participants will be able to:

1. Understand what advocacy is all about and key concepts around it.
2. Describe key steps for developing an advocacy strategy.
3. Develop an action plan for influencing SRHR of young people in their communities.

Materials Needed

- Flip chart
- Marker pen
- Sticky cards
- Pieces of paper

Session 4.1.

SETTING THE TONES: WHAT ARE HUMAN RIGHTS

(40 Minutes)

SESSION OBJECTIVES

A quick recap to explore participants' current personal understanding of basic concepts of human rights and SRHR as human rights.

What are Human Rights

Human rights as are entitlements inherent to all human beings, whatever our nationality, place of residence, sex, national or ethnic origin, colour, religion, language, or any other status. We are all equally entitled to our human rights without discrimination. These rights are all interrelated, interdependent and indivisible." (UN Office of the High Commissioner for Human Rights)

“All human beings are born free and equal in dignity and rights.” (Article 1 of the Universal Declaration of Human Rights)

The international and regional communities have also agreed to promote, protect and fulfill these entitlements under different human rights agreements. These agreements form the international and regional human right law. Some of the international and regional human rights agreements include: - 1. The universal Declaration for Human Rights (UDHR - 1948); the International Covenant on Economic, Social and Cultural Rights (ICESCR - 1966), the Convention on the Elimination of all form of Discrimination Against Women (CEDAW - 1979), and the Convention on the Rights of the Child (CRC - 1989), and Protocol to the African Charter on Human and Peoples’ Rights in Africa (the Maputo Protocol - 2003). All these human rights instruments have provisions that guarantee “the right to a standard of living adequate for the health, and wellbeing of himself and his family...; the right of everyone to the enjoyment of the highest attainable standard of health...; the rights to live free from violence and discrimination.”

Other human rights instruments include:

- International Convention on the Elimination of All Forms of Racial Discrimination (ICERD) – 1965.
- International Covenant on Civil and Political Rights (ICCPR) – 1966.
- Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) – 1984.
- International Convention on Protection of the Rights of All Migrant Workers and Members of Their Families (ICMRW) – 1990.
- International Convention for the Protection of All Persons from Enforced Disappearance (CPED) – 2006.
- Unintended Nations Convention on the Rights of Persons with Disabilities (UNCRPD) – 2006.
- The African Charter on the Rights and Welfare of the Child (ACRWC – 1990)

Features of Human Rights

- **‘Fundamental’**: individuals need them to survive.
- **‘Inherent’**: not ‘given’ to someone. Every person has them and is entitled to them by virtue of being human.
- **‘Inalienable’**: cannot be taken away because they are linked to the human existence. However, in particular circumstances some – though not all – may be restricted. For example, someone found guilty of a crime, his or her liberty can be restricted; or in times of national emergency, a government may restrict people’s movements by imposing curfews and lockdowns.
- **‘Universal’**: they apply equally and available to all people everywhere in the world without distinction of “race” or ethnicity, color, age, sex, sexual orientation, disability, language, religion, political or other status.
- **‘Indivisible’**: no hierarchy in rights. There is no right bigger or important than another
- **‘Interdependent’**: Human rights are not separable, they are intrinsically connected and cannot be viewed in isolation from each other. The enjoyment of one right depends on the enjoyment of many other rights.

SRHR as Human Rights

Activity 4.1. Brainstorming: Example of human rights and SRHR

Procedure

1. Ask participants to quote some human rights they may know
 - Right to Health
 - Right to Life and to be free from harm
 - Right to Education
 - Right to Information
 - Right to Bodily Integrity & Personal Autonomy
 - Right to Privacy
 - Right to freedom of thought & expression
 - Right to equality & freedom from discrimination
2. Allow them to brainstorm and quote some SRHR discussed in the previous module.
3. Emphasize that SRHR are NOT NEW rights; are actually existing human rights.

Conclusion

Conclude the session by emphasizing that *“Human rights entail both rights and obligations.”* Whereas we are rights holders; we have the obligation of respecting the human rights of others. As a duty bearer, the State assumes obligations and duties under international law to respect, to protect and to fulfil human rights of all.

Session 4.2.

ADVOCACY GENERALITIES

(2 hours)

SESSION OBJECTIVES

To build mutual understanding of what advocacy is all about and why it's important for change

Materials Needed

- Flipchart
- Marker pens
- Sticky cards
- Masking tape
- Pieces of papers

What is Advocacy

The term 'advocacy' means different things to different people (see below). Basically, advocacy is fundamentally influencing the policies, attitudes and behavior of people and organizations with power. It refers to the different ways we can build political, financial or public support to bring about action for change. It involves influencing leaders and decision makers to address the root causes of problems and to generate long-term sustainable solutions.

Advocacy is about

making your views heard, or acting on another's behalf to make his or her views heard, by people making decisions on issues affecting you or other person, and about enabling people to take control over their rights/lives and thereby also influencing their communities.

Some Example Definitions

- "Advocacy is speaking up, drawing a community's attention to an important issue, and directing decision makers toward a solution. Advocacy is working with other people and organizations to make a difference." *CEDPA: Cairo, Beijing and Beyond: A Handbook on Advocacy for Women Leaders.*
- "Advocacy is defined as the promotion of a cause or the influencing of policy, funding streams or other politically determined activity." *Advocates for Youth: Advocacy 101.*
- "Advocacy refers to the planned process of organized citizens to influence public policy and programs." *Corporación PARTICIPA 2003.*
- "Advocacy is a set of targeted actions addressed to decision makers in support of a specific political cause." *Policy Project, 1999*
- "Advocacy is the process of building support for an issue or cause and influencing others to act." *FCI Mobilising communities on young people's health and rights. An Advocacy Toolkit.*
- "Advocacy means identifying and calling for change in laws, policies, practices and structures in order to improve people's lives." *Young people as advocates. Your Action for Change toolkit of IPPF.*

What is a Campaign?

Often the terms advocacy and campaigning are used interchangeably. They often reinforce each other to reach the same goal. In summary, a campaign is an effort to bring about change in the society. Real change requires the support of a variety of actors, from citizens in local communities to national political leaders and beyond. Campaigns can provide a platform to unite like minded individuals at all levels with a common agenda. It is not one single action, but a combination of a number of actions, reports and events put together in a sequenced plan.²¹ These could include advocacy activities which are often more focused on policy change. A campaign should be big enough to make a difference, but manageable enough to get short-term results. It should build the base for future campaigns and actions.²²

Box 1: A campaign for Sanitary napkin policy change

In Kenya, young girls were dropping out from high school because they could not afford to pay for sanitary napkins. This violated not only their right to health, but also their right to education. A simple policy change was sufficient to improve their situation: the Kenyan government cancelled taxes on sanitary napkins and the costs declined by 75%. However, this only happened after the problem had reached the national media through the campaign of a non-governmental organisation.

This case illustrates that governments can be sensitive to pressure by public opinion, and also that both the general public and the government are not aware of many daily realities facing young boys and girls.

²¹ UNDP, Blue Book

²² CIVICUS MDG Campaign toolkit

Objectives and Levels of Advocacy

Advocacy can have many different objectives. For example, we can advocate to increase support for a cause, to influence leaders and decision makers, to build an environment that enables young people to exercise their rights, or to change laws or legislation. All forms of advocacy aim to influence decision makers in order to bring about change.

Change can take place on several levels, such as:

- At Individual level (for example with changing individual attitudes, behavior and practices)
- At local level (for example with local government, police, religious leaders, school system)
- At national level (for example with national governments, ministries)
- At international level (for example with UN agencies, the World Bank, the Global Fund to Fight AIDS, Tuberculosis and Malaria)

At both levels, change usually happens in at least three different phases:

- **Head (knowledge).** Firstly, your target audience needs to have accurate information and understand the change you are advocating for and why you are proposing it.
- **Heart (attitude).** Secondly, even if your target audience has all the technical information, they might still need to be convinced about the benefits and value of your proposal, to know in their heart that what you are proposing is the right thing to do.
- **Hands (practice/implementation).** Once you have allies for your cause, you may still need to support them to translate the proposed change into action. This involves monitoring how the change is being implemented to make sure that your strategies are working effectively towards change. Sometimes, it might be necessary to work with others to adjust your strategies to maximize effectiveness.

How is advocacy different?

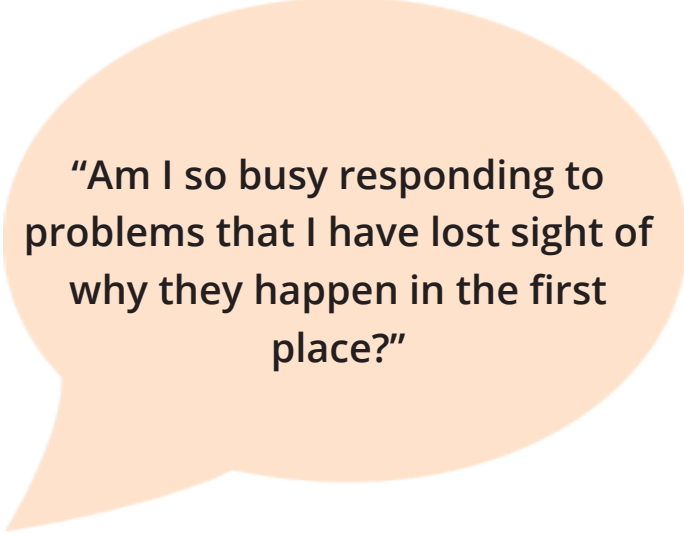
It can be confusing to understand how advocacy is different from other related strategies, including information, education and communication, comprehensive sexuality education and public relations.

Advocacy and Related Strategies				
Strategies	Messengers	Objectives	Target audiences	Methods & activities
Information, education and communication	<ul style="list-style-type: none"> • Service providers • NGOs • Social workers • Public health agents • Peer educators 	<ul style="list-style-type: none"> • To inform, educate or communicate on a specific topic • To raise awareness and trigger interest in a particular topic • Can include behavioural change 	<ul style="list-style-type: none"> • Individuals • Specific population groups (such as young people, people living with HIV etc) • General public 	<ul style="list-style-type: none"> • Pamphlets or flyers • Posters or billboards • Websites • Social networking sites • Newspapers • Text messaging • Theatre

Advocacy and Related Strategies				
Strategies	Messengers	Objectives	Target audiences	Methods & activities
Comprehensive sexuality education	<ul style="list-style-type: none"> • Teachers • Sex educators • Peer educators • Parents 	<ul style="list-style-type: none"> • To provide comprehensive and in-depth information about sexuality and gender • To increase knowledge and understanding of diverse aspects of sexuality and gender 	<ul style="list-style-type: none"> • Students • Children and young people (both in and out of school) 	<ul style="list-style-type: none"> • Formal education curricula • Informal educational programmes
Public Relations	<ul style="list-style-type: none"> • Businesses • Commercial agencies • Manufacturers 	<ul style="list-style-type: none"> • To promote a product, service, company or organization • To increase sales 	<ul style="list-style-type: none"> • Consumers 	<ul style="list-style-type: none"> • Large-scale advertising (TV, radio, print media, internet) • Public events
Advocacy	<ul style="list-style-type: none"> • NGOs • Service providers • Research Institutions • Universities • Advocates 	<ul style="list-style-type: none"> • To generate political, public or financial support for a particular issue • To change laws or policies • To influence the allocation of public resources 	<ul style="list-style-type: none"> • Policy makers • Decision makers • Governments • Religious leaders • Community Leaders • Donor agencies 	<ul style="list-style-type: none"> • Campaigns • Petitions or letter writing • High level meetings with decision makers, such as parliamentarians • Public debates • Factsheets, policy briefings or reports • Press conferences • E-advocacy

Why is advocacy important?

Sometimes, thinking about all the change you want to happen can seem overwhelming. It's a bit like coming home to find your house flooded from a leaky tap. Your initial reaction might be to grab a mop and start cleaning up the water as fast as you can. The problem is that no matter how quickly you mop, the tap will continue to drip. What you need to do is find a way to repair the leaky tap. Once the water stops leaking, it will be much easier to mop up the floor.

Ask yourself:

“Am I so busy responding to problems that I have lost sight of why they happen in the first place?”

Advocacy is important, because it can:

- » Influence changes in policies and mindsets: Generating commitment and buy-in from leaders and decision makers is vital to ensure sexual and reproductive health and rights for all. Advocacy can help generate this commitment. It can influence the creation, implementation and improvement of laws and policies.
- » Secure funds and resources: For change to happen, commitments to sexual and reproductive health and rights must be backed by financial, human and technical resources. Advocacy can ensure that sufficient resources are allocated for programme implementation and service delivery.
- » Mainstream sexual and reproductive health and rights: Sexual and reproductive health and rights are closely linked to many other aspects of life and development, including education, economics, the environment and human rights. It's therefore important to take a comprehensive approach. The problem is that sexual and reproductive health and rights are often treated as a health issue in isolation from other sectors. Advocacy can be used to generate awareness and an understanding about the importance of mainstreaming these rights into all aspects of development.
- » Build a movement: The most powerful social movements are those that unite commitment and activism from all levels: local, national, regional and international. Advocacy plays a key role in generating support on each level, creating a stronger movement.
- » Safeguard and protect previous achievements: A lot of progress has already been made towards ensuring sexual and reproductive health and rights around the world. However, political, economic and cultural landscapes are constantly changing so it's important for us to protect the gains we have already won. Advocacy allows us to do this by acting as a watchdog to make sure that governments and leaders uphold their commitments to sexual and reproductive health and rights.



Who can be an Advocate? Who can Champion Young people's SRHR?

Anyone with a passion for an issue or cause can be an advocate. However, Young people can be some of the best advocates and champions for youth sexual and reproductive health and rights, because they have the best understanding of their own needs, realities, desires and capacities.

In fact, it is a human right for young people to participate in decision making that affects their lives and to have their voices heard by decision makers. This right is enshrined in the UN Convention on the Rights of the Child and in the African Charter on the Rights and Welfare of the Child, which has been ratified by almost every country in the world and in Africa respectively. So, young people of every age and from every social class can all be sexual and reproductive health and rights advocates or champions.

But, what does it take to be an effective advocate? The recipe is quite simple. You need:

- Passion and dedication to an issue or cause
- A clear vision of what change needs to happen
- The ability to collaborate with others
- Time and commitment to prepare and follow up with advocacy interventions
- Strong communication skills
- The persistence to keep going

You can lead change in your immediate surroundings or the world at large. Being an agent for change in your immediate surroundings can be very powerful.

Never underestimate the 'ripple effect': you inspire someone who inspires someone else who inspires someone else, and so on, until the ripples from a drop of rain transform into ocean waves.

We can also be champions and agents of change at a higher level, such as at national, regional or international levels. Advocacy at these levels has the potential to affect an even larger group of people, but change might happen at a slower pace than local level advocacy.

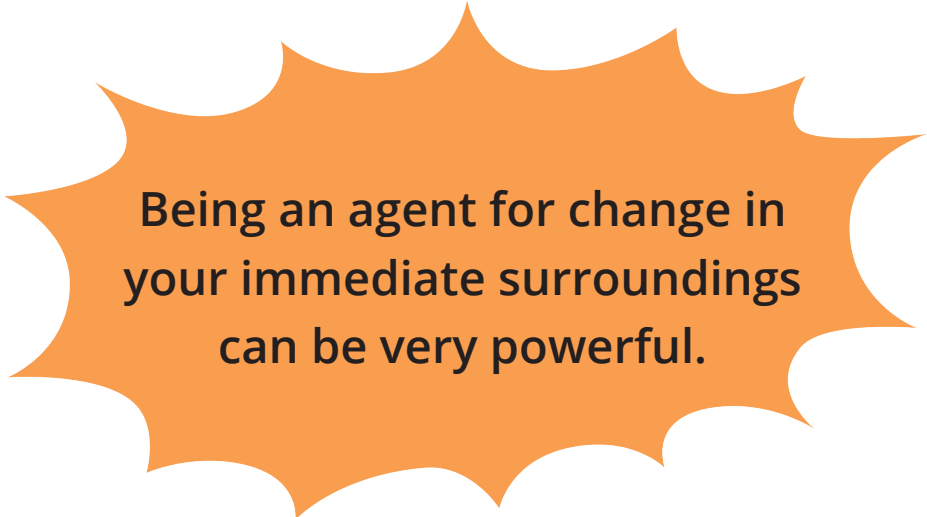
What do Advocates/Champions do?

As an advocate you can play many different roles. For example, you can:

- Raise awareness about sexual and reproductive health and rights or related issues among leaders and decision makers to make specific changes to legislation, policies and/or their implementation
- Collaborate with other young people and advocates in campaigns to promote sexual and reproductive health and rights
- Ensure that leaders (your government, religious leaders, school etc) respect, protect and fulfil young people's sexual and reproductive rights.
- Write and distribute factsheets, reports or other materials to provide evidence about the importance of prioritizing young people's sexual and reproductive health and rights

But, remember, you don't have to do this alone. Other organizations and people may have different skills, and access to different knowledge or target audiences that can be useful for your advocacy goals. Collaborative advocacy can often generate stronger voices that reach wider audiences and lead to lasting change.

Change is possible! There is always something you can do, no matter how large or small.



**Being an agent for change in
your immediate surroundings
can be very powerful.**

How do we do advocacy: Seven key steps

<p>STEP 1: What needs to change?</p>	<p>Advocacy is about identifying and calling for change, so we need to be very clear about exactly what it's that we are trying to change. Before starting out on an advocacy initiative, make sure you identify accurately what it is that you are trying to change. It is best to do this with input from as many stakeholders as possible, especially young people themselves. It's really important to identify clearly what needs to change to make sure your advocacy efforts don't go off in too many different directions</p>
<p>STEP 2: Who can make that change happen?</p>	<p>Once we have correctly identified what needs to change, we must look at who can make this change happen – in other words, who are we targeting? There are a lot of people you may want or need to convince: your peers, family, school, community leaders or parliamentarians. Keep in mind that the goal of advocacy is to influence policies, laws or structural change. When deciding who to target, think about who is most able to influence these changes.</p>
<p>STEP 3: How can I influence my advocacy targets to make that change?</p>	<p>We have correctly identified the essential change, and identified who can make the change happen. The next step is to look at how we can influence these people to make the change happen. For this, we need to develop the right approach and the right tools to reach the identified targets effectively.</p>
<p>STEP 4: How can I ensure meaningful participation of young people?</p>	<p>Young people's meaningful participation in decision making that affects their lives is a human right. When advocating for young people's SRHRs, it's important that they are involved as equal partners throughout the entire process. Young people needs to be involved in identifying key problems relating to their SRHR, devising solutions to address these problems, developing advocacy messages, and speaking in their own right to decision makers and other advocacy targets, and in monitoring and evaluating advocacy efforts.</p>
<p>STEP 5: Who Can I work with</p>	<p>Successful advocacy generally relies on the support of a number of individuals and organizations. To create support for your issue, it is important to be able to network, participate in coalitions, and influence as many individuals and organizations as possible to join in. In essence, a coalition is a group of like-minded people or organizations working together to achieve common goals. The good thing about coalitions is that by working together with like-minded groups, you will have combined intelligence and resources</p>

**STEP 6:
What obstacles
might I face?
How can I
overcome
obstacles and
risks?**

Next we need to identify potential obstacles or risk factors we might face. Not only will this help us to be prepared in case something goes wrong, but it might also stop us from wasting valuable time on something that is too risky to attempt in the first place. Of course, once we have identified these obstacles, we also need to come up with solutions to overcome them so that we can move forward on our journey to changing the world!

**STEP 7:
How will I
monitor and
evaluate my
advocacy to
prove it is
working?**

Congratulations – you are nearly ready to start changing the world! Although we are now eager to get on with putting all of this into practice, there is one last step that we need to consider but which often gets left out of advocacy: we need to think about monitoring and evaluating our advocacy work.

Monitoring: is an ongoing and systematic activity used to track whether activities are carried out according to plan.

Evaluation: is an assessment of the relevance, efficiency, effectiveness, performance and sustainability of a project. It requires an in-depth review at specific points in the life of the project, usually at the mid-point or end of a project. Evaluation verifies whether project objectives have been achieved or not.

Action Planning

What can we advocate on?

You can advocate on any issue you feel strongly about. Your passion can have a huge impact on the success of your campaign.

Look back at step 1 of 'How do we do advocacy?' (see page 69). Ask yourself: What issues are the most urgent or affect young people the most? Now, learn as much as you can about these issues so that you feel comfortable advocating for them. Also, be aware of what the Tanzania legislation provides for the issue you want to advocate for.

Here is a bit of background to some key sexual and reproductive health and rights issues, including services, education and violence. However, there are many more issues out there that you can advocate for. Whatever you choose to advocate on, remember the following core principles about young people's sexual and reproductive health and rights.

Sexuality is an integral part of being human for ALL young people. All young people are sexual beings – whether or not they are sexually active. Young people are very diverse and experience their sexualities in very different ways. Many factors influence young people's sexual behaviors, relationships, feelings, identity, desires and attitudes. Therefore, each young person's experiences are unique. A truly responsive advocacy campaign should reflect these

diversities. Despite these differences, every young person is entitled to personal fulfillment and to freedom from coercion, discrimination and violence, regardless of age, gender, race, ethnicity, religion, marital status, HIV status, sexual orientation, health status etc. As sexual and reproductive health and rights advocates, we must emphasize the principles of non-discrimination, integrity and choice. It is important to make a strong case for recognizing young people's sexuality from a human rights-based approach.

The evolving capacities of children and young people must be recognized. Childhood and youth are periods of transition and change. In general, young children need more protection and help to make decisions than older youth and adults. The importance and relevance of some rights change as someone makes the transition through the different phases of their life. This means that the rights of children and young people must be approached in a progressive and dynamic way. Approaching young people's sexual rights in this progressive way puts the onus on us, as advocates, to respect their diversities and ensure they are empowered both to exercise rights on their own behalf, while also being protected and guided with their best interests in mind.

Services

When advocating for services, think about the service, the client, the quality and the method of delivery, including the involvement of young people.

- » ***Access to comprehensive sexual and reproductive health services for all young people, particularly the unmarried:*** This is about ensuring that all young people have access to a full range of youth friendly sexual and reproductive health services. This means a wide range of affordable contraceptives, including emergency contraception; testing and care for sexually transmitted infections, HIV; pregnancy tests; pre-, ante- and post-natal care; safe and post abortion care; support for young people living with HIV; and support for young people who experience sexual violence. Making services youth friendly means just that – providers are approachable, non-judgmental, non-discriminatory and trained in providing services to young people. It also means ensuring confidentiality and privacy while always respecting the dignity and rights of all young people. Young people themselves should participate in every aspect of planning, delivering and evaluating services. Your advocacy efforts can highlight the importance of providing youth friendly services and could also highlight the consequences of denying young people access to the services they need. These include ill health, mortality, lack of development opportunities for individuals and communities, and poverty.
- » ***Access to condoms:*** All young people should have access to free or affordable high-quality condoms, regardless of age, sex and other socio-economic circumstances. If we're serious about combating sexually transmitted infections and unintended pregnancies then easy access to condoms is a must. We need to ensure that male and female condoms are available, together with information on how to use them correctly, and how they contribute to safer sex.
- » ***Increasing access to emergency contraception for all young women:*** Emergency contraception prevents pregnancy. It does not cause an abortion. Women sometimes need emergency contraception for many reasons, even though they use contraceptives

regularly: the condom broke; they might have forgotten to take the contraceptive pill; sex might have been forced or unplanned. In all these circumstances, the responsible course of action is to use emergency contraception to prevent an unplanned pregnancy. Access to emergency contraception doesn't increase sexual activity among young people, but denying them access to it may increase unintended teenage pregnancy²³.

- » **Access to safe and legal abortion services:** Faced with the stigma of an unplanned teenage pregnancy, some young women turn to abortion whether or not it is legal in their country. As many young people do not have access to comprehensive youth friendly services, they delay seeking advice and resort to clandestine abortions performed by unskilled practitioners under hazardous conditions. This can have disastrous consequences such as infections, severe bleeding and even death. As advocates for young people's sexual and reproductive health and rights, access to safe and legal abortion should be high on your agenda. No matter what value we place on fetal life, we cannot ignore the consequences of an unsafe abortion on the quality of young women's lives. When young women are deprived of information and the ability to decide to have or not have a legal safe abortion they suffer, and their families suffer.
- » **Parental or spousal consent for sexual and reproductive health services should not be mandatory:** This is not an easy one. Parents should ideally be involved in and supportive of their children's sexual and reproductive health. But we have to admit that in some circumstances, such as in the case of incest, this is not feasible or appropriate. What is important, however, is that when a young person needs a service they should not be denied it due to lack of parental consent. Parents have a special duty to protect and promote their children's rights. As a child grows and evolves, the parents' role makes the transition progressively towards supporting their child to exercise rights on their own behalf. According to the Convention on the Rights of the Child, parents and adults should always make decisions in the best interests of a child or young person. Three principles must be taken into account. These are: - 1) all children have the right to be treated without discrimination; -2) all children have the right to survival and development; -3) all children have the right to participate in decision making.
- » **Sexual and reproductive health services for young people living with HIV:** Being young and HIV-positive shouldn't prevent someone from expressing their sexuality. Young people living with HIV have sexual and reproductive health needs and have the right to express and enjoy their sexuality like all other young people. Unfortunately, stigma, discrimination and taboos about sexuality often prevent young people living with HIV from accessing the sexual and reproductive health services and information they need. We need to ensure that youth friendly clinics welcome young people living with HIV and allow them to participate in the same way as other young people. We also need to ensure that young people living with HIV and the communities around them are aware of their sexual and reproductive rights, including: • the right to decide if, when and how to disclose one's HIV status
- » **Promote female condoms:** While male condoms are often cheaper and more easily available, the female condom is still a mystery to many young people. Pharmacies and clinics rarely offer them and, when they are available, they often cost much more than male condoms. Unfortunately, negative messages about their size, the sound they make, their appearance, lubrication and other physical concerns have overshadowed the promotion of female condoms. There is a need to address the reasons that prevent

²³ SIECUS, www.communityactionkit.org/pdfs/Getting_Ready_To_Advocate/Debunking_Condoms.html

young people accessing female condoms, including lack of information about them, poor availability, slow production and import processes, and lack of financial investment from donors.

- » ***Young people with a disability should have access to sexual and reproductive health services so that they can have a safe and satisfying sex life***²⁴: To be human is to be sexual. Societies sometimes view young people living with disabilities as 'defective' and as asexual. They are denied basic human rights, particularly rights relating to sexuality and reproduction. When sex and disability are discussed, it is mostly about fertility or pregnancy, but almost never about broader aspects of sexuality such as pleasure. Yet sexual expression is a natural and important part of every human life; to deny that a young person with a disability is sexual is to deny them the basic right of expression. Additionally, because of a lack of understanding about their sexuality, they are often victims of sexual abuse and violence. We must remember that young people's abilities and disabilities are varied and therefore their needs and wants are varied too. We need to make our services accessible. This is not just about having a wheelchair ramp or information, education and communication materials in Braille; what is needed are comprehensive and appropriate services that cater specifically for their sexual health needs. Working in partnership with young people with disabilities is crucial if we are to uphold their rights to participation.

Education

- » **Promoting comprehensive, gender-sensitive and rights-based sexuality education**
The right to information and education is unarguable. Comprehensive, gender-sensitive and rights-based sexuality education is essential to help young people prepare for healthy and fulfilling lives. High quality information and comprehensive sexuality education can equip young people with the knowledge and skills they need to make informed choices now and in the future. It also helps to enhance their independence and self-esteem and to experience sexuality and relationships in a positive way. A large and growing body of research shows that high quality, comprehensive and rights-based sexuality education programmes can delay the initiation of sexual activity and unprotected intercourse, decrease the number of sexual partners, increase contraceptive use, and therefore decrease unintended pregnancies and sexually transmitted infections among young people.
- » **Challenging "Abstinence-only" Messages**
It has been argued that abstinence-only messages are the most successful at making young people delay sexual activity, because abstinence is the only contraceptive method that is 100 percent effective. However, there is currently no strong evidence that proves that abstinence-only programmes delay sex or reduce teenage pregnancy. In reality, young people around the world are sexual beings and engage in sexual activity. Sometimes they choose to be sexually active, but sometimes they are forced into it. Abstinence is often defined in vague terms, leaving young people confused about what it really means. Promoting an abstinence-only approach does not respond to the realities of young people's lives.

²⁴ See the UN Convention on the Rights of Persons with Disabilities, www.un.org/esa/socdev/enable

Some studies show that abstinence-only programmes can promote other sexual practices that can put young people at greater risk of sexually transmitted infections.

Abstinence-only messages leave young people ignorant about sexual health. This makes it harder for them to make informed decisions about safer sex when they start to become sexually active, whether in marriage or not. Providing comprehensive information on safer sex encourages young people to be sexually responsible and empowers them to make informed decisions

» **Young mothers should be allowed to continue their education.**

When a girl becomes pregnant she is often forced to leave school and, after having her child, it is often impossible to return. This is unjust. What about the young man involved? Does he have to leave school as well? No, he doesn't. Ideally, they should both be supported in their education and in their parenthood. Becoming a mother as an unmarried teenager has a major impact on a young woman's life. In addition to her own worries about the possible lack of further education, employment and about being a parent, she could also be stigmatized by her community. Think about the dilemma that a young woman faces – limited information on safer sex, limited access to contraceptives, no access to safe abortion services, no support to continue her education and now she is pregnant. Something needs to change! We know that educating girls is vital for development and a way of breaking the cycle of poverty. This is why we need to advocate for an education system that helps girls complete their education and supports young parents with child care while in school.

Violence

» **Promoting the right to be free from sexual violence**

According to the Convention on the Rights of the Child, all young people have the right to be protected from harmful practices, and have the right to be free from abuse and exploitation²⁵. Special attention must be given to all forms of sexual violence, including rape, incest, physical and verbal harassment, trafficking and female genital mutilation. Violence can happen anywhere: within the family, within marriage, when dating or in a relationship, in the street, in school or at the workplace. Sexual violence is always associated with stigma and shame, and the victim often gets the blame.

So, what can we do?

- We must change attitudes surrounding sexual violence that promote feelings of shame and guilt in its victims and encourage victims to come forward. Changing public perceptions of rape and sexual violence is an essential first step.
- We must support those who have been affected by sexual violence and help them heal through effective and compassionate services that respect their dignity and privacy.
- Too often, victims of sexual assault feel re-victimized by the criminal justice system. We need to fight for responsive, sensitive criminal justice practices.
- Prevention of sexual assault is essential and education is a key component.
- We must engage men and boys as partners in promoting sexual and reproductive health and rights.

²⁵ Convention on the Rights of the Child (1989), Articles 19, 24 (3), 34

» **Young men and sexual violence**

While the majority of sexual assault victims are women, men too face rape and other forms of sexual violence; often the shame, guilt and stigma they face when reporting such violence is greater because of false assumptions about masculinity. When changing public perceptions about rape, we must also include male survivors. Involving men and boys in sexual assault prevention is not only common sense, but it gives greater strength and credibility to our purpose. Effective sexual violence awareness programmes should be developed in collaboration with young men and should be aimed at both young men and women. Programmes should also work with young sex offenders to prevent re-offending. Above all, we should adopt and promote a zero-tolerance approach to all forms of violence.

Meaningful Youth Participation

The meaningful participation of young people in decision making is an essential component of ensuring sexual and reproductive health and rights worldwide. Young people should be involved in a meaningful way in all aspects of sexual and reproductive health programmes and policy making for several reasons: (1) to ensure that interventions respond to the realities of young people; (2) to inspire ownership and commitment by young people over sexual and reproductive health interventions; and (3) to empower young people with greater confidence and leadership abilities. The Tanzania government, as signatory of the UN Convention on the Rights of the Child and the African Charter on the Rights and Welfare of the Child, is committed to promote youth participation in decision making. However, young people still experience a great deal of exclusion, tokenism and patronizing attitudes. As sexual and reproductive health and rights advocates, it is important to promote meaningful youth participation in all aspects of our programmes and policies.

APPENDICES

Annex 1: Template of Tanner Stage Table

Tanner stages in Boys	Age at Start	Noticeable changes
Stage 1	After the 9th or 10th birthday	None
Stage 2	Around age 11	Pubic hair starts to form
Stage 3	Around age 13	Voice begins to change or "crack"; muscles get larger
Stage 4	Around age 14	Acne may appear; armpit hair forms
Stage 5	Around age 15	Facial hair comes in

Tanner Stages in Girls	Age at Start	Noticeable Changes
Stage 1	After the 8th birthday	None
Stage 2	From age 9–11	Breast "buds" start to form; pubic hair starts to form
Stage 3	After age 12	Acne first appears; armpit hair forms; height increases at its fastest rate
Stage 4	Around age 13	First period arrives
Stage 5	Around age 15	Reproductive organs and genitals are fully developed

Annex 2: Cross the Line Statements

Instructions

Read some of the following statements, beginning each time with, "Cross the line if ..." After participants have moved, follow up each statement with, "observe who crossed the line and who did not notice how it feels to be wherever you are ... now please all move back to the same side of the line."

Cross the line if:

- You were raised to believe that sexuality should not be openly discussed
- You have ever felt uncomfortable talking about sexuality
- You or someone you are close to has had a boy/girl friend?
- You have been asked to keep someone's sexual relationship secret
- At some point in your life, you have ever felt the need for intimacy and love making with opposite sex
- You believe there is a need for a supportive social environment for sexuality education for young people
- You believe all young people deserve access to comprehensive sexuality education and SRHR services?
- You have known a close friend who was sexually active.

Appendix 3: Value Statement, Agree/Disagree/Unsure

A = Agree D= Disagree U = Unsure

Instructions: Read out loud the various value statements, giving time for participants to go to the side of the room that reflects their answer based on the third part.

Statements:

1. Contraceptives services should be available to girls and boys whenever they need them
2. Young people should seek parents consent to access injectable/oral contraceptives
3. Comprehensive Sexuality Education (CSE) accelerates young people's early sexual inter-course.
4. Decisions over the use of contraception should be made by a boyfriend and the girl-friend shall adhere to.
5. Menstruation is taboo in our society and male should not be involved into its discussion
6. If a young girl was pregnant and HIV/AIDS positive, she should be advised to terminate her pregnancy, even if she wanted it.
7. A young unmarried girl should not be allowed to terminate an unwanted pregnancy.

Instructions: Read out loud the various value statements, giving time for participants to go to the side of the room that reflects their answer based on the personal value.

Statements

1. Contraceptives services should be available to me whenever need them
2. I should seek parents consent to access injectable/oral contraceptives
3. Comprehensive Sexuality Education (CSE) can accelerate me to early sexual inter-course.
4. Decisions over the use of contraception should be made by my boyfriend and I shall adhere to.
5. Menstruation is taboo in my society and male should not be involved into its discussion
6. If I was pregnant and HIV/AIDS positive, I should be advised to terminate the pregnancy, even if I wanted it.
7. If i am not married I should not be allowed to terminate an unwanted pregnancy.

Appendix 4: SRHR Champion Quiz

Instructions: Put a tick in the correct answer

Question	Answers		
1. Dual protection means wearing 2 condoms at a time.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
2. If a man is circumcised, he still has to use a condom to protect against HIV or STI infection.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
3. It is possible for girls/women to get pregnancy during menstruation.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
4. Using pads during menstruation is harmful because can result into a reproductive cancer.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
5. Reproductive rights are special for the married couples only.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
6. To provide sexual and reproductive health education is very crucial to the adolescents.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
7. Providing HIV/AIDS and contraceptive services to young people is against human rights.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
8. Using local ways during abortion is safer for young girl's reproductive health than applying scientific methods.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
9. When a young girl gets pregnant it is her own fault.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
10. Only people on antiretroviral therapy (ART) need HIV care services.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
11. Adolescents are more likely to give in to peer pressure which increases their risk for STIs, HIV and unplanned pregnancy.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
12. Young people who are sexually abused need to get medical and psychological support.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
13. Men can also suffer from gender- based violence.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure
14. SRHR Champions are also community educators and advocates and can help change policies and practices that affect youth SRHR.	<input type="radio"/> Agree	<input type="radio"/> Disagree	<input type="radio"/> Unsure

