Sexual and reproductive health and rights, and HIV 101 workshop guide

A guide to facilitating a workshop on linking up HIV and sexual and reproductive health and rights with young key populations
About the International HIV/AIDS Alliance

We are an innovative alliance of nationally based, independent, civil society organisations united by our vision of a world without AIDS.

We are committed to joint action, working with communities through local, national and global action on HIV, health and human rights.

Our actions are guided by our values: the lives of all human beings are of equal value, and everyone has the right to access the HIV information and services they need for a healthy life.

Acknowledgements

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Link Up aims to improve the sexual and reproductive health and rights (SRHR) of young people affected by HIV across five countries in Africa and Asia. The project is being implemented by a consortium of partners led by the International HIV/AIDS Alliance. For more information, visit www.link-up.org

Funded by the Ministry of Foreign Affairs of the government of the Netherlands.
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<td>Workshop introduction</td>
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<td>Expectations and participation</td>
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<td>1.4</td>
<td>Who are young key populations?</td>
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<td>Lunch</td>
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<td>Integration and linkages</td>
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<td>1.6</td>
<td>Human rights and sexual and reproductive rights</td>
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<td>16:10–16:30</td>
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<td>Break</td>
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<td>16:30–16:45</td>
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**DAY 2**

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<td>Gender and social norms (including extra session)</td>
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<td>Understanding sexuality (parts 1 and 2)</td>
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<td>2.7</td>
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* Times indicated are for guidance only. Feel free to schedule the days to suit your context. However, the length of the sessions shown in minutes should be maintained for the content to fit comfortably, without rushing through and missing important learning opportunities.
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<td>Role play on entry points to integration</td>
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Introduction

Background

The key focus of the Link Up project is to make a significant contribution to the integration of vital sexual and reproductive health and rights (SRHR) and HIV interventions for young key populations at country level. The International HIV/AIDS Alliance 101 workshop on linking up HIV and sexual and reproductive health and rights with young key populations, has been designed to support this aim. The workshop, which focuses on the specific issues that young key populations face, complements the Integration works! A guide to facilitating a workshop on integrating HIV and sexual and reproductive health and rights that focuses on integrating and linking SRHR and HIV activities for all ages. The Good Practice Guide: Integration of HIV and sexual and reproductive rights is also useful for background information on the International HIV/AIDS Alliance (the Alliance)’s work in this area.

The workshop was originally delivered to project staff in the five countries of the Link Up project: Bangladesh, Burundi, Ethiopia, Myanmar and Uganda. It helped team members understand what integration and linkages mean, and what impact they may have on their community mobilisation, outreach and service delivery mechanisms and approach. It also offered participants an opportunity to explore and reflect on their attitudes towards working with young key populations, and supporting their leadership in addressing the issues that affect their health and lives.

However, the workshop could be delivered by any Linking Organisation, from any country, working on SRHR and HIV integration with young key populations. The workshop programme could also be delivered in modules, where capacity needs to be developed in a specific area or where a refresher is required. For example, a session on sexual rights and could be delivered during a team meeting or team development day.

Learning objectives for the workshop

1. Enhance understanding of critical concepts of integration and linkages, gender and sexuality, stigma and discrimination.
2. Enhance understanding among partners of entry points for the provision and uptake of integrated services for young key populations.
3. Enable self-reflection around working with young key populations.

Introduction to the guide

This facilitator's guide describes how to plan, deliver and evaluate the workshop effectively. The workshop is designed to take five consecutive days in one week, although it can be adapted for shorter trainings as needed. Each day covers a different area of SRHR and HIV integration, with the order and flow of sessions designed to relate back to each other. The workshop culminates with a site visit and group discussion.

Sessions include suggestions, tips and reminders for facilitators, and list materials needed. References to useful resources are also provided. These can be sourced in advance and either distributed to participants or a reference copy shared during the workshop. You may have relevant country-specific documents and materials yourself that can also be used.

The annex section contains materials referred to throughout the guide. These can be photocopied and used as handouts to support the learning.

Planning the workshop

We suggest that you read through the entire guide in preparation for the workshop. If there is to be more than one facilitator, you will need to meet to decide which sessions each of you will lead. Consider the following tips for this:

- **Facilitators should be competent and experienced in leading workshops, and feel comfortable with the content.** Reading through the supporting documents in advance and exploring the links contained in each session can help ensure this. Facilitators may feel more comfortable with certain sessions than others. Play to each other's strengths, and base your decision on who shall lead individual sessions on these.
- **Check your own attitudes** towards the workshop content and be aware of how they may influence your tone and delivery.
- **Consider having a representative** from young key population groups as a co-facilitator, especially if they are confident about the workshop content. This will bring a strong community perspective to the training.
- **The content of each session can be adjusted** to suit the level of experience of participants in each setting. During your planning process, different facilitators may be able to suggest how to adapt sessions while keeping the content and learning points intact.
- **Choose a venue that is appropriate for the group.** Consider its location and any connections; for example, whether it is linked to an authority like the police or military, or aligned to a religious group or political party. These might affect how far participants can relax and share with one another.
- **Set up the workshop in a bright and spacious room,** where participants can take part comfortably and feel safe to share their views and experiences. If possible, hold the workshop away from their usual workplace to avoid distractions and interruptions. Ideally, seat participants in a U-shape or semi-circle (with or without tables). This helps everyone to feel included and gives facilitators a better view of everybody in the room.
Consider using a translator for all or part of the workshop, in particular to help young key populations communicate freely and comfortably in their first language. The translator could be someone from the group or be brought in from the outside. Make sure that the translator understands and maintains respect and confidentiality.

Make sure that you have everything you will need before the workshop starts, including equipment, handouts and supporting documents.

Participants should be selected appropriately and receive advance information on what to expect. It is important to ensure that young key populations from the project are among the participants. They should be supported before and during the workshop, and their meaningful involvement ensured.

On Day 2 there is a session (2.5) involving a panel discussion with young key populations. When they are invited in advance of this, they should be told what the session involves and that their input will be treated in confidence and with respect. This principle should also be conveyed to the whole group and ensured by the facilitator. A film on stigma and discrimination from your country could be shown on Day 2, if available.

The five-day schedule is outlined on pages 3 and 4, with suggested running times for sessions, including breaks. Each day receives a separate section in the guide, together with a timetable. Sessions start at 09:00 and a finish at 17:00, but you can adjust to an earlier or later start and finish according to what works best in your context. Agree the best timings for your setting and communicate these with participants in advance.

Workshop principles

- Ground or base each session on participants’ own context through reflection and sharing of their experiences. Use the resources in the room.
- Adopt a sex-positive approach to the workshop.³
- Establish a safe space and encourage open and honest dialogue. No question is a silly one! Agree with the group to keep statements and experiences shared within the confines of the workshop. Ask them to respect the confidentiality of all participants.
- Involve young key populations from your projects as facilitators or guest speakers in specific sessions.
- Be prepared for participants to find the workshop emotionally draining or upsetting. Sometimes the content and the level of sharing can be overwhelming. Appoint someone with skills, experience or personality suited to supporting individuals who may need to take some time out or talk privately.
- Make sure that confidentiality and privacy is understood and maintained throughout the workshop.

³ A sex-positive approach accepts that sex and sexuality are part of life, and that open expression of sexuality, free from taboo, shame and judgement, is important to an individual’s wellbeing.
● Allow participants to lead icebreakers. They often have fun ideas and it makes everyone feel more involved in the workshop.

● Encourage critical and in-depth reflection to help participants identify aspects of their own practice and behaviour that may be stigmatising.

● Ensure everyone takes responsibility for their own learning during the workshop, reading ahead of the following day’s sessions or reflecting on content and discussions at the end of each day.

● Remain practical and responsive to the specific needs of participants. You may need to build flexibility into the agenda to respond to the learning needs and dynamics of the group as they evolve during the workshop.

● Finally, have fun!
## Day 1

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<td>1.2</td>
<td>Expectations and participation</td>
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<td>11:30–12:00</td>
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<td>1.3</td>
<td>Know your epidemic</td>
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<td>1.4</td>
<td>Who are young key populations?</td>
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<td>Lunch</td>
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<td>Integration and linkages</td>
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<td>Human rights and sexual and reproductive rights</td>
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<td>Reflection and debrief</td>
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Session 1.1
Workshop introduction

Facilitator’s notes

1. Welcome

10 minutes

Participants are welcomed either by a country director, a senior management team representative or a young person.

2. Icebreaker: ‘Getting to know you’

20 minutes

Ask participants to introduce themselves by saying their names, the names of their organisations and the work they do there.

Ask them to describe what they would do if they were able to have one superpower or if they ruled the world (this can be fun or serious). For example: My name is Imran and I provide SRH services to young people. If I ruled the world I would remove stigma experienced by people living with HIV.

3. Introduction

30 minutes

Introduce the workshop to participants. If there is more than one facilitator, the lead facilitator should provide the introduction.

4. Presentation

30 minutes

Give a presentation on your work on SRHR and HIV integration with young key populations.
Session 1.2
Expectations and participation

Facilitator’s notes

Objective
To explore our expectations of the workshop and what we can contribute, and reflect on what participation means to us.

Activities

1. Exercise: Our expectations and contributions

20 minutes

- Ask participants to write their expectations of the workshop on Post-it notes of the same colour (one expectation on each Post-it note). On different coloured Post-it notes, ask them to write what they can contribute to the workshop, such as particular skills, knowledge or expertise.
- Now group together the expectations and contributions that share similar themes and place on the flip chart labelled ‘Expectations’ and ‘Contributions’. Explain to participants which of these themes will be addressed in the workshop. If some will not be covered, make this clear to them as well.
- Finally, check that participants feel comfortable about expressing their feelings, and remind them about confidentiality during the workshop.

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2. What participation means to us

15 minutes

- Ask participants to think individually of a workshop or training where either:
  (A) they experienced a well-facilitated and positive participatory process  
  or
  (B) their opinions were used in a tokenistic or superficial way.

- Then ask them to write down any themes that stand out from that experience. If they need any suggestions, here are a few:

  - Gender
  - Power
  - Talking
  - Silence
  - Language
  - Group dynamics
  - Sexual orientation
  - Characteristics of facilitator
  - Education
  - Social class
  - HIV status
  - Age

- Ask for a show of hands from those who answered A, and then from those who answered B. Pair up the participants who answered A, then pair up those who answered B. Ask them to discuss with each other what themes they might have in common. Suggest they share a short summary of their experience if they want to.

- In a plenary, write up the themes in columns headed ‘A’ and ‘B’ on a flip chart.

3. Group contract

5 minutes

- Wrap up by agreeing a group contract for the workshop. This might include arriving on time, mobile phones on silent, respecting different opinions, having fun, and helping others to participate while being actively engaged as individuals.
Session 1.3
Know your epidemic

Facilitator’s notes

Objective
To increase our understanding of the HIV epidemic in our country based on the “Know Your Epidemic” strategy.

Activity
1. Know your epidemic

30 minutes

- Explain why the root causes of HIV and sexual and reproductive ill health are similar. Emphasise why it matters to address both in an integrated way.
- Brainstorm the following questions with the group and write up their responses on a flip chart:
  - What are the main factors contributing to the HIV epidemic in your country?
  - Are these similar to other SRHR issues, like unintended pregnancies, gender-based violence, sexually transmitted infections (STIs)?
  - Are other factors contributing, like violence?
  - Who is most vulnerable to poor-quality SRHR and HIV in your country? Are specific areas or groups of people vulnerable?
  - Who gets the attention of your programmers?
  - What is the impact of HIV and SRHR on young people? Does this worry you?
  - Why should we work with young key populations?
- Wrap up by explaining that certain populations are key to the dynamics of the HIV epidemic, as well as essential partners in an effective response. For example, men who have sex with men are at greater risk of HIV through having unprotected anal or oral sex. They are more vulnerable due to the criminalisation of same-sex behaviour and lack of access to user-friendly services.
Session 1.4
Who are young people?

Facilitator’s notes

Objective
To introduce definitions of child, adolescent, youth and young person, and challenge traditional ways of thinking about young people.

Activities

1. Personal reflection

10 minutes
- Ask participants to think back to their own adolescence and consider the following questions:
  - Who helped shape your attitudes towards your first sexual experience?
  - What did you learn about your sexuality and/or body from school?
  - Can you remember what it was like to go to a sexual and reproductive health service provider?
  - What might it have been like if you were gay or facing early marriage?

2. Exercise: Understanding adolescence and youth

20 minutes
- Lay out the line drawing of the young person’s body on the floor or table.
- Ask participants to write words frequently used in their communities to describe young people or being young on separate Post-it notes and stick them on to the drawing.
- When everybody has finished, group the Post-it notes into themes. Notice if the themes indicate any differences between young men and women, or questions about gender identity or sexual orientation.
- Explain how negative and gendered labelling affects young people and the expectations that adults have of them. Ask how the labelling changes for young key populations.
- Discuss:
  - How is an adolescent or young person distinguished from a child and an adult in your community?
What age, social or legal markers are used to define adulthood (e.g. marriage, employment, completion of studies, etc.)? Think about 10–24 years and the wide range of ages it encompasses

Are these markers of adulthood the same for males and females?

Say that there are many differences among rural and urban communities, minority groups and genders in understanding the phase of life between childhood and adulthood. While internationally there are age-related definitions of adolescents and young people, it is important to be aware that these are also cultural constructs and vary from place to place. The expectations placed on adolescents and young people can be diverse and impact significantly on their SRHR.

3. Exercise: A dynamic concept of youth

15 minutes

Write ‘Youth’ and ‘Adult’ on a flip chart with a line between the two words. Ask participants:

- What are the differences between them?
- Are all the young people and adults you know like this?
  Some of these ideas may come up:

Now interchange the column headings ‘Youth’ and ‘Adult’. Ask:

- Do you know any young people and adults like this?

Discuss whether we can properly think of ‘youth’ and ‘adult’ as separate categories of people. In reality, we cannot say that all young people are the same, just as we cannot say that all adults are the same. Explain that a dynamic concept of youth takes into account many factors, including:

- social status (e.g. class, gender, ethnicity, race, geographical location)
- cultural formation (e.g. youth subcultures)
- unequal provision, opportunities and outcomes
- state regulation according to social status (e.g. indigenous/tribal young people and the police)
- diverse life experiences and cultural norms for growing up
- young people having multiple dimensions.

Ask:

- What else would a dynamic concept of youth include?
- How does it impact on health-seeking behaviours?
Key messages

- All adults have their own perceptions and expectations of young people. Together with negative and gendered labelling, these can impact enormously on the way we design and implement our programmes. So it is important to be aware of our assumptions and recognise that young people are not all the same.

- While internationally there are age-related definitions of adolescents and young people, these are also cultural constructs and vary from place to place. It is important to have a dynamic concept of youth that takes into account multiple factors.

- Before we can address young people’s SRH vulnerabilities successfully, we need first to explore how we ourselves see young people. Some of us may envy young people and wish we were young again. Others may like to stereotype them.

- Popularly, young people are seen as risk-taking pleasure-seekers who live only for the present. Do we view them like this or as social agents for change? Do we, or the societies we live in, have ambivalent attitudes towards young people, viewing them as ‘small adults’ yet at the same time as immature, inexperienced and untrustworthy.

- Young people are often given work inside and outside of the family that involves a lot of responsibility. Although at a household or community level their value is often recognised, their legal rights can be unclear and differ widely.

- In some countries, young people have a criminal responsibility as young as seven years old. Yet the laws that affect their ability to decide about their own health do not always reflect the same assessment of their capacities. Some can marry while they are still children (under the age of 18) and access health services. But many girls who are sexually active, whether married or not, have no right to make decisions about their own health.

- Our assumptions about young people can discourage us from accepting their sexualities and their SRHR. This may powerfully influence our policy and practice in relation to young people and their sexual health.
Session 1.5
Integration and linkages

Facilitator’s notes

Objective
To define ‘integration’ and ‘linkages’, describe advantages and challenges of integrating SRHR and HIV programmes, and introduce key principles governing SRHR and HIV linkages.

Activities

1: Exercise: Integration and linkages

20 minutes

- Break into three groups, giving each an empty Venn diagram on a flip chart consisting of two circles overlapping in the centre.
- Assign each group a different kind of service delivery point. These could be a government health service provider, a private service provider or an NGO service provider. Ask them to discuss and write in the empty diagram which services are provided in an SRH clinic and which are provided in an HIV clinic. Then ask them to write in the overlapping area the services that can be provided in both.

- Display the flip charts on a wall and discuss them together, comparing the service delivery points. Summarise the areas of integration and point out the linkages with other services that need to be made by referral. Examples could be care and support, income generation, a violence shelter, legal support.
- Refer to the Link Up Interventions Package in Handout 2.

Materials

- Handout 1
- Handout 2
- Flip chart paper & pens

Resources


The Integra Initiative www.integrainitiative.org


Time
45 minutes

What
This session makes sure that participants understand what ‘integration’ and ‘linkages’ mean and how they impact on HIV and SRHR programmes.

Why
Promoting linkages and integration of core HIV and SRHR interventions is key to the Alliance approach and the Link Up project. It is essential that participants understand how to programme HIV and SRH interventions in an integrated way.

Materials

- Handout 1
- Handout 2
- Flip chart paper & pens

SRH services
HIV services

Services provided by both
2. A framework for priority linkages

5 minutes

- Give participants Handout 1, highlighting anything not already covered in the first exercise above.

3. Group discussion: integration and linkages

20 minutes

- In the three groups, ask participants to brainstorm (10 minutes) advantages and challenges to integration for:
  - clients/young key populations (Group 1)
  - healthcare providers/clinics (Group 2)
  - health policymakers, such as the ministry of health or education (Group 3)

- Using the group responses, discuss (10 minutes) the rationale for integration and linkages of SRHR and HIV interventions. You can include any of the talking points below. Also provide examples of how integration and linkages work in different settings, including where integration is already happening. Explain that it is not a one-model-fits-all approach, and emphasise client-centeredness.

- Programme evaluations have shown that integrated SRHR and HIV interventions improve access, increase uptake, and provide better care and increased efficiency (time and resources). More details can be found in the Alliance Good Practice Guide: Integration of HIV and sexual and reproductive health and rights (see Resources). However, integration can have its challenges too. Potentially, it can (or be perceived to) overburden services and facilities, and be a drain on already limited resources unless carefully planned.

Source: Adapted from WHO (2005), Sexual and reproductive health and HIV/AIDS: a framework for priority linkages.
and budgeted for. Staff may also need additional support and training.

- Both SRHR and HIV mainly serve reproductive-age populations.
- Sexual and reproductive ill health and HIV share root causes, including poverty, harmful gender norms and inequality, cultural norms and social marginalisation.
- Both SRHR and HIV interventions have common desired outcomes, such as improved quality of life, gender equality and a reduction in maternal, newborn and child mortality.
- Both SRHR and HIV interventions rely on community participation to address sensitive sexuality issues and sociocultural determinants of behaviour change.
- Most HIV infections are sexually transmitted or associated with pregnancy, childbirth and breastfeeding.
- The risk of HIV transmission and acquisition can be increased by the presence of certain STIs.
- Both SRHR and HIV interventions are interested in addressing vulnerability, focus on behaviour change, and use similar behaviour change communication channels.
- In resource-poor settings, both SRH and HIV services are typically offered through decentralised public health services. However, due to feared and actual stigma and discrimination, many key populations access healthcare provided through NGOs and trusted private healthcare providers.

Alliance accreditation standard C1: Our organisation promotes the linking and integration of sexual and reproductive health and HIV in policies, programmes and services.⁴

- **Definitions**: Participants often have some difficulty understanding that integration and linkages have different meanings:
  - **Linkages** are the policy, programmatic, services and advocacy synergies between SRHR and HIV. Linkages also involve addressing the social and structural issues that make people vulnerable to sexual and reproductive ill health and HIV.
  - **Integration** refers to different kinds of SRH and HIV interventions and services that can be joined together to enhance outcomes.

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⁴ International HIV/AIDS Alliance (2014), Accreditation Standards Guidance Cycle II. Available at: [www.aidsalliance.org/resources/336-alliance-accreditation-system](http://www.aidsalliance.org/resources/336-alliance-accreditation-system)
Bi-directional integration and linkages mean that SRHR components can be linked to HIV programmes and HIV components can be linked to SRHR programmes.

There are many different approaches to service integration rather than a single blueprint. Here are a few:

One-stop shop provision of comprehensive and integrated services, such as drop-in centres or clinics that offer HIV services (HIV counselling and testing, prevention, care and treatment) with SRHR services (family planning, STI, vertical transmission, maternal, newborn and child health (MNCH), safe abortion, post gender based violence care).

A referrals approach, where an HIV service (community or clinic based) provides information and referrals to an SRHR service. For example, the Network Support Model in Uganda trains people living with HIV to improve access to prevention, care, treatment and support. It offers community-based palliative care, adherence counselling and HIV prevention. Some are selected as network support agents, who accompany and empower people living with HIV to use existing government community-based wrap-around health services, including family planning, vertical transmission and STIs.

Physical and functional integration can include a variety of combinations: different services in the same room; the same provider for both services; the same facility but a different room; the same provider but in different rooms or at different times; and a combination of services received in one visit.

5. Prevention of vertical transmission of HIV, also known as prevention or elimination of mother-to-child transmission (PMTCT or eMTCT), refers to interventions to prevent transmission of HIV to an infant during pregnancy, labor and delivery, and/or during breastfeeding.
**Session 1.6**
Human rights and sexual and reproductive rights

**Facilitator’s notes**

**Objective**
To define human rights and sexual and reproductive rights.

**Activities**

1. **An overview of human rights and sexual and reproductive rights**
   
   **20 minutes**
   
   - Ask participants some open-ended questions to find out how much they already know about human rights and sexual and reproductive rights. For example, ask:
     - What does the idea of human rights mean to you?
     - Can you name or describe a human right?
     - Is the idea of human rights new to anyone in the room?
     - Are any of you lawyers or experts in SRHR?
     - Has anyone studied human rights at university?
   
   This will help you to pitch your introduction to human rights at an appropriate level. If it is a new subject, go into more detail. But if it is familiar to most people, cover the background quickly and then move on.

   - Then explain the four principles of human rights (refer to the resources listed to help you):
     1. **Universal** Human rights are applicable everywhere and at all times.
     2. **Interdependent and interrelated** All rights are linked; for example, the right to education is linked to the right to health, and vice versa.
     3. **Accountability** Countries and individuals have a responsibility to promote and respect human rights, as well as report violations.
     4. **Indivisible** All rights must be fulfilled, with the exemption of none.

**Resources**


● Explain the main categories of human rights:
  ● Civil and political rights
  ● Economic, social and cultural rights

● Issues relating to HIV and key populations cut across many human rights. HIV is often framed within the context of the human right to health, which is an economic, social and cultural right. The accurate language is the ‘human right to the highest attainable level of health’, where health is defined as not only the absence of disease but also a complete state of physical and mental wellbeing (as noted in the founding constitution of the World Health Organization (WHO) in 1946).

● The information in this session can feel dry and people may have different levels of interest in the detail. You don’t want to lose their attention. So without getting too technical, explain State obligations and realisation of rights by summarising the following (do not read it out as is written):

  ● Discuss how and why integrating SRH and HIV relates to human rights, making sure that the connection is clear to everyone. Explain that sexual and reproductive rights are not all contained in a single human rights agreement. Instead, different documents and treaties refer in part to sexual and reproductive rights (starting from the ICPD Programme of Action). Activists have searched through all the human rights treaties and international agreements to pull out the parts that relate to SRH.

2. Sexual and reproductive rights

J 5 minutes

● Using the Exclaim! Poster in Handout 3, introduce the sexual and reproductive rights of young people and talk through the ten sexual rights from the IPPF Declaration on Sexual Rights.

Governments have three levels of obligation: to respect, protect and fulfil human rights (civil and political, and economic, social and cultural rights).

Given the resource and knowledge restraints faced by many countries, the International Covenant on Economic, Social, and Cultural Rights recognises that the fulfilment of economic and social rights can only be achieved over time, and calls for the progressive realisation of rights. Progressive realisation of rights does not mean that governments do not have obligations in terms of these rights until a certain level of economic development is reached, but rather that there will be continual progress on the status of these rights.
3. Exercise: Working with case studies

60 minutes

- Break into five groups and ask participants to discuss one case study each (see page 25) and answer the questions in their group (30 minutes).
- In plenary, ask:
  - Briefly (3–4 minutes for each group) summarise your case study and responses to the questions (20 minutes).
- Highlight that it is often easier to understand rights by looking at violations.
- Then ask the whole group:
  - Are the situations in the case studies familiar to you?
  - Do you have an example of how your project has addressed (or could address) sexual rights issues through policies and activities? (10 minutes)

4. Conclusion

15 minutes

- Remind participants that in order to address the SRHR of young people effectively, it is important to think about their own values and the rights of other people whose lives and lifestyles may be different to their own. (This may have come up already in the discussion.)
- Highlight the fact that emotional factors and perceived injustice are often the motivating factors for people who work with young people and advocate on their behalf. Explain that clarifying a concept (such as ‘human rights’) is a step towards social change because it challenges social, cultural and religious norms, beliefs and expectations. If these are not interrogated, the needs and rights of young people, especially those from key populations, will be ignored, neglected and violated.
- Ask if anyone has any thoughts or concerns about how their programme delivery would be affected by any of the issues suggested by the case studies covered in Step 2.
- Emphasise the importance of understanding access to justice (including barriers, challenges and opportunities) and legal literacy about human rights for young people.
Good practice standard 2: In collaboration with others, our organisation promotes the sexual and reproductive needs and rights of all people.6

- Sexual and reproductive rights are human rights.
- If those who are most vulnerable, such as young key populations, are not aware of their human rights, they cannot take appropriate steps to access them and reduce negative health outcomes, such as HIV infections and unsafe abortions.
- Community activists, service providers and policymakers play a significant role in ensuring that young key populations are aware of their human rights and are able to access services.
- People can demand and claim the realisation of their human rights. Governments have an obligation to protect, respect and fulfil human rights for all.

Case study 1
A 15-year-old couple would like to have sex but do not know about contraception or where to get advice. They are too afraid to discuss it with anyone.

Discussion
- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

Case study 2
A young girl who is living with HIV is told by a service provider that she should not have sex or attend school.

Discussion
- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

Case study 3
A young sex worker has no information about where to find safe abortion services. She visits a ‘doctor’ who performs an illegal and unsafe abortion. She suffers a severe haemorrhage and dies.

Discussion
- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

Case study 4
A young boy cannot go to the local clinic to get tested for HIV because he fears that people he knows might see him and that the nurse might tell his parents.

Discussion
- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?

Case study 5
A young girl is denied contraceptive services because she is not married.

Discussion
- How do you feel about this?
- Which rights are likely to have been violated?
- Are there other rights that might not be fulfilled?
- What could your organisation do to realise these rights?
Session 1.7
Reflection and debrief

Facilitator’s notes
Each day finishes with a short evaluation, reflecting on what has been learnt. There is also a recap at the beginning of Days 2 to 5.

Activity
1. Introduction
15 minutes

- On Day 1, explain the purpose of reflection and ask the group to think about what was good about the day (structure, speed, pitch of information, logistics, etc.). Then ask them what could be improved.
- Make a note of their answers and decide what can be changed on the remaining days. Some things might be easier to change than others.
- Explain that each morning will start with a 20-minute recap summarising the content and learning from the previous day.
- Ask participants for volunteers to present the recaps on Days 2 to 5, and note their names.
- Explain that they can present in any way they like – the more fun, imaginative and energetic the better! As a guide, they should try to include:
  - What did we talk about?
  - What are the implications for Link Up teams?
  - Based on what we learnt, what action could we take to improve SRHR and HIV integration?

Thank you!
Day 2

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Session 2.0
Recap of Day 1

Activity

1. Group discussion

- Invite participants to lead a recap of the previous day's key messages. Remind them of the time limit (they might not need all of this). Ask:
  - What happened yesterday?
  - What did we learn?
- After the session has been delivered, thank the presenters and remind the group who is presenting tomorrow.
Session 2.1
Young people’s sexual rights and evolving capacity

Facilitator’s notes

Objective
To understand young people’s sexual rights and how the concept of their ‘evolving capacity’ applies to programmes and services.

Activities

1. Introduction and discussion

10 minutes

- Explain to participants that children and adolescents enjoy the same human rights as adults. In some rights documents their rights are further emphasised. For example, the ICPD Programme of Action calls on governments to provide adolescents with access to sexual and reproductive information and education, and recognises that reproductive and sexual health services “must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent” (paragraph 7.45).

However, young people of 18 years and under are covered by an additional human rights convention that adults are not: the Convention on the Rights of the Child (CRC). The CRC is an important document for working with young people’s rights because it introduces a number of concepts that only apply to rights for under-18 year-olds. A particularly important concept is that of evolving capacity.
Evolving capacity is about individual development and autonomy. It refers to the way that each young person gradually develops the ability to take full responsibility for their own actions and decisions. This happens at a different pace for each individual. At any given age, some young people will be more mature and experienced than others. Context and personal circumstances will almost certainly influence each individual’s development.

Evolving capacities is a concept that was first introduced into international law in the (almost) universally accepted Convention on the Rights of the Child (CRC). There are several articles within the CRC that further explain evolving capacities. You could write these three on a slide or flip chart for participants to see:

- **Article 5:** young people’s evolving capacity to exercise their own rights must be taken into consideration by those who provide guidance and direction to young people.
- **Article 12:** young people must be able to freely express their views, which should be given weight in accordance with their evolving capacity.
- **Article 14:** young people must be afforded freedom of thought, conscience and religion.

- Explain that quite often the best interests and the evolving capacities of young people – both concepts found within the CRC – are seen as being in opposition. However, the two are not mutually exclusive, nor are they contradictory. What is in the ‘best interests’ of a young person is only apparent once the views of young people, as well as the contexts of their lives, are taken into account. In some instances, this may mean that they need to be protected or guided, and in other instances that they are able to decide the best course of action for themselves. In other words, it is all about achieving a balance between protection and autonomy.

- Ask participants:
  - Do you understand what we mean by ‘best interests’ and ‘evolving capacities’?
  - Are you familiar with these ideas?
  - Do you have any questions?

2. Exercise: Evolving capacities in practice

40 minutes

- Write ‘Agree’ on a sheet of flip chart paper, ‘Disagree’ on a second sheet and ‘Not sure’ on a third sheet. Then place each sheet in different corners (or one in the middle) of the
room. Explain to the group that they need to take a position based on the statements being read out.

- Take the case studies (see below) and read aloud the first part of Case study 1. Ask participants to stand next to the sign most appropriate to how they feel about the scenario. Then read out aloud the second part of the case study and tell participants they can change their position if they wish. Discuss why participants chose their position, and whether and why the extra information changed their mind. Repeat with each of the case studies.
- There are no easy answers to these case studies. Each scenario raises issues about a young person’s right to choose and make their own decisions, but also about the need to protect them.

Case study 1
Part 1: You are an outreach worker. You have met a 16-year-old who has been in a sexual relationship with an adult who is 20 years older for the past two years. He/she is being paid for sex by the adult. The young person has clearly stated that he/she is happy for this situation to continue.

Do you think this young person is capable of deciding to continue the relationship?

Part 2: The young person has been living on the streets for four years following the death of his/her mother. During this time, he/she has supported their two younger siblings, who are still in school.

Would you change your response as a result of this new information?

Note: You can also change the age of the street child (e.g. reduce it to 14) to see if people change their position. If they do, ask what would be the ‘right’ age for this child to make their decision and why. This helps to emphasise the importance of separating age from the capacity and abilities of the individual, as well as their circumstances.

Case study 2
Part 1: You are a service provider. A young woman aged 17 has come to you for a pregnancy test. The test is positive and she is certain that she wants to keep the baby. One week later she returns saying that she does not want to keep the baby, and she wants an abortion that same day. There are parental/guardian consent laws around such services for those aged under 18.

Do you think this young woman is capable of deciding to terminate her pregnancy?

Part 2: The young woman explains that her change of mind is as a result of her boyfriend not agreeing to marry her, as he had promised.

Would you change your response as a result of this new information?

Case study 3
Part 1: You are a service provider. A 22-year-old man visits your clinic requesting a vasectomy.

Do you think this young man is capable of deciding to have a vasectomy?

Part 2: The young man explains in a very articulate manner that he has no desire to marry or have children, and he is happy to think of spending his life as a single man.

Would you change your response as a result of this new information?
Children and adolescents enjoy the same human rights as adults, but the way in which these rights are fulfilled will differ.

Young people of 18 years and under are covered by the Convention on the Rights of the Child which introduces a number of concepts that only apply to rights for this age group. One of them is ‘evolving capacity’.

The concept of ‘evolving capacity’, when applied to SRHR and young people, can be complicated and there are no clear-cut right or wrong answers. This forces us to think about everything that we do through a rights-based lens, otherwise we end up with programmes, policies and services that do not reflect the realities of young people’s lives.
Session 2.2
Gender and social norms

Facilitator’s notes

Objective
To understand that gender is a concept constructed by society or a community.

Activity

1. Exercise: Where do you stand?

   25 minutes

   ● Write ‘Society’ and ‘Biology’ on two sheets of flip chart paper and stick them on opposite walls. Then ask participants to stand in a straight line in the centre of the room.

   ● Read aloud one statement at a time (see below). After each statement, ask participants to move a step towards the walls labelled ‘Society’ or ‘Biology’ depending on whether they think the statement is socio-culturally or biologically based.

   Statements
   1. Girls are gentle; boys are not.
   2. Having sex with her husband is a woman’s duty.
   3. Women can get pregnant; men cannot.
   4. Men are good at logical and analytical thinking.
   5. Real men don’t cry.
   6. Women can breastfeed babies; men cannot.
   7. Women are creative and artistic.
   8. Women have maternal instincts.
   9. Men’s voices break at puberty; women’s voices don’t.
   10. Men have a greater sex drive than women.
   11. Women like to dress up and wear makeup.
   12. Men should be the wage earners of a family, not women.
   13. In a heterosexual relationship or marriage, the man has to be older than the woman.
After all the statements have been read out, most people should be closer to the ‘Society’ wall since all but 3 of the 13 statements have a sociocultural basis. The statements that have a biological basis are: ‘Women can get pregnant; men cannot’, ‘Women can breastfeed babies; men cannot’ and ‘Men’s voices break at puberty; women’s voices don’t’.

Ask participants to discuss the statements and explain their feelings about individual statements to each other. Ask:

- Which statements did you not all agree are based on either biology or society, and why did you not all agree?
- Which statements are examples of how society expects people to be and act based on their gender rather than innate qualities?
- Do you understand how gender is constructed by society? Can you give other examples of how we learn gender roles?

Until recently, our sex was considered to be unchangeable. Now it can be changed through medical intervention (sex reassignment surgery).

Gender is socially constructed, which means that it is determined by our social, cultural and psychological surroundings and environment. It is not innate in the same way that our biology (sex) is believed to be. It refers to how societies view women and men, how they are distinguished, and the roles assigned to them. People are generally expected to identify with a particular gender that has been assigned (gender assignment) to them, from their sex at birth, and act in ways deemed appropriate to this gender.

Gender is variable and can change from time to time, culture to culture, and sub-culture to sub-culture.

The way girls and boys are socialised to be ‘feminine’ or ‘masculine’ is called gendering.

It is important to distinguish between what society has constructed/created for each gender and what is biological. For example, the idea that men are strong and should not cry is created by society, whereas a woman giving birth is biological.

SRH decisions can be influenced by a person’s gender. For example, in a marital relationship, it may be the man who has the power to decide whether to have children or not, when to conceive them, and how many children to have.
2. Plenary discussion: Where do we stand? exercise

25 minutes

- In plenary, ask groups to reflect on their responses to the statements on the “Where do we stand?” exercise. Then facilitate a discussion about the sociocultural (and legal) factors that affect the sexual and reproductive lives of young key populations. Ask:
  - What patterns, similarities and differences did you see among the statements?
  - How do our expectations of masculine and feminine behaviours (gender norms) affect their SRH and HIV vulnerability?
  - How do our expectations of sexual behaviours (sexual norms) affect their SRH and HIV vulnerability? Which sexual behaviours are privileged (accorded more power)?
- If time allows, you could include this extra exercise to extend group discussion on the impact of gender and social norms on sexual and health-seeking behaviours.

- People who fall outside the norm of heterosexual and marital relationships are often excluded from society and therefore from important aspects of life: for example, education, health services, employment and legal redress. This makes them more vulnerable to HIV and other kinds of sexual and reproductive ill health, such as other STIs, unwanted pregnancy and unsafe abortion.
- Stigma and discrimination against those who do not conform to society’s expectations are often compounded by factors such as their legal status and barriers that impact on their ability to access health information and services, and to practise safer sex or safer injecting.
- Special efforts need to be made to address the realities of those who fall outside of sociocultural gender and sexual norms to ensure they can access life-saving information and services. We can achieve this by first becoming aware of the many ways in which sexual and gender norms affect everyone’s sexual behaviour, health-seeking behaviour and access to services.

3. Exercise: Group work on factors that shape sexual and health-seeking behaviours

25 minutes

- Explain you are going to explore in more depth how sexual and gender norms shape sexual and health-seeking behaviours, and therefore vulnerability to HIV and other SRHR issues.
- Break into groups and ask each to represent a character from the list below. Adapt the characters and number of groups to suit your setting.

| A 17-year-old college girl who is HIV positive. Her boyfriend does not know her status and wants to have sex with her. She would like to have sex with him too. |
| A 21-year-old female garment factory/migrant worker with a boyfriend. While they used condoms at the start of their relationship, they have not done so recently as they have been together now for six months and their relationship is getting more serious. |

| An affluent 21-year-old, heterosexual male university student who uses drugs. He often pays for sex when going out with his friends to ‘have a good time’. |
| A 15-year-old, self-identified homosexual boy who is out only to his best friend. Other boys often make jokes about hijra and kothi or panthi (South Asian terms for cultural transgender identities). He has had sex once with a young boy who also lives on the same street. |

| An 18-year-old young man who has sex with both men and women. He lives with his extended family, who assume he is heterosexual. He is attracted to and looks for validation from older men, who assume a more dominant role. |
| A 14-year-old schoolgirl who has a steady boyfriend and several older male sexual partners who give her gifts and money. Her boyfriend sometimes gets jealous, so she doesn’t use a condom with him to show that he is special to her. |

| A young, transgender woman. Although she is accepted by her community, she faces harassment on the streets. |

- Ask groups to answer these questions for their character:
  - What kind of sex is this person having and where are they having sex?
  - Where are going to get information on sex?
  - What information on sex are they getting?
  - How do these factors affect their vulnerability to HIV and sexual and reproductive ill health?
  - How would you address the gaps in their information and access to services?

4. Plenary discussion: Factors that shape sexual and health-seeking behaviours.

- In plenary, ask groups to present the key points from their group work on how sexual and gender norms shaped the sexual and health-seeking behaviour of the characters they discussed. Then facilitate a discussion about how these factors affect the vulnerability of young key populations to HIV and poor SRH.
Session 2.3
Understanding sexuality: part 1

Facilitator’s notes

Objective
To understand sexuality as more than a physical act, and become confident in discussing sexuality and the continuum of sexual orientation and gender identities.

Activities

1. Preparing a sexuality story (in advance)
   - Before the session starts, prepare a sexuality story in four stages of a young person growing up. The suggested stages (see below) can be developed to also include first love, a first kiss, the first time the character has sex and so on.
   - Choose a name for the young person that is specific to your culture and could be for a male or female character (for example, Jo(e) in English or Kiran in a South Asian context). Make sure that throughout the story you never use the pronouns ‘he’ or ‘she’, or ‘him’ or ‘her’). Only use the name you have selected.
   - Ask for some local help to tailor the story to your context. The exercise works best if it is specific and relevant.
   - As you write the story, make sure you include the following four stages:
     - **Stage 1: Jo is at home in the village**
       Jo is a good child, helpful in the home, really interested in school work and a good student. Jo has hobbies such as playing football with the other children, tending the garden and collecting firewood. (Make sure you choose hobbies that could be for either a girl or a boy.)
     - **Stage 2: Jo moves to a bigger town or city to go to high school**
       Jo’s favourite subjects are maths and literature. Jo does well in school and wins a scholarship to go to university. (You can add more details here, if you like.) Jo also discovers a social life, with music and dancing, and falls in love for the first time with best friend, Katherine. (Choose a culturally specific female name.) It is quite awkward since they are both teenagers and don’t know how to express their feelings, but they vow to keep in touch when Jo goes off to university.

Materials
- A colourful drawing pinned to the wall showing different scenes from your story character’s life.
- A slide or flip chart drawing of the Genderbread Person (see Handout 5)

Resource
Stage 3: Jo moves to the capital city and excels at university
As a recent graduate, Jo gets a really good job in the city working for an agricultural production company and is active in local community/church life. Jo also falls in love with the captain of the football team, Frank. (Choose a culturally specific masculine name.)

Stage 4: Jo is happily married with three children
Jo has two girls and a boy and has settled in the city.

Once you have prepared the story, you could draw illustrations for each of the four parts of the story to put up on the wall.

2. Story time

5 minutes

- Read the story to the group, making sure you don’t use a pronoun (no ‘he’ or ‘she’, ‘his’ or ‘her!’).

3. Discussion

15 minutes

- Ask the group to think about the story and raise their hand if they think Jo is:
  - male?
  - female?
- There will be some confusion as participants begin to realise that they are interpreting different signs of gender throughout the story. They might also be perplexed as to how Jo could have been attracted to both a female and a male. Some members of the group are bound to try to catch you out saying that you gave it away in one direction or the other!
- Then ask:
  - Why did you think Jo was female?
  - Why did you think Jo was male?

4. Understanding the continuum of sexual orientation and gender identity

15 minutes

- Explain that:
  - we all make assumptions about gender roles and how they are performed in society
  - sexuality (and sexual orientation) can be fluid over time
  - sexuality is about love and intimacy as well as the physical act of sex.
Then present a slide or flip chart drawing of the Genderbread Person (also on Handout 5), and make sure participants understand it. Explain that a gingerbread man is a traditional flat ginger biscuit shaped like a person.

See Handout 5 for definitions of sex and sexuality.

- Sexuality is about much more than who a person has sex with.
- Sexuality can be fluid and change over time.
- Sexuality can viewed on a continuum from 100% heterosexual through to 100% homosexual, with everyone fitting somewhere within that continuum.
- Sexuality is experienced and expressed differently for different individuals.

This exercise is designed to cause confusion – of the constructive kind! So be ready to let the group become confused but then guide them back to the main considerations about sexuality, gender, intimacy and sexual orientation.
Session 2.3
Understanding sexuality: part 2

Facilitator’s notes

Objective
To describe and understand a positive approach to sexuality.

Activities

1. Exercise: Positive and negative approaches to sexuality

Time
25 minutes

● In a group, ask participants to brainstorm all the reasons why people have sex. Some suggestions could be:
  - Pleasure and fun
  - Reproduction
  - Cultural duty
  - Intimacy
  - Expected gender roles

Make sure that pleasure and fun are included.

Did anyone mention STIs or HIV on the list? These aspects of health and prevention aren’t at the forefront of the reasons why people have sex, and yet they are often the only aspect of sex that is addressed in messaging and education about sexuality.

● Then ask participants to use this list to help them think about different approaches to talking about sex, health and sexuality. Emphasise the impact that a particular approach can make on the motivation of young people to learn about and discuss sexuality. For example, ask:
  - How do young people respond when a teacher, peer educator or health service provider says that having sex before marriage is very bad, or that it is very risky and unhealthy because it can cause HIV or unwanted pregnancy?
  - Explain that a negative approach just defines sexuality as being about good sex and bad sex. Respect for others and their culture or personal opinions is not encouraged. Young people do not get complete information and are afraid to ask questions.
If there is time, ask participants to develop a positive and a negative message about the same topic to make sure they have properly understood the difference between the two approaches. Some suggestions for topics are:

- Sex before marriage
- Using a condom
- Prevention of vertical transmission of HIV.

Any SRHR topic can be framed in a positive or negative way. For example, we now take a positive approach to ‘people living with HIV’ compared to the negative messaging in the 1980s and 1990s of ‘people dying from AIDS’.

Approaching sexuality and related topics positively might conflict with what you personally believe and feel. It is important that you leave your personal ideas behind and give open, honest and complete answers to young people.

If your personal feelings are getting in the way of your work, it is only professional to be aware of your limitations in communicating with young people. If you can, find ways to overcome these.

If it is difficult for you to do your work because of your personal feelings, it is better to ask to work with another group or on another topic. Your personal feelings or attitudes might be inappropriately influencing the information you are giving. From a rights-based perspective, everyone is entitled to receive information to enable them to make their own informed decisions about sexuality.
Session 2.4
Stigma and discrimination

Facilitator’s notes

Objective
To think about our own experience of being stigmatised or of stigmatising others.

Activities

1. Discussion: Differences between stigma and discrimination

   5 minutes

   - Ask participants what experiences come to mind when you say the word ‘stigma’ and then when you say the word ‘discrimination’. Alternatively, ask them to brainstorm the differences between stigma and discrimination.

   **Stigma** is a process of devaluation. In other words, if one is stigmatised one is discredited, seen as a disgrace and/or perceived to have less value or worth in the eyes of others.

   **Discrimination** is an action which involves treating someone in a different and unjust, unfair or prejudicial manner, often on the basis of their belonging, or being perceived to belong, to a particular group. It is often viewed as the end result of the process of stigmatisation.

2. Exercise: Our own experience of being stigmatised

   10 minutes

   - Ask participants to sit on their own. Then ask:
     - Think about a time in your life when you felt isolated or rejected for being seen to be different from others – or when you saw other people treated this way.
     - Explain that they do not have to find examples of HIV stigma; just any form of isolation or rejection for being seen to be different. Then ask them to share with someone with whom they feel comfortable:
       - What happened?
       - How did it feel?
       - What impact did it have on you?

Materials

- Flip chart paper & pens
- A film on stigma and discrimination, if available (particularly if produced locally or regionally). For example, Call me Kuchu, from Uganda. Available at: http://callmekuchu.com/
Invite the participants to share their stories in plenary if they would like to – it is not compulsory.

3. Exercise: Our own experience of stigmatising others

10 minutes

- Ask participants to sit on their own. Then ask:
  - Think about a time in your life when you isolated or rejected other people because they were different. What happened?
  - How did you feel?
  - What was your attitude? How did you behave?
- Invite them to write down any thoughts, feelings or words they associate with stigma. Then ask each participant to read their list aloud and write the points on a flip chart.

4. Wrap up

5 minutes

- Explain that everybody has felt ostracised or treated like a minority at different times in their lives. We have all experienced this sense of social exclusion. It is good to remember how that felt when we work with vulnerable populations, such as those involved with the Link Up project.
- Finally, ask:
  - What impact can stigma and discrimination have on access to SRH and HIV services?
  - What are the differences between stigma and discrimination?
  - How can we work together to overcome this?
  - Can we ever get rid of it completely?

- Stigma and discrimination are different. Stigma is a process of devaluation; discrimination is an action (that can often result from stigma). Stigma can be harder to pinpoint or articulate.
- The attitudes and behaviours that create stigma are often unconscious parts of our daily interactions, based on the social and cultural context we were brought up in. So we are all responsible for stigma.
- A person’s HIV status, gender or sexual orientation is only one part of their life. One way to overcome stigma is to challenge ourselves to remember that people are complicated and made up of multiple identities. We need to be open to this if we want to adopt non-judgemental attitudes.
Session 2.5
Interactive session with young key populations

Facilitator’s notes

Objective
To hear directly from young key populations in order to understand the kinds of stigma and discrimination they have encountered and the impact this has had on their lives, especially on their health and sexual and reproductive lives.

Activity
1. Exercise: Panel discussion

60 minutes

- Host a panel discussion with invited young key populations on the kinds of stigma and discrimination they have encountered and the impact this has had on their lives, especially their health and sexual and reproductive lives.
- The panel could be conducted like a television chat show with celebrity guests. A young person should interview the panellists using the questions on the next page.
- Refer back to the discussion on evolving capacities (2.1), and model good practice in terms of the consent process and in creating a safe environment for the young people to participate.
- The exercise will enable discussion of topics like the impact of double standards, gender-based violence, and stigma and discrimination.
- Wrap up the session by asking volunteers from the group to say what they have learnt from or will do or think differently because of the panel discussion. Thank everyone, especially the young people, for their open and honest participation. Then close the session.
Interview questions

- What do you think makes young people vulnerable to HIV in our country today?
- How can HIV prevention activities (services, campaigns and information) be designed to suit young people’s needs?
- Can you describe your experiences of dealing with the police and the education system, and of accessing the health system? Did they meet your needs?
- If you feel comfortable to do so, can you describe how HIV has affected you in different ways (directly or indirectly)?
- What is your message (or wish) either to policymakers, programme managers, the people in this room or the Link Up project?
- What single piece of advice would you give to the president/prime minister to improve things for young people in our country?

For meaningful and safe participation of young people, make sure:

- the experience is kept simple and light
- that the young people have help with translation, if they need it
- that the session is set up to recognise that young people have valuable insights into their health and wellbeing that adults do not possess
- that the panellists have given informed consent and are adequately supported (either by friends and family and/or an institutional representative accompanying them to the session). To do this, learn more about the family, friends and environment in which the young people live
- that privacy and confidentiality are guaranteed, and that the young people know it. You could do this by referring back to the group contract agreed at the start of the workshop
- the young people feel comfortable. One way to protect the panellists is by having a mediator (the lead facilitator) filter questions from the audience back to the panel, and vice versa. In that way, if something inappropriate is asked and/or one of the young people’s answers needs clarification, these can be provided respectfully by the facilitator. Also let the young people know they can skip answering any questions.
Session 2.6
Defining violence and its impact

Facilitator’s notes

Objective
To reach a common understanding of what violence is and how it impacts on SRHR, HIV and health-seeking behaviour.

Activities

1. Defining violence

In a large group, brainstorm definitions of violence and record participants’ answers on a flip chart. You can refer to Handout 6 to ensure that all kinds of violence are covered.

2. Impact of violence on SRHR and HIV

Break into smaller groups, and each group discuss one of the following questions:

- What are the different types of violence faced by men, women and transgender people?
- Is violence ever deserved? Why?
- What are the SRH consequences, including HIV vulnerability, of violence?
- What is the impact of violence on health-seeking behaviour?
- What do you do if someone is experiencing violence?

Then present the outcomes in a plenary.

Resources
● Violence may be experienced, expected and performed differently by people depending on their gender, age, social class and identity as part of a key population.
● Violence screening and support services can be an entry point for providing integrated SRHR and HIV services, especially since many young key populations experience stigma or discrimination that may result in violence.
● Intimate partner violence, or domestic violence, is a serious issue that can be difficult to recognise and seek help for.

Don’t get too stuck on definitions! The point of this session is to identify a potential association between violence, gender, stigma and discrimination and other issues discussed in the workshop so far. It is also to see this association as a potential entry point to better-integrated services and linked policies.
● In this session you can also to begin to identify how to support people who experience violence (counselling, referrals, post-violence clinical care, legal services).

Session 2.7
Reflection and debrief

● Refer back to Session 1.7 and repeat the activity 15 minutes), seeking feedback on the day and ways to improve. Remind participants who are presenting the recap on the following morning what is required of them.
● Thank everyone for their participation and engagement throughout the day.

Thank you!
## Day 3

<table>
<thead>
<tr>
<th>TIME</th>
<th>MINUTES</th>
<th>SESSION</th>
<th>TOPIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>09:00–09:20</td>
<td>20</td>
<td>3.0</td>
<td>Re-cap of Day 2</td>
</tr>
<tr>
<td>09:20–10:50</td>
<td>90</td>
<td>3.1</td>
<td>Entry points to SRHR and HIV integration</td>
</tr>
<tr>
<td>10:50–11:10</td>
<td>20</td>
<td></td>
<td>Break</td>
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<tr>
<td>11:10–12:10</td>
<td>60</td>
<td>3.2</td>
<td>Role play on entry points to integration</td>
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<tr>
<td>12:10–13:40</td>
<td>90</td>
<td>3.3</td>
<td>Meaningful youth participation</td>
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<tr>
<td>13:40–14:40</td>
<td>60</td>
<td>Lunch</td>
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<tr>
<td>14:40–15:40</td>
<td>60</td>
<td>3.4</td>
<td>Creating a safe environment for young people</td>
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<tr>
<td>15:40–16:00</td>
<td>20</td>
<td>Break</td>
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<tr>
<td>16:00–16:40</td>
<td>40</td>
<td>3.5</td>
<td>Service delivery role play</td>
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<tr>
<td>16:40–17:00</td>
<td>20</td>
<td>3.6</td>
<td>Reflection and debrief</td>
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</table>
Session 3.0
Recap of Day 2

Activity

1. Group discussion

Time 20 minutes

- Invite participants to lead a recap of the previous day’s key messages. Remind them of the time limit (they might not need all of this). Ask:
  - What happened yesterday?
  - What did we learn?
- After the session has been delivered, thank the presenters and remind the group who is presenting tomorrow.

Materials

- Flip chart paper & pens
- Any other available materials participants would like to use—imagination is key!
Session 3.1
Entry points to SRHR and HIV integration

Facilitator’s notes

Objective
To provide an overview of family planning methods, and interventions and opportunities for SRHR and HIV integration, including a rights-based approach.

Activities

1. Overview of family planning

- Provide participants with an overview of contraceptive methods, emphasising the importance of thinking of clients as individuals with multiple needs, and providing them with a choice of methods.
- Explain that service providers need to enable clients to assess their own risks and understand the concept of dual protection. Share the tools that are available to help with this:
  - Use the table of the four prongs of prevention of vertical transmission of HIV from Handout 7.

2. Group work

- Break into five groups and provide each of them with one of the scenarios opposite. They all depict a young person from a key population group presenting at a clinic for a certain service. Ask the groups to list what other services this person might need.
- Discuss participants’ responses to the scenarios in a plenary. Then return to the groups and ask participants to refer to Handout 7. Ask them to choose the ‘best’ contraceptive option for the client, giving their reasons, as well as the second- and third-best options eligible to them. Discuss these responses in a plenary.

Resources


Alliance (2011), HIV Update: integrating maternal, new-born and child health into community-based HIV programmes (page 2)

The detail in the case studies such as status and number of children is important to the discussions. The emphasis of the feedback should be on eligibility, client choice and dual protection.

Scenarios
- A 16-year-old sex worker comes in for an STI check up.
- A 22-year-old garment factory or migrant worker comes in for an abortion.
- A 14-year-old boy comes in with an anal fissure.
- A 24-year-old woman with three children keeps coming in for contraception but still experiences unintended pregnancies.
- A 17-year-old university student who uses drugs comes in for an HIV test.

Challenges of dual protection:
- It can be difficult to know if your partner is HIV negative due to a lack of youth-friendly HIV counselling and testing services, or their reluctance to take a test or disclose their status due to fear of stigma and discrimination.
- Delay or abstinence can be particularly challenging for young people who wish to explore their sexuality and experience sexual relationships.
- Using condoms as well as an additional contraceptive method in a long-term relationship can be seen as a sign of infidelity or lack of trust in your partner.
- Although using condoms and/or using condoms plus another contraceptive method is the most robust guidance to give, it is important to explore in individual safer sex counselling the multiple barriers and risks involved.

Community role in family planning and HIV:
- Discuss rights and fertility intentions with everyone, and the rights component of SRHR.
- Include messages around family planning and dual protection in community awareness-raising and information, education and communication (IEC).
- Promote condoms and other non-clinical contraceptives as part of outreach and home visits (community-based distribution).
- Make referrals to clinics for clinical contraceptive methods (injectables, implants, intrauterine devices (IUDs), sterilisation).
- Provide information on reduced efficacy of some contraceptives if taking tuberculosis (TB) treatment, antiretrovirals (ARVs) and methadone.
- Advocate for key population-friendly family planning services, and document cases of denied access or coercive treatment.

- Family planning is important in preventing unintended pregnancies and enabling couples to choose if, how many and when to have children.
- The more choices available in a country, the higher the rate of contraception use there.
- Unless service providers ask the right questions, they will not know the extent of the health service needs of the client.
- The four prongs of prevention of vertical transmission of HIV is also a key intervention for SRHR and HIV integration.
- People’s contraceptive choices and ability to use condoms are influenced by issues related to social and cultural practice, gender relations and family life.
- Dual protection means preventing unintended pregnancy and STIs (including HIV). It is part of the first and second prongs in comprehensive vertical transmission prevention. Interventions include using male or female condoms:
  - correctly and consistently in every sexual encounter
  - plus an additional modern contraceptive.
- Most HIV infections occur in regions where there are both high fertility and HIV prevalence rates among women, especially in sub-Saharan Africa.

### 4 prongs of prevention of vertical transmission of HIV

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary prevention of HIV among women of reproductive age</td>
<td>The prevention of unintended pregnancies among women and girls living with HIV.</td>
<td>HIV testing and counselling for all pregnant women, with fast referral to antiretroviral therapy (ART), care and support; ART prophylaxis; safer delivery; use of co-trimoxazole for HIV-exposed infants and safer infant feeding. Testing of partners and safer sex promotion, as risk of HIV transmission is very high if partner is recently infected.</td>
<td>Long-term ART for mothers and children living with HIV. Ensure that mothers and children get long-term support with nutrition, prevention of infections, treatment and care.</td>
</tr>
</tbody>
</table>
Session 3.2
Role play on entry points to SRHR and HIV integration

Facilitator’s notes

Objective
To reinforce learning about positive and negative approaches to sexuality, and use role plays to understand how entry points to integration play out practically.

Activity

1. Role play

近代に15 minutes

- Break into six groups, ideally with four to five participants in each group. Present one of the three scenarios on page 54 to two groups at a time, asking one of the pair to take a positive approach and the other a negative approach.
- Explain that the groups have 10 minutes to prepare for their performance, and that each performance should take 3 to 5 minutes (30 minutes in total).

2. Performances

近代に30 minutes

3. Debrief and award ‘Oscars’

近代に15 minutes

- After the performances, take a vote for the best actor to receive an ‘Oscar’.
- Conduct a short debrief to draw out:
  - entry points for integrated services/referrals
  - quality of services provided
  - attitudes of providers, including the receptionist, or other aspects of the environment if that has been included in the performances.
- Finally, present an award (or Oscar!) for the best performance.

Resources

Alliance (2015), Integration works! A guide to facilitating a workshop on integrating HIV and sexual and reproductive health and rights. www.aidsalliance.org/resources/591-link-up-integration-works

**Scenarios**

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th>Discussion</th>
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<tbody>
<tr>
<td>A young woman, aged 19, who sells sex is brought into a clinic by her friend to see a healthcare provider because she has been raped the night before.</td>
<td>Points could include the range of services offered, such as post-rape care, counselling, HIV counselling and testing, post-exposure prophylaxis and emergency contraception. They could also include the attitude of the provider in terms of empathy or stigma relating to age and sex work as a source of employment. Ask what other services could be offered and how they should be provided in the context of violence.</td>
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</table>

<table>
<thead>
<tr>
<th>Scenario 2</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A young man, aged 15, comes to a clinic asking for condoms.</td>
<td>Points could include the range of services offered, such as condoms, other contraceptive methods and counselling about delaying sex, intimacy, choosing partners and relationships. They could also include the attitude of the provider to the young man’s sexuality in terms of age of consent, stigma and so on.</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Scenario 3</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>A young woman living with HIV, aged 22, who is three months pregnant, attends a clinic for her antenatal screening.</td>
<td>Points could include choices about antenatal care, range of services such as vertical transmission counselling, family planning, adherence to antiretroviral therapy (ART) and treatment literacy. They could also include the attitude of the provider towards the right of a young woman living with HIV to have children.</td>
</tr>
</tbody>
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**Key messages**

- Reinforce that any SRHR concern can be framed either positively or negatively. Sometimes an individual may experience both positive and negative attitudes from different service providers during any one visit to a clinic; for example, a judgemental receptionist and empathetic provider.
- Remind participants of the importance of listening to young people and appreciating them as whole people with multiple needs.
- Positive or negative SRHR messages can come from many different people:
  - service providers and other clinic staff in their attitudes towards clients and their SRHR concerns
  - clients themselves in their own attitudes towards the situations they face (for example, internalised stigma)
  - communities surrounding the clinic (for example, protestors outside a clinic providing safe abortion services)
  - families and friends of clients.
Session 3.3
Meaningful youth participation

Facilitator’s notes

Objective
To understand youth participation and youth–adult partnerships, and assess the level of youth participation in own project or organisation.

Activities

1. What is youth participation?

Brainstorm definitions of youth participation with the group and write their responses on a flip chart. Ask:

- What different ways can young people participate in an organisation or project?
- What different roles can they play?
- Why should young people participate?

Explain that usually there are many more ways for young people to become involved in an organisation or project than people have tried out so far. We can start thinking creatively about the opportunities organisations can create for young people to participate. These could include:

- decision-making roles
- research
- monitoring and evaluation
- advocacy and awareness creation campaigns
- peer education, and
- as staff, consultants and trainers.

Resource

● Then share these definitions of youth participation (write them on flip chart paper in advance):

“Adolescents partaking in and influencing processes, decisions and activities.”
Roger Hart, in Children’s Participation: From Tokenism to Citizenship

“Adults work in full partnership with young people on issues facing youth and/or on programmes and policies affecting youth.”
Advocates for Youth

● Explain that youth participation is increasingly viewed as youth–adult partnerships, as the emphasis has shifted from prevention (using peers for behaviour change) to power sharing. Youth participation has moved beyond peer education to governance, advocacy and monitoring and evaluation.

● Emphasise that participation is not achieved by any of these means singly but by all of them, because different young people will be interested in becoming involved in different ways. While one young person might be happy to attend board

● Different levels of youth participation requires different levels of responsibilities of young people and adults

● Some forms of youth participation are forms of tokenism and are not considered youth participation.

● Young people have different timetables and obligations than adults, and may want to participate in different levels.

● Be clear on the required commitment and accompanied responsibilities in youth-adult partnership from both adults and young people.

● Youth participation implies a shift in power within the structure of an organisation

● Youth participation needs attention for training because of different experiences and knowledge of young people and adults. meetings regularly, another might only want the chance to give their views anonymously on services from time to time.
2. Levels of youth participation

25 minutes

- Draw a **Flower of Participation** on flip chart paper (see Handout 8 page 101) in advance of the session. Then explain the diagram and provide a few examples. The leaves are considered negative forms of participation and the petals are positive.

- Alternatively, write or print the text from the diagram in advance on separate cards. Then break into small groups and ask participants to rank the labels from low to high levels of participation.

- In small groups, ask participants to identify examples from their existing outreach work, programme management and institutional governance that might fit onto different petals or leaves of the flower. Ask them to write these on Post-it notes. Then invite them, group by group, to pin these onto the flower and discuss why they have placed it on the particular petal or leaf.

- Emphasise that in the implementation of this project we want to see more examples on the petals and none on the leaves. Ideally, we want the most examples to be on the ‘best’ petal (i.e. meaningful youth participation).

3. Personal values relating to participation

45 minutes

- Write ‘Agree’ and ‘Disagree’ on two sheets of flip chart paper, and place them at opposite sides of the room. Then read out the statements on page 58, asking participants to move to the appropriate sign depending on whether they agree or disagree with it; or, take a provocative opinion (that may not necessarily be your own) for a lively debate. Ask participants to be honest with themselves. You do not have to use all the statements, only as many as time permits.

- After each statement, ask participants why they agree or disagree. If there is enough time, you could also encourage discussion among the ‘Agree’ and ‘Disagree’ groups of participants for each statement.

- Explain that it is important to be aware of our values and where we stand on these issues in case we have to adjust our opinions to work effectively in partnerships.
<table>
<thead>
<tr>
<th>Statement</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statement 1</strong>&lt;br&gt;Adults should always make the final decision regarding the SRHR of young people.</td>
<td>Young people are experts on their own lives. Informed decision-making should be encouraged, whereby the role of adults is to ensure that young people are well equipped with the skills and knowledge they need to make their own decisions about their SRHR.</td>
</tr>
<tr>
<td><strong>Statement 2</strong>&lt;br&gt;Young people don’t have the skills to develop effective SRHR and/or HIV programmes.</td>
<td>Examples exist of young people of various ages successfully developing programmes and advocacy actions on SRHR and HIV. Given encouragement and capacity-building, young people can be as effective as anyone in programme development. Remember, they are the experts on their own lives!</td>
</tr>
<tr>
<td><strong>Statement 3</strong>&lt;br&gt;Young people should be respectful of their elders and do as they are told.</td>
<td>Several cultures expect young people to be respectful and unquestioningly obedient to people older than them. This is a hierarchical social structure aimed at maintaining power for adults. It is in the interests of young people to develop critical analysis skills and decide for themselves what course of action would be best for them. While being respectful is always appreciated, actions should be based on informed decisions rather than unquestioning obedience.</td>
</tr>
<tr>
<td><strong>Statement 4</strong>&lt;br&gt;Young participants in a programme planning consultation should be fully paid for their activities.</td>
<td>It is important to remain aware that young people often do not have their own income. It is good practice to reimburse them for any out-of-pocket expenses they incur in the course of participating in our programmes.</td>
</tr>
<tr>
<td><strong>Statement 5</strong>&lt;br&gt;A young sex worker can be on the advisory board of the project.</td>
<td>For programmes aimed at reaching young people who sell sex, it is advisable to ensure that they have an equal say on programme advisory or other decision-making bodies. Global evidence on effective programming suggests that the target populations must be involved at all levels of programmes.</td>
</tr>
<tr>
<td><strong>Statement 6</strong>&lt;br&gt;Condoms should be provided to under-15 year-olds.</td>
<td>Young people, regardless of age, are engaging in sex. Providing condoms to ensure that sex is safer is the responsible action to take.</td>
</tr>
<tr>
<td><strong>Statement 7</strong>&lt;br&gt;Youth participation is donor driven.</td>
<td>While in some parts of the world youth participation may be donor driven, it is important that programme implementers understand the importance of youth participation in itself, rather than viewing it simply as part of a donor agenda to be ticked off the checklist.</td>
</tr>
</tbody>
</table>
Session 3.4
Creating a safe environment for young people

Facilitator’s notes

Objective
To understand how to create and maintain a safe space while working with young key populations.

Activity
1. Exercise: What would you do if?

45 minutes

- Break into seven groups (or as many scenarios as you would like to be discussed). Give each group a scenario (see pages 60–61) and ask participants the following questions in relation to their scenario:
  - How do you feel about these scenarios?
  - What do you need to do to address them?
  - What measures are already in place to address them in your organisation?
  - What are the challenges to addressing them?
- Ask groups to present their discussions in a plenary and note the key points on a flip chart. Summarise using the discussion points below each scenario.

Resources

UNICEF. Adolescents and youth: enabling environments. www.unicef.org/adolescence/index_environments.html
### What would you do if?

#### Scenario 1
A staff member of a youth programme is looking at pornography websites, including child pornography.

**Discussion**
Depending on the laws in your country, child pornography is usually illegal. Even if it is not, viewing it is certainly against Alliance child protection and IT policies. This would entail disciplinary action that would most likely result in dismissal and possibly police action. If the staff member is a consenting adult watching adult pornography in their own time on their own equipment, this is not really an issue for the organisation. However, a discussion about the values of the organisation may be relevant.

#### Scenario 2
A peer educator from your programme is alone in a room with a girl/boy. Afterwards, the girl/boy complains that the peer educator has touched her/him intimately.

**Discussion**
The child protection focal person would need to initiate an investigation. This would involve meeting with each of the parties to become clear about the accusations (facts not assumptions) and documenting them. It would also entail informing each party about the process as well as the extent of confidentiality (who would need to know). Organisations should have child protection committees that would respond to the reports and, depending on the context and evidence, might need to report the case to the police.

#### Scenario 3
A young person who is living with HIV tells you that a staff member from your organisation has told his teacher and parents of his HIV status, even though the young person had not openly shared this information.

**Discussion**
Depending on the organisational policy, this could lead to immediate dismissal (if there is zero tolerance for breach of confidentiality) or other disciplinary action for the staff member once it has been ascertained that they have breached confidentiality. Reassurance must be provided to the young person about the action taken and other staff assigned to them so they do not have to encounter the same staff member again (in the case of a service delivery setting). Special sessions on living with HIV and the impact of stigma and discrimination may be held for teachers the boy’s school, parents’ groups and other community groups in the area.

#### Scenario 4
You notice that male staff members are making inappropriate and suggestive comments to a sex worker who comes to your office frequently as a member of your project planning committee.

**Discussion**
If the sex worker is an adult, this would be treated as harassment and dealt with in house through a disciplinary procedure that might involve verbal and written warnings. If the sex worker is a young person, this would be dealt with under the child protection policy and would also result in disciplinary action based on the organisation’s policy and code of conduct. Depending on the severity of the circumstances, the male staff members might face dismissal, as with any disciplinary action.
2. Understanding good practice

15 minutes

- Distribute the International HIV/AIDS Alliance policy on protection of children and vulnerable adults. Discuss the policy and the need for an organisational child protection policy to be in place. Ask:
  - How many of you have seen the Alliance child protection policy before?
  - Has the policy been explained to you?
  - Do you have any questions about it?
- Emphasise that a child protection policy that just sits on a shelf is no use. There must be a focal person for the policy who is ready to respond. Everyone should be familiar with the policy and the consequences of breaching it.
- Remind participants about the Link Up workshop guide on Safeguarding the rights of children and young people (see Resources).

Scenario 5
The young man who uses drugs who has been a staff member in your team has stopped coming to the office. Your colleagues tell you that the police have been hanging around the office.

Discussion
When dealing with people from populations that may be harassed or in trouble with law enforcement agencies, the organisation should have protection protocols in place. These might include maintaining a working relationship with the local police, ensuring that drug use does not take place on organisational premises, and having referral linkages with legal support services.

Scenario 6
A staff member tells you that the young man who is a staff member of your men who have sex with men-focused project has been called names by other staff members.

Discussion
This is a harassment issue, needing a response similar to the young sex worker case (see scenario 4).

Scenario 7
A young peer educator feels intimidated and bullied by an adult staff member into behaving in a certain way.

Discussion
Ask about and document the allegation, recording facts not assumptions. Explain issues of confidentiality (who will need to know), and that this will need to be discussed with the adult staff member. Establish whether the allegation can be mediated between them, or should result in a disciplinary procedure for the staff member.
Time
40 minutes

What
This session enables us to enact what can happen when our personal opinions and assumptions affect how we deliver services.

Why
We all have opinions and make assumptions about people in our communities, although we may not be aware of them. It can be difficult for us to identify and confront our own behaviours, and to understand and accept the impact these can have on how we deliver services.

Preparation
Chairs arranged at the front of the room for observing the role play (like a stage).

Session 3.5
Service delivery role play

Facilitator’s notes

Objectives
Enhance understanding on the underlying assumptions that service providers have and how these affect service delivery to young key populations

Activity

1. Exercise: Romeo and Juliet role play

   40 minutes

   ● Ask four participants to volunteer to take the roles of Romeo (a male client), Juliet (a female client), a male service provider and a female service provider.
   ● Ask the service providers to wait outside while you explain the role play to Romeo and Juliet:
   ● Ask the other participants to observe the role plays and to note down any differences or similarities they see in how the service providers behave with Romeo and Juliet.
   ● Invite the service providers back into the room. Ask each of them to role play a consultation with, separately, Romeo and then with Juliet.
   ● As a group, discuss how the male and female service providers respond similarly or differently to the needs of the young man and the young woman. Think about how social expectations of young men and women influence how SRHR information and services are provided. Ask:
     ● Does the SRHR information and services reinforce gender stereotypes?
     ● Does it reflect the real needs of the clients?

Romeo and Juliet are a young married couple who do not want to have children. Romeo has been using condoms for the last six months but wishes to stop using them. Juliet is reluctant to start using other contraceptives and would prefer Romeo to continue using condoms. This has caused some tension in their relationship. They each visit a male and female service provider to discuss the problem.
If there is time, introduce two new, hidden aspects of Romeo and Juliet’s lives (make sure you tell Romeo and Juliet about these in advance). If you have less time, you can introduce only one:

- Romeo had a boyfriend before he was married to Juliet and still meets him regularly to have sex.
- Juliet often sells sex to support the household income.

Ask participants:

- How would these hidden aspects of their lives affect the service delivered to them?
- How could service providers find out about these hidden aspects to ensure they receive optimum services?

Conclude by asking one or two participants how they feel about what has been discussed, and whether they would see it as a large or a small problem in their own context.

- Young people who visit SRHR services may be heterosexual, bisexual or homosexual, or can be questioning their sexual orientation. They may be sexually inexperienced, or they may have more or different experiences to those of the staff members they encounter.
- There are many ways that people experience sexual desire (a longing for sexual expression or a feeling of sexual attraction). There is no one ‘normal’ way to experience it.
- A person’s level of sexual desire may change over a short time, or over the course of their life. People may experience sexual desire until the end of their lives, although their physical response may change with age.
- The social environment can also influence the expression of desire. For example, couples may lack privacy or people may feel shy or nervous.
- What determines whether a person experiences desire for the same sex, the opposite sex or both is not well understood. These desires cannot be changed by religion, therapy or medication.

Usually, the service providers in the role play will end up offering information and services based on their own organisational focus; for example, Alliance Linking Organisation staff will most likely talk about HIV testing, condoms being the best barrier method against STIs, including HIV, and so on. It is important to point this out in case participants do not pick up on it, and to identify opportunities for integration and expanding the range of SRHR and HIV services offered.
The clients have come in specifically looking for other forms of contraception, since their main concern seems to be preventing unwanted pregnancies. So this concern must be addressed first to ensure that the client is satisfied and to create a trusting rapport with them.

Integrated service delivery means that SRHR and HIV-related services must be addressed together rather than focusing on one or the other. While condoms are an excellent barrier method for preventing STIs, including HIV, there are far more effective methods of contraception available. Clients should be given choices so they can make informed decisions on the best method for them.

Clients can have complex lives and service providers must be open to all kinds of possibilities. Making assumptions (for example, that they are married, heterosexual or monogamous) based on some of the information shared by the client will limit the service provider’s ability to address the client holistically. Non-judgmental attitudes and holding back from making assumptions are both important.

Session 3.6
Reflection and debrief

- Refer back to Session 1.7 and repeat the activity (15 minutes), seeking feedback on the day and ways to improve. Remind participants who are presenting the recap on the following morning what is required of them.
- Thank everyone for their participation and engagement throughout the day.

Thank you!
# Day 4

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<th>TOPIC</th>
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<td>17:00–17:15</td>
<td>15</td>
<td>4.4</td>
<td>Reflection and debrief</td>
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</table>
Session 4.0
Recap of Day 3

Activity

1. Group discussion

- Invite participants to lead a recap of the previous day’s key messages. Remind them of the time limit (they might not need all of this). Ask:
  - What happened yesterday?
  - What did we learn?
- After the session has been delivered, thank the presenters and remind the group who is presenting tomorrow.

Materials

- Flip chart paper & pens
- Any other available materials participants would like to use – imagination is key!
Session 4.1
Site visit briefing

Facilitator’s notes

Objective
To prepare participants for the field visit in terms of logistics and ground rules and guidance on key issues to identify and observe for SRHR and HIV integration in specific settings.

1. Site visit briefing

40 minutes

- Brief participants on the need to be minimally disruptive during their site visits. Explain that there will be clients present. Any information that participants might be given or overhear should be treated as confidential and with respect.

- Discuss with the group acceptable standards for taking photographs. Photographs can be disruptive and breach client anonymity if they are used on websites or personal social media sites.

- Tell participants there will be specific time set aside for questions. To minimise disruption, decide how and when these questions can and should be asked.

- Prepare questions and/or discuss key points for observation/discussion with the group before they go (see Handout 9 for examples).

- Ask for a volunteer rapporteur to report back in the debriefing (Session 4.3).

Facilitator’s tips

- It is better for host organisations if participants visit different sites to those they are already familiar with.

- Co-facilitators should split up and attend different sites (if possible). Step back as leaders for these visits – let the participants direct their own learning.
Session 4.2
Site visit

Facilitator’s notes

Objective

To learn what SRHR and HIV integration means by seeing actual programme delivery in action.

1. Site visit

- Visits to two or three sites could be arranged depending on the size of the group. Remember to consider transport logistics. Also think about the level of disruption to the site services. For example, would the timing of the site visit prevent services from being delivered during a busy time? Is there a quieter time?
- Sites need time to prepare for the visit. They should be told in advance about it and know what to expect.
- Consider minimising the number of participants who enter the facility/outrach setting at any one time (some facilities can be very small). Ask the facility manager to brief the group together and then arrange for a site tour so participants can understand how the service works at the site.
- Remember, it is neither necessary nor ethical for participants to observe actual clinical procedures. This is not a clinical training, and there is no learning benefit to being present in a procedure room. It may be acceptable for a few participants to be present at a group counselling session. However, the reason for their presence should be discussed in advance with the clients and their permission sought.

Time
4–5 hours

What

A visit to a site where HIV and SRHR services are being delivered alongside each another in a clinical or outreach setting to a particular young key population group, such as young men who have sex with men, transgender people, sex workers, people living with HIV and people who use drugs.

Why

It is important to put theory into practice and give participants a chance to see in action what they have learnt in the workshop, so they can replicate this in their own workplace.
Session 4.3
Site visit debriefing

Facilitator’s notes

Objective
To share insights and observations that they identified in terms of good practices for integration, any gaps and barriers, and entry points and opportunities for working with young key populations.

1. Site visit debriefing

Time
60 minutes

What
This session enables participants to discuss their observations and questions arising from the site visits, and share learning.

Why
Participants will have spent three days learning about what integration means in SRHR and HIV programming, followed by a site visit to see this in action. Observations about what works best can be explored in this session.

Materials
- Flip chart paper & pens
- Handout 9

In a plenary or in smaller groups ask participants to discuss the questions from Handout 9 (spokesperson has already been identified). They used these questions during their visits, either to guide their observation of how the site functions or to steer their discussions with site personnel.

If participants have broken into smaller groups, bring the discussion back into a plenary and write the main observations on a flip chart under the headings ‘Strengths’, ‘Gaps’, ‘Integration’. Try to answer any questions that arise, or tell the group you will find answers by the final session tomorrow.

Then ask:
- Have the visits given you ideas for doing anything differently in your workplace?
- What action points will you take forward?

Strengths
Gaps
Integration

Facilitator’s tips
Make sure the discussion is open and constructive, as representatives from host organisations may be present. Host organisation(s) could be offered a reply to the points and observations made about their site. Participants should be respectful of the privilege of being hosted at a site.
Session 4.4
Reflection and debrief

- Refer back to Session 1.7 and repeat the activity (15 minutes), seeking feedback on the day and ways to improve. Remind participants who are presenting the recap on the following morning what is required of them.
- Thank everyone for their participation and engagement throughout the day.

Thank you!
## Day 5

<table>
<thead>
<tr>
<th>TIME</th>
<th>MINUTES</th>
<th>SESSION</th>
<th>TOPIC</th>
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<tr>
<td>09:00–09:20</td>
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<td>5.2</td>
<td>Sources of technical assistance</td>
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<tr>
<td>10:35–10:55</td>
<td>20</td>
<td></td>
<td>Break</td>
</tr>
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<td>10:55–11:55</td>
<td>60</td>
<td>5.3</td>
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<td>11:55–12:35</td>
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<td>5.4</td>
<td>Workshop evaluation, reflection, appreciation and close</td>
</tr>
<tr>
<td>12:35–13:35</td>
<td></td>
<td></td>
<td>Lunch</td>
</tr>
</tbody>
</table>
Session 5.0
Recap of Day 4

Activity

1. Group discussion

- Invite participants to lead a recap of the previous day’s key messages. Remind them of the time limit (they might not need all of this). Ask:
  - What happened yesterday?
  - What did we learn?
- After the session has been delivered, thank the presenters and remind the group who is presenting tomorrow.

Materials

- Flip chart paper & pens
- Any other available materials participants would like to use – imagination is key!
Session 5.1
Solutions and strategies

Facilitator’s notes

Objective
To sum up important strategic and operational aspects of our project in our particular country context.

Activities

1. Challenges to SRHR and HIV integration, and youth participation

20 minutes

- Brainstorm some of the cultural, religious or attitudinal challenges that might arise as participants try to implement some of the key concepts into practice (e.g. participation, meaningful engagement with young key populations). Ask:
  - What would stop you setting up integrated programmes in your area, project or site?

2. Paired sharing about legal age minimums

25 minutes

- Link back to Session 2.1 on evolving capacity in order to revisit the laws and policies, particularly in relation to the age of consent, that might influence young people’s ability to access integrated services – and the willingness of providers to enable this.

- Ask participants to break into pairs and briefly share the legal age minimums in their country for:
  - sex
  - marriage
  - access to contraception if married and not married
  - drop-in centres
  - needle and syringe programmes
  - HIV counselling and testing.

- Give a few examples, and discuss the impact of these age barriers on young people’s access to SRHR and HIV services. Highlight any contradictions in legal age minimums; for example, where the age of consent for sex is 16 but the legal age minimum to access HIV testing is 18.
Key messages

- Legal age barriers and social norms impact on young people’s access to SRHR and HIV services.
- Although Link Up may encounter policy and other obstacles to effective implementation, the expertise of participants and their organisations (and other potential partners) can be used to find strategies or solutions for overcoming these.

Facilitator’s tips

This session is designed to be flexible and particular to each workshop. Different issues exist in different countries, and issues that are context specific will arise during the discussions, group work and site visits. On the previous evening, co-facilitators should discuss the most important focus for this session and plan accordingly.
Session 5.2
Sources of technical assistance

Facilitator’s notes

Objective
To identify where technical assistance is needed as well who might provide it.

Activity
1. Group discussion

● In small groups or a plenary, brainstorm (or consolidate if already discussed) key areas where technical assistance may be needed.
● Identify who may be able to provide that technical assistance, and what (if any) additional resources are needed.
● Prioritise into short- and medium-term actions.
● For each area identified, allocate a potential source of technical assistance. These could include a partner in country, a Link Up partner in another country, and/or the Alliance secretariat.

Frame the session constructively, so you identify weaknesses and areas to be strengthened rather than failures. This should be a collaborative effort to ensure that partners selected will be as strong as possible. Remember that although some partner organisations represented in the group may be stronger than others, all organisations will have both an offer as well as a need in terms of technical assistance.
Session 5.3
Testimonials and personal commitment

Facilitator’s notes

Objective
To make a commitment to the Link Up project, and document the diversity of participants and their expectations of commitments to implementing Link Up.

Activities

1. Individual commitment statements

   15 minutes

   - Write out the statements (below) in large letters on separate sheets of flip chart paper and pin them up in different parts of the room. You can add other statements if you wish. Ask participants to complete individually one or more of the statements.

   Integration is important because …

   I think this project has potential in my country because …

   Meeting the needs and rights of young people aged under 15 is important because …

   The one new thing I have learnt this week has been …

   Link Up will make a difference in this country by …

   I am dedicated to working with key populations because …

2. Sharing commitment statements with the group

   25 minutes

   - Read out the statements again, and after each one ask for a show of hands from participants who completed it. Then ask if anyone wants to volunteer to share their statement.
3. Documenting commitments

**20 minutes**

- This should be fun! If possible (depending on time and budget), a photographer can be arranged in advance to take professional portrait photographs of participants holding up their statements (in bold and legible handwriting!) on flip chart paper – and perhaps a group photo at the end.
- You could also encourage participants to stand by a statement they would like to talk about and use a mobile phone camera or other video equipment you have available to record them.
- Another idea is to ask participants to write their statements on large Post-it notes and stick them to the flip chart sheet whose statement they have completed. These can then be grouped into common themes, discussed with the group and documented in the evaluation. They can be kept anonymous if participants prefer.
- Alternatively, you or the participants themselves can write their statements on flip chart paper to include in the workshop evaluation.

- For Link Up to be successful, it will take the personal and professional commitment of everyone involved.
- We all must take responsibility for translating the learning from this workshop into actions that will contribute to the success of Link Up.

You can do this activity in many different ways. The main thing is to keep it quick and light-hearted but meaningful. The session should be fun, reflective and action oriented.
Session 5.4
Workshop evaluation, reflection, appreciation and close

Facilitator’s notes
You will have your own ideas for closing a workshop, but if you need some suggestions these activities may help you.

Activities

1. Workshop evaluation

- Revisit the expectations that participants discussed at the beginning to make sure that they have been met. No new questions or issues should be raised during this activity. It is a symbolic finale to allow participants to leave with a sense of closure.
- Then distribute evaluation forms for participants to complete. Remind everyone of the importance of honest evaluation. It helps to improve the workshop each time it is delivered.
- Allow enough time for these to be completed – some people take longer than others. Then collect the forms.

2. Reflection

- Make a ball out of old newspapers large enough to be thrown around from one participant to another. Write the following questions in large letters on a flip chart and post it where it can be clearly seen from anywhere in the room:
  - What one thing would improve this workshop if it were to be facilitated again?
  - What was the most exciting thing about this workshop (note: it could be either content or methodology)?
- Ask participants to form a circle and tell them that you will throw the ball to one of them. As they catch it, ask them to pick one of the two questions on the flip chart to answer. Then ask them to throw the ball to someone else who will answer one of the questions.

Time
40 minutes

What
A wrap-up session at the end of the workshop.

Why
It is important to appreciate the contribution of participants and recognise that they left behind their families and regular jobs to travel to the workshop. Also acknowledge and congratulate all involved in making the workshop happen.

Materials
- Old newspapers to make a ball
- Flip chart paper & pens
- Evaluation forms
Repeat until all participants have answered a question. Make sure that no one gets the ball a second time.

3. Closing activity: Circle of appreciation

10 minutes

- Remain in the circle and ask participants to say one thing they appreciated about someone in the circle this week. Ask them not to choose someone who has already been spoken about, nor the facilitator.
- The facilitator starts and ends the circle of appreciation. To start, make your first comment about any of the participants.
- Decide in advance if this kind of wrap-up is appropriate in your country context. Adjust it as you see fit, or replace with another activity that you think would work better.
- Finally, close the workshop by thanking everyone.

Thank you!
Annex 1: Handouts

Handouts are intended for your own reference, as well as to be given to participants during or after sessions. Photocopy them in advance if their use is suggested in the session notes.

Handouts included are:

1. Integration and linkages
   (Session 1.5, page 17)

2. Integration and linkages: Link Up interventions package
   (Session 1.5, page 17)

3. Sexual rights, young people and evolving capacity
   (Session 1.6 and 2.1, pages 21 and 29)

4. Understanding sexuality
   (Session 2.1, page 29)

5. Sex and sexuality
   (Session 2.2 and 2.3, pages 33, 37 and 40)

6. Defining violence and its impact
   (Session 2.6, page 46)

7. Entry points to SRHR and HIV integration
   (Session 3.1, page 50)

8. Meaningful youth participation
   (Session 3.3, page 55)

9. Site visit
   (Session 4.2, page 69)
Handout 1. Integration and linkages

A framework for priority linkages

Integration refers to different kinds of SRH and HIV interventions and services that can be joined together to enhance outcomes (for example, referrals). It is based on the need to offer comprehensive services.

Linkages are the policy, programmatic, services and advocacy synergies between SRHR and HIV. The concept refers to a broader human rights approach, of which integrated services are one component. Linkages can happen between core HIV interventions and core SRHR interventions. Linkages also involve addressing the social and structural issues that make people vulnerable to sexual and reproductive ill health and HIV.

Bi-directional integration and linkages mean that SRHR components can be linked to HIV programmes and HIV components can be linked to SRHR programmes.

Different approaches to integration include:

- **One-stop shop** provision of comprehensive and integrated services, such as drop-in centres or clinics that offer HIV services (HIV counselling and testing, prevention, care and treatment) with SRHR services (family planning, STI, vertical transmission, maternal, newborn and child health, and safe abortion). An example is the Kenya AIDS NGOs Consortium (KANCO)’s sex worker drop-in centre.

- A **referrals** approach, where an HIV service (community or clinic based) provides information and referrals for a SRH service. For example, the Network Support Model in Uganda trains people living with HIV to improve access to prevention, care, treatment and support. It offers community-based palliative care, adherence counselling and HIV prevention. Some are selected as Network Support Agents who accompany and empower people living with HIV to use existing government community-based wrap-around health services, including family planning, vertical transmission and STIs.

- **Physical and functional integration** can include different services in the same room; the same provider for both services; the same facility but a different room; the same provider but in different rooms or at different times; and a combination of services received in one visit.

These are all types of integration; there is no blueprint.

Source: Adapted from WHO (2005), Sexual and reproductive health and HIV/AIDS: a framework for priority linkages.
### SESSION 1.5

**Handout 2. Integration and linkages: Link Up interventions package**

<table>
<thead>
<tr>
<th>Output</th>
<th>Intervention/activity</th>
<th>Target audience/site</th>
<th>Methods/tools</th>
<th>Person(s) responsible</th>
</tr>
</thead>
</table>
| 1.1 Integrated HIV and SRHR peer education and outreach | **1. Health promotion and supportive counselling.** Topics: growing up (menstruation, developing sexual feelings, wet dreams); HIV and STI knowledge; family planning and maternal health; vertical transmission; self-examination for breast cancer; gender and sexuality; violence prevention and post-violence counselling and care. Distribution of condoms, lubricants and oral contraceptives (where permitted). | • Young people living with HIV  
• Young people who sell sex  
• Young men who have sex with men  
• Young transgender people | • 1-2-1/individual sessions; small group sessions; couple sessions by peer educators and outreach workers  
• Curriculum with modules on key topics and health education/job aids; e.g. flip charts, audio-visual materials, leaflets, brochures  
• Commodities: condoms, lubricants and oral contraceptives  
• Checklist for assessing risks and referral forms/cards | |
### OUTCOME AREA 1: Young people are better informed and able to make healthier choices about their sexuality

**Outcome core indicator:** Percentage increase in young people affected by HIV aged 10–24 reporting improved ability to make healthier choices as a result of a supportive environment at peer, family and community levels

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</table>
| 1.2 Integrated home- and community-based care and support | 1. Psychosocial and medical support: growing up (menstruation, developing sexual feelings, relationships, wet dreams); positive living; supportive counselling, including family planning, vertical transmission, maternal health, gender and sexuality, violence prevention; self-examination for breast cancer; opportunistic infection treatment; adherence support; positive health, dignity and prevention; palliative care; livelihood support. Distribution of condoms, lubricants and oral contraceptives (where permitted). | Homes and support group settings | ● 1-2-1/individual sessions; support group sessions; couple and family sessions  
● Counselling protocols and health education/job aids; e.g. flip charts, audio-visual materials, leaflets, brochures  
Commodities: condoms, lubricants and oral contraceptives  
● Checklist for assessing risks and referral forms/cards | |
| 2. Referrals: | Antiretroviral therapy (ART), family planning services, STIs, vertical transmission, MCH, breast and cervical cancer screening, post-violence care (medical, counselling and legal services). Psychosexual counselling and harm reduction where available. | | | |
| 1.3 Community mobilisation on HIV and SRHR integration for young people affected by HIV | 1. Sensitisation of influential groups and opinion leaders (e.g. parents, teachers, community and religious leaders, police, bar owners, pimps/madams and journalists) on the SRHR of young people and those affected by HIV. Topics: relationships; having children; access to SRH and HIV services; sexual and reproductive rights; harmful socio-cultural and gender norms; early marriage; gender based violence; safe motherhood; stigma and discrimination. | Police stations  
● Homes  
● Schools  
● Religious gatherings  
● Socio-cultural events  
● Marketplaces and public venues  
● Television, radio shows, mobile/SMS  
● Facebook, blogs and internet chat rooms | ● Small and large group sessions  
● Community theatre  
● IEC materials | |
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<tr>
<td>2. Public awareness events and infotainment activities. Topics: relationships; having children; access to SRH and HIV services; harmful socio-cultural and gender norms; early marriage; GBV; safe motherhood; stigma and discrimination; and sexual and reproductive rights.</td>
<td></td>
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<tr>
<td>3. Tailored HIV and SRHR integration, IEC development and media campaigns. Topics: growing up; relationships; HIV; STIs; family planning; vertical transmission; MNCH; harmful socio-cultural and gender norms; early marriage; violence; safe motherhood; stigma and discrimination; and sexual and reproductive rights.</td>
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<tr>
<td>1.4 Leadership development and empowerment for young people affected by HIV</td>
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<tr>
<td>1. Leadership training. Topics: organisational development; motivational and presentation skills; advocacy; entitlements and rights; self-determination and efficacy; networking; monitoring and documentation.</td>
<td>• Youth clubs and associations</td>
<td></td>
<td>Workshops for NewGen, Y-PEER-nominated leaders, key population youth leaders • 1-2-1 coaching/mentorship • Leadership curriculum</td>
<td></td>
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<tr>
<td>2. Small grants programme: funding innovative projects by youth leaders and providing mentorship and coaching support.</td>
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</tbody>
</table>
OUTCOME AREA 2: A growing number of people have access to antiretroviral drugs, contraceptives and other commodities required for good sexual and reproductive health

Outcome core indicator: Percentage of young women affected by HIV aged 15–24 with unmet need for family planning

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<tr>
<td>2.1 Integrated SRH and HIV drop-in centres and health facilities</td>
<td>1. Integrated safer-sex counselling on family planning; HIV and STIs; positive health, dignity and prevention; gender and sexuality, with condom, lubricant and contraceptives promotion.</td>
<td>Mobile clinics; e.g. tuk tuk</td>
<td>Individual and couple counselling using counselling protocols and commodities</td>
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<tr>
<td></td>
<td>2. Provision of STI diagnosis and syndromic management (oral, anal, penile, vaginal).</td>
<td>HIV drop-in centres</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>3. HIV counselling and testing</td>
<td>Voluntary Counselling and Testing centres</td>
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<tr>
<td></td>
<td>4a. For HIV facilities (where applicable): provision of or referrals for HIV care and treatment; referrals for family planning methods (e.g. injectables, intra-uterine devices, implants, long acting and permanent methods); vertical transmission; MNCH; safe conception advice; post-violence care; safe abortion/post-abortion care; TB screening and treatment; and cervical cancer screening services. Psychosexual counselling and harm reduction where available.</td>
<td>ART centres</td>
<td></td>
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</tr>
<tr>
<td></td>
<td>4b. For family planning clinics (where applicable): provision of family planning methods (e.g. injectables, intra-uterine devices, implants, long acting and permanent methods); safe abortion/post abortion care; MNCH services; safe conception advice; breast/cervical cancer screening; referrals for HIV care and treatment; vertical transmission; post-violence care; TB screening and treatment; and psychosexual counselling and harm reduction where available.</td>
<td>Family planning clinics</td>
<td></td>
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### OUTCOME AREA 2: A growing number of people have access to antiretroviral drugs, contraceptives and other commodities required for good sexual and reproductive health

**Outcome core indicator:** Percentage of young women affected by HIV aged 15–24 with unmet need for family planning

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<tr>
<td>4d. Facilitated group sessions. Topics: HIV and STI knowledge; family planning and maternal health; vertical transmission; self-examination for breast cancer; gender and sexuality; violence prevention and post-violence counselling.</td>
<td>● Support group sessions  ● Health education/job aids; e.g. flip charts, audio-visual materials, leaflets, brochures</td>
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</tbody>
</table>

### OUTCOME AREA 3: Public and private clinics provide better sexual and reproductive healthcare services that are used by increasing numbers of people

**Outcome core indicator:** Percentage of service providers and civil society organisations demonstrating increased capacity and deliver improved HIV and SRH services

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<tr>
<td>3.1 Technical and thematic capacity-building and refresher trainings</td>
<td>1. 101 Workshop on linking up HIV and sexual and reproductive health and rights with young key populations</td>
<td>● Linking Organisation (LO) and implementing partner managers  ● Frontline workers</td>
<td>● Workshop manual and protocols (Integration works! and Marie Stopes International protocols)  ● E-learning follow-up</td>
<td></td>
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<tr>
<td>2. HIV and SRHR integration peer education and outreach</td>
<td></td>
<td>● LO and implementing partners  ● Frontline workers</td>
<td>● Curriculum-based training, including job aide based coaching, project site visits, ongoing technical support and supervision</td>
<td></td>
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<tr>
<td>3. Policy and advocacy 101 training</td>
<td></td>
<td>● LO and implementing partners  ● Policy staff and youth advocates</td>
<td>● Workshop training manual</td>
<td></td>
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<tr>
<td>4. Youth leadership trainings to implement small grant schemes</td>
<td></td>
<td>● LO and implementing partners, led by youth advocates</td>
<td>● Small grants scheme guide</td>
<td></td>
</tr>
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### OUTCOME AREA 3: Public and private clinics provide better sexual and reproductive healthcare services that are used by increasing numbers of people

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<tr>
<td>3.2 Organisational development</td>
<td>1. Quality and capacity self-assessment on HIV and SRHR integration with young key populations</td>
<td>● LO and implementing partner managers</td>
<td>● Tool-based mentoring and coaching, and follow up</td>
<td>● Link Up partners in country</td>
</tr>
<tr>
<td></td>
<td>2. Implementation of youth and key population-friendly policies, including child protection/safeguarding rights policy and HIV workplace policies</td>
<td>● LO and implementing partner managers</td>
<td>● Alliance Accreditation</td>
<td>● Link Up LO project staff</td>
</tr>
<tr>
<td></td>
<td>3. M&amp;E and reporting systems</td>
<td>● LO and implementing partner managers</td>
<td>● Roll out of Link Up M&amp;E framework</td>
<td>● Alliance Technical Support Hub, Ukraine</td>
</tr>
<tr>
<td>3.3 Adaptation of tools (curricula, training manuals, job aides)</td>
<td>1. Adaptation of Link Up standard tools in country</td>
<td>● LO and implementing partner managers ● Frontline workers</td>
<td>● Adapting Link Up tools based on national protocols</td>
<td>● National consultants</td>
</tr>
<tr>
<td>3.4 South-to-south learning and knowledge sharing</td>
<td>1. Exchange visits and study tours</td>
<td>● LO and implementing partner managers ● Youth advocates ● Frontline workers</td>
<td>● Alliance Horizontal Learning Exchange programme</td>
<td>● Senior Adviser, Knowledge-sharing ● Regional technical advisers</td>
</tr>
<tr>
<td></td>
<td>2. Documentation of case studies</td>
<td>● Civil society ● Government ● Technical agencies – national and international</td>
<td>● Based on Alliance case study templates</td>
<td>● LO and implementing partner staff and youth advocates, with support from regional technical advisers</td>
</tr>
<tr>
<td></td>
<td>3. Presentations in national, regional and international conferences</td>
<td>● Civil society ● Government ● Technical agencies – national and international</td>
<td>● Abstract submission and presentations</td>
<td>● LO and implementing partner staff and youth advocates</td>
</tr>
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</table>
### Outcome Area 4: Greater respect for the sexual and reproductive rights of people whose rights are denied

**Outcome core indicator:** Percentage of young people affected by HIV aged 15–24 participating in local, national and global HIV and SRHR advocacy activities

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<tr>
<td><strong>4.1 Development and/or implementation of advocacy strategy</strong></td>
<td>1. LO and core country group lead process of developing advocacy strategy that identifies and includes all key allies.</td>
<td>All key allies, including ● LO staff ● Link Up country policy partners; e.g. ATHENA Network, GYCA, SAN!, MSI. ● National advocacy network partners ● Youth advocates/representatives ● Issue champions</td>
<td>● Training by external advocacy specialist to equalise understanding of what advocacy entails and how to develop an advocacy strategy ● Workshop to develop advocacy strategy that will guide national-level advocacy for Link Up</td>
<td>● Country-level policy partners</td>
</tr>
<tr>
<td><strong>4.2 Increased involvement of young key populations in youth, HIV, health, human rights and other coalitions</strong></td>
<td>1. Relevant advocacy coalitions include young key populations and expand coalition agendas to include HIV and SRHR integration advocacy for young people affected by HIV.</td>
<td>● Youth and key population coalitions and networks ● Other relevant networks and coalitions; e.g. HIV, health, SRHR, human rights</td>
<td>● Facilitate including young people affected by HIV in youth and key population coalitions and networks ● Identify leaders to represent technical working groups through a transparent process ● Capacity build young people affected by HIV to articulate their needs and influence coalition agendas</td>
<td>● LO led, with support from GYCA national counterpart or national networks</td>
</tr>
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### Outcome Area 4: Greater respect for the sexual and reproductive rights of people whose rights are denied

**Outcome core indicator:** Percentage of young people affected by HIV aged 15–24 participating in local, national and global HIV and SRHR advocacy activities

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<tr>
<td>4.3 Implemented human rights monitoring and response system (REAct) to monitor and collect evidence of young key populations’ experience of human rights violations and barriers to access</td>
<td>1. Robust monitoring systems are established at local and national levels, allowing evidence to be collected that demonstrates the extent to which young key populations face barriers in accessing health services or demonstrate the quality of the services they access.</td>
<td>Civil society and government monitoring platforms; e.g. human rights commissions</td>
<td>Youth and key population networks set up with local, mobile or online tools to register access to and quality of services; workshops to collate and analyse the data and agree key issues (see below)</td>
<td>LO led, working with national networks and GYCA and ATHENA national counterparts</td>
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<tr>
<td></td>
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<td>Young key populations who share their experiences</td>
<td>Set up mechanisms to ensure confidentiality and safety of data use, using good practice guides(^1)</td>
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<td></td>
<td></td>
<td>National MPs and other champions who can profile the issues</td>
<td>Advocacy network documents cases of young people being denied SRHR services and experiencing violence and coercive practices from healthcare providers</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Using a legal, policy and social environment perspective, analyse factors that affect key populations’ access to HIV interventions or full achievement of their human rights(^2)</td>
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<td></td>
<td>Media work and awareness-raising events among potential champions (particularly high-profile figures)(^3)</td>
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</table>

| 4.4 Increased participation by young people in national and global policy forums and processes | 1. Young people affected by HIV are active members of technical working groups and processes. | Youth leaders/advocates to join groups with Link Up partner/LO support | Identifying existing and new youth advocates/representatives | LO led, working with national networks and GYCA and ATHENA national counterparts |
| | | Technical Working Group members | Building capacity for representation on forums | |
| | | | Engaging with Technical Working Group leadership and processes to make more accessible | |

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2. The Alliance’s MENA (Middle East and North Africa) programme is a good model of a mapping service.
3. Using the Alliance’s Key Correspondents Training programme.
### OUTCOME AREA 4: Greater respect for the sexual and reproductive rights of people whose rights are denied

**Outcome core indicator:** Percentage of young people affected by HIV aged 15–24 participating in local, national and global HIV and SRHR advocacy activities

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<tr>
<td><strong>4.5 Advocacy for including HIV and SRHR integration for young people affected by HIV in national strategies and policies</strong></td>
<td>1. Our messages on HIV and SRHR integration for young people affected by HIV are fully reflected in national strategy documents and policies.</td>
<td>● Key national policymakers and bodies and strategy development processes &lt;br&gt;● MPs and other influential opinion formers &lt;br&gt;● In-country donor offices</td>
<td>● Documentation sharing in appropriate forums through briefings and consultations &lt;br&gt;● Lobbying/Information sharing with key stakeholders through national advocacy plans using power-mapping exercises &lt;br&gt;● Training on funding and advocacy mechanisms created by international donors (using Alliance resources) &lt;br&gt;● Development of a national public campaign</td>
<td>● LO led, working with national networks and GYCA and ATHENA national counterparts</td>
</tr>
<tr>
<td><strong>4.6 Joint national, regional and international advocacy and learning exchange with youth leaders, and GYCA, SAN! and ATHENA Network, for SRHR and HIV</strong></td>
<td>1. National-level young key population and HIV and SRHR integration advocacy issues and learning are profiled at regional and international levels to achieve policy change. They are linked to similar issues in other countries to facilitate horizontal learning, solidarity and support.</td>
<td>● Global donors, especially from the UK, USA, Netherlands, European Union, Denmark, and Commonwealth Secretariat &lt;br&gt;● UNAIDS, UNFPA, UNHCR &lt;br&gt;● Regional bodies, including ASEAN, AU, SADC, EAC &lt;br&gt;● International human rights bodies and other relevant INGOs</td>
<td>● Developing case studies and using national evidence on SRHR and HIV issues faced by young people affected by HIV &lt;br&gt;● Youth advocates and Linking Organisations engaging with consultations on post-2015, ICPD + 20 etc. &lt;br&gt;● Youth advocates and LOs trained and supported to engage with regional and international policy forums related to HIV and SRHR: UNGA, Family Planning Conference, ICASA, ICAAP, IAC and other opportunities as they arise &lt;br&gt;● National and global advocacy plans</td>
<td>● Global policy partners led, with support from LOs</td>
</tr>
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</table>
Handout 3. Sexual and reproductive rights

Sexual rights: An IPPF Declaration

Sexual rights are human rights related to sexuality

Article 1: Right to equality, equal protection of the law and freedom from all forms of discrimination based on sex, sexuality or gender

All human beings are born free and equal in dignity and rights and must enjoy the equal protection of the law against discrimination based on their sexuality, sex or gender.

Article 2: The right to participation for all persons, regardless of sex, sexuality or gender

All persons are entitled to an environment that enables active, free and meaningful participation in and contribution to the civil, economic, social, cultural and political aspects of human life at local, national, regional and international levels, through the development of which human rights and fundamental freedoms can be realized.

Article 3: The rights to life, liberty, security of the person and bodily integrity

All persons have the right to life, liberty and to be free of torture and cruel, inhuman and degrading treatment in all cases, and particularly on account of sex, age, gender, gender identity, sexual orientation, marital status, sexual history or behaviour, real or imputed, and HIV/AIDS status and shall have the right to exercise their sexuality free of violence or coercion.

Article 4: Right to privacy

All persons have the right not to be subjected to arbitrary interference with their privacy, family, home, papers or correspondence and the right to privacy which is essential to the exercise of sexual autonomy.

Article 5: Right to personal autonomy and recognition before the law

All persons have the right to be recognized before the law and to sexual freedom, which encompasses the opportunity for individuals to have control and decide freely on matters related to sexuality, to choose their sexual partners, to seek to experience their full sexual potential and pleasure, within a framework of non-discrimination and with due regard to the rights of others and to the evolving capacity of children.

Article 6: Right to freedom of thought, opinion and expression; right to association

All persons have the right to exercise freedom of thought, opinion and expression regarding ideas on sexuality, sexual orientation, gender identity and sexual rights, without arbitrary intrusions or limitations based on dominant cultural beliefs or political ideology, or discriminatory notions of public order, public morality, public health or public security.
Article 7: Right to health and to the benefits of scientific progress
All persons have a right to the enjoyment of the highest attainable standard of physical and mental health, which includes the underlying determinants of health and access to sexual health care for prevention, diagnosis and treatment of all sexual concerns, problems and disorders.

Article 8: Right to education and information
All persons, without discrimination, have the right to education and information generally and to comprehensive sexuality education and information necessary and useful to exercise full citizenship and equality in the private, public and political domains.

Article 9: Right to choose whether or not to marry and to found and plan a family, and to decide whether or not, how and when, to have children
All persons have the right to choose whether or not to marry, whether or not to found and plan a family, when to have children and to decide the number and spacing of their children freely and responsibly, within an environment in which laws and policies recognize the diversity of family forms as including those not defined by descent or marriage.

Article 10: Right to accountability and redress
All persons have the right to effective, adequate, accessible and appropriate educative, legislative, judicial and other measures to ensure and demand that those who are duty-bound to uphold sexual rights are fully accountable to them. This includes the ability to monitor the implementation of sexual rights and to access remedies for violations of sexual rights, including access to full redress through restitution, compensation, rehabilitation, satisfaction, guarantee of non-repetition and any other means.


IPPF Charter on Sexual and Reproductive Rights

1. The right to life
2. The right to liberty and security of the person
3. The right to equality and to be free from all forms of discrimination
4. The right to privacy
5. The right to freedom of thought
6. The right to information and education
7. The right to choose whether or not to marry and to found and plan a family
8. The right to decide whether or when to have children
9. The right to health care and health protection
10. The right to the benefits of scientific progress
11. The right to freedom of assembly and political participation
12. The right to be free from torture and ill treatment
Exclaim! poster

**Handout 4. Sexual rights, young people and evolving capacity**

**International Conference on Population and Development, Cairo, 1994**

**What is it?**

The United Nations International Conference on Population and Development (ICPD) was held in September 1994 in Cairo, Egypt. It drew some 11,000 delegates from 179 countries, including governmental delegates, representatives from United Nations agencies, intergovernmental delegations, non-governmental organisations (NGOs) and the media. This was the largest ever conference on population and development.

**What's the big deal?**

From the negotiations in Cairo, a consensus was reached by 179 countries, who committed to promoting a 20-year programme of action, with set priorities and time-bound goals to guide national-level policymaking. It concretely addressed a diverse array of topics related to population and development, including sexual and reproductive health, education, human rights, the environment, internal and international migration, and the prevention and control of HIV and AIDS.

The ICPD Programme of Action calls on governments to provide adolescents with access to sexual and reproductive information and education, and recognises that reproductive and sexual health services:

> “must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent”. (paragraph 7.45)

**The United Nations Convention on the Rights of the Child**

**What is it?**

A convention is an agreement between countries to obey the same law. When the government of a country ratifies a convention that means it agrees to obey the law written down in that convention.

The United Nations Convention on the Rights of the Child (UNCRC) was adopted by the United Nations General Assembly on 20 November 1989. At the end of 1993, 154 states had ratified the convention (i.e. given formal approval to it). This obliges them to report to the United Nations Committee on the Rights of the Child within two years of signing it, explaining what progress they have made in meeting its goals.
What’s the big deal?

The UNCRC has 54 articles in all. Articles 43 to 54 are about how adults and governments should work together to make sure all children and young people get all their rights.

The UNCRC states:

**Article 5:** Young people’s evolving capacity to exercise their own rights must be taken into consideration by those who provide guidance and direction to young people

**Article 12:** Young people must be able to freely express their views, which should be given weight in accordance with their evolving capacity

**Article 14:** Young people must be afforded freedom of thought, conscience and religion

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**Evolving capacity** is about individual development and autonomy. It refers to the way that each young person gradually develops the ability to take full responsibility for their own actions and decisions. This happens at a different pace for each individual. At any given age, some young people will be more mature and experienced than others. Context and personal circumstances will almost certainly influence each individual’s development.
Sex and sexuality

Sex refers to the biological difference between females and males present at birth. These include anatomical differences, such as the presence of a vagina or penis; genetic differences as in a person's chromosomal makeup; or physiological differences, such as menstruation or sperm production. Sex can also be used to describe physical acts of sex that includes but is not limited to penetrative penile–vaginal intercourse, oral sex, anal sex, masturbation and kissing, among other acts.

Sexuality as a concept has been examined for many years. There are a number of definitions that cover the various components of sexuality. While there is no single agreed definition, the one below provides a basic and fairly comprehensive understanding of the concept.

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, behaviours, 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, religious and spiritual factors.

Sexuality is more than acts of sex. It is also different from gender, which refers to how societies view women and men, the differences between them, and the roles assigned to them.

Sexuality is a complex and sensitive issue, and includes personal and social meanings as well as sexual behaviour and biology. It includes roles and personality, gender and sexual identity, biology and behaviour, and emotions, thoughts, feelings and relationships. It includes very positive aspects but also extremely negative aspects. It is influenced by social, ethical, economic, cultural, spiritual and moral concerns.

Sexuality is reflected in the total expression of who we are as human beings. It encompasses our values, attitudes, behaviours, physical appearance, beliefs, emotions and personality, as well as the ways in which we have been socialised. It involves our sexual identity and orientation, begins at birth and lasts our lifetime.

The expression of sexuality is influenced by ethical, spiritual, cultural and moral factors. Everyone does not experience sexuality in the same way. Being aware of these differences helps us cater to individual needs and provide effective services to people.

Sexuality encompasses many ideas and is subjective. Any definition of sexuality needs to reflect this diversity, which is why it would be longer and more complex than expected. The definition of sexuality has been evolving along with our understanding of sexuality.
Multiple factors are influenced by and influence our sexuality. For example, we cannot assume that all people are motivated by the same reasons to have sex or be in a relationship – some people might make this choice to have children, others for companionship.

**Sex positivity** is an attitude that celebrates sexuality as an enhancing part of life that brings happiness, energy and celebration. Sex-positive approaches strive to achieve ideal experiences, rather than solely working to prevent negative experiences. At the same time, sex-positive approaches acknowledge and tackle the various concerns and risks associated with sexuality without reinforcing fear, shame or taboo of young people’s sexuality and gender inequality.

### Sexual orientation and gender identity

Gender identity refers to a person’s internal sense of being male, female or something else. For many people, their gender identity often corresponds to their biological sex. A person who identifies as transgender has a gender identity that does not correspond to their biological sex.

Source: [http://itspronouncedmetrosexual.com](http://itspronouncedmetrosexual.com)
Gender expression relates to how a person chooses to communicate their gender identity to others through clothing, hair, styles, mannerisms and so on. This communication may be conscious or unconscious. While most people’s understandings of gender expressions relate to masculinity and femininity, there are countless combinations that may combine both masculine and feminine expressions, or neither, through androgynous expressions.

Sexual orientation describes whom we are romantically attracted to and love. A person’s gender identity does not predetermine their sexual orientation.

It is important to understand that these are all on a continuum and they are all fluid. This means that anyone could begin life at one point on a continuum and, depending on their circumstances, choices and bodies, they could change (or not) and move between the extremes on either side. For example, there could be two people A and B who were born female (biological sex), have a masculine gender expression, and identify as bisexual (loving and desiring both sexes). Person A might live their life expressing this, while person B might grow up to realise that they were born in the wrong body and would rather be male (biological sex). Person C might have grown up to identify as heterosexual, but may change to find others of the same sex attractive and perhaps even try out a homosexual relationship.

People who change from one side of the gender identity continuum to the other are known as transgender. People who change from one side of the biological sex continuum to the other are known as transsexual (undergoing hormone replacement and/or surgery). People who are intersex are born with ambiguous genitalia, and often the doctor or parents decide for the infant which sex they should be. This choice could be wrong, therefore intersex people are advocating against doctors or parents making the choice for infants.

In order to counter the gender norms that are assigned to ‘males’ and ‘females’, there is also a movement to bring up children in a gender ‘neutral’ manner. This means not making distinctions between boys’ and girls’ clothes, colours, toys and activities (for example, blue for boys, pink for girls; cars for boys, dolls for girls; football for boys, playing house for girls).

A question that may be raised is that if sex and sexuality are all fluid, then could we change people of homosexual orientation to heterosexual orientation? However, the key point here is that all of these points on the continuum are related to self-identification rather than labels that can be applied to us by others or by us to others. Just as you cannot force a person to fall in love with someone, you cannot force a person who identifies as homosexual to fall in love with or desire someone of the opposite sex, or vice versa.
Handout 6. Defining violence and its impact

Definitions

WHO defines violence as "Intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation."

World Health Organization (2002), World report on violence and health: summary

“Gender-based violence is violence involving men and women, in which the female is usually the victim. It is derived from unequal power relationships between men and women. Violence is directed specifically against a woman because she is a woman, or affects women disproportionately. It includes, but is not limited to, physical, sexual, and psychological harm. It includes that violence which is perpetuated or condoned by the state.”


Violence against women refers to “any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”

Declaration on the Elimination of Violence Against Women, adopted by the United Nations General Assembly in 1993

Sexual violence is “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic or otherwise, directed against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.”


Young key populations may be exposed to many forms of violence throughout their lives:

- **psychological abuse**, which includes suffering insults, humiliation, bullying, ‘Eve-teasing’ (an Asian term meaning harassment of young women, such as on the street), confinement and withholding of basic needs such as food
- **physical abuse**, which includes beating, kicking, pulling hair, biting, acid throwing and female genital cutting
- **sexual violence**, which includes economically coerced sex, date, marital and gang rape, incest, forced pregnancy and child sexual abuse.
Overview of family planning methods

**More effective**
Less than 1 pregnancy per 100 women in one year

- Implants
- IUD
- Female Sterilization
- Vasectomy

**How to make your method more effective**

- **Implants, IUD, female sterilization:** After procedure, little or nothing to do or remember
- **Vasectomy:** Use another method for first 3 months

- **Injectables:** Get repeat injections on time
- **Lactational Amenorrhea Method (for 6 months):** Breastfeed often, day and night
- **Pills:** Take a pill each day
- **Patch, ring:** Keep in place, change on time

- **Condoms, diaphragm:** Use correctly every time you have sex
- **Fertility awareness methods:** Abstain or use condoms on fertile days. Standard Days Method and TwoDay Method may be easiest to use.

- **Withdrawal, spermicides:** Use correctly every time you have sex

**Less effective**
About 30 pregnancies per 100 women in one year

- Male Condoms
- LAM
- Pills
- Patch
- Vaginal Ring
- Withdrawal
- Spermicides

Four prongs of prevention of vertical transmission of HIV

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<td>Primary prevention of HIV among women of reproductive age</td>
<td>The prevention of unintended pregnancies among women and girls living with HIV.</td>
<td>HIV testing and counselling for all pregnant women, with fast referral to antiretroviral treatment (ART), care and support; ART prophylaxis; safer delivery; use of co-trimoxazole for HIV-exposed infants and safer infant feeding. Testing of partners and safer sex promotion, as risk of HIV transmission is very high if partner is recently infected.</td>
<td>Long-term ART for mothers and children living with HIV. Ensure that mothers and children get long-term support with nutrition, prevention of infections, treatment and care.</td>
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Handout 8. Meaningful youth participation

The Flower of Participation

- **Youth-initiated. Shared decisions with adults**
  - High responsibility
- **Youth-initiated and directed**
  - High responsibility
- **Consulted and informed**
  - Low responsibility
- **Assigned but informed**
  - Low responsibility
- **Adult-initiated. Shared decisions with youth**
  - Medium responsibility
- **Decorism**
  - No responsibility
- **Tokenism**
  - No responsibility
- **Manipulation**
  - No responsibility

Source: CHOICE for Youth and Sexuality has developed the Flower of Participation, inspired by Roger Hart's ladder of participation.
Definitions

**Manipulation:** This takes place when young people don’t have any understanding of the issues and therefore don’t understand their actions. An example is when a four-year-old AIDS orphan shakes the hand of President Bush to make him invest more in orphans.

**Decorism/decoration:** This looks like manipulation, but this time young people might understand their actions. However, they are still being used to support adults’ causes indirectly, and adults do not pretend that their cause has been inspired by young people. An example is young people singing to the delegates at the opening of a conference on youth.

**Tokenism:** Young people are given a voice, but in fact have little say on the subject or the style of communicating it, and are given little or no opportunity to formulate their own opinions. This can happen when children are given seat on conference panels or when young people are included in a delegation but are not allowed to say anything.

**Assigned but informed:** This can be seen as the start of participation. Young people now understand the aim of the project, they know who made the decisions concerning their involvement and why, and they have a meaningful role. They volunteered for this project after the project was explained to them. An example is a community activity that is planned by adults but young people join in the activity.

**Consulted and informed:** The project is designed and run by adults, but young people understand the process, are consulted, and their opinions are treated seriously.

**Adult-initiated, shared decisions with youth:** Although projects are initiated by adults, decision-making is shared with young people.

**Youth-initiated and directed:** When the conditions are supportive (adult support), young people can work together cooperatively in large groups, and design and run their own projects.

**Youth-initiated, shared decisions with adults:** Young people ask adults to join in a certain activity that is initiated by young people.
Fifteen tips for good practice in youth participation

1. Provide training and support for young people; e.g. assertiveness training, negotiation and communication.

2. Provide training and support for adult decision-makers to help them engage with young people and listen to their views.

3. Provide young people with jargon-free information that is accessible to them.

4. Ensure hard-to-reach groups of young people are aware of and encouraged to be part of projects. Consider their specific access needs.

5. Ensure meetings are accessible, at times and locations young people can comfortably manage.

6. Offer a variety of options so young people have a choice of ways to engage.

7. Make participation voluntary and don’t expect long-term commitment.

8. Allow adequate time for projects; results will not be achieved immediately.

9. Value the input of young people – take their views seriously and give clear feedback on the impact of their contribution.

10. Ensure there is clear and transparent communication about the limits to their involvement and the expectations of them.

11. Make sure there is the necessary financial commitment to the project.

12. Set up systems for reviewing and continuously improving the process of involving young people.

13. Have fun in the project; build in opportunities for socialising.

14. Recognise young people's contribution and input; e.g. certificate of achievement.

15. Provide support to project staff to develop their skills in working with young people.
Handout 9. Site visit

Participants should have guiding questions to inform discussions, questions and answers, and observations during the visit.

For example:

- What SRHR interventions/services are being implemented?
- What HIV interventions/services are provided?
- What SRHR and HIV interventions are integrated?
- How are young people involved in the services?
- What gaps/barriers exist as challenges?
- What are the opportunities and entry points for integration?
- What are the opportunities for youth leadership?
- How is sustainability (financial and human resources, commodities) being ensured?
- What is the level of community involvement, and in which activities?
- How is the programme addressing stigma and discrimination in the community and among service providers?
- How are human rights addressed and upheld?
- What is in place to support someone who experiences gender-based violence?
- Does the facility/organisation have a child protection policy? Have all staff signed a code of conduct?
- How does the facility/organisation measure and assure the quality of the services they provide and refer their clients to?

Add more questions to the list, as appropriate.