Sexual and Reproductive Health for young HIV positive adolescents: The club concept in support groups

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Sexual and reproductive health for young HIV positive adolescents: the club concept in support groups
Acronyms

ARV  antiretroviral
ART  antiretroviral treatment
ASH  adolescent sexual health
ECP  emergency contraceptive pills
HAART  highly active antiretroviral therapy
IG  intergenerational
LGBT  lesbian, gay, bisexual and transgendered
MCP  multiple and concurrent partnerships
MSM  men who have sex with men
PID  pelvic inflammatory disease
PMTCT  prevention of mother-to-child transmission of HIV
SIV  simian immunodeficiency virus
SRH  sexual and reproductive health
STI  sexually transmitted infection
TOP  termination of pregnancy
TS  transactional sex
VYA  very young adolescent
WHO  World Health Organisation
Foreword

Access to antiretroviral treatment has meant that increasing numbers of perinatally-infected children are now entering adolescence. Emphasis on the scale up of antiretroviral treatment has however tended to overshadow other important needs.

These young people face unique challenges related to their HIV positive status, most notably around issues of sex and sexuality.

Perinatally-infected adolescents are no different from their non-infected peers in terms of the concerns that are typical at this stage of development, for example starting to form romantic relationships and explore their sexuality.

However their experiences are often clouded by fears about status disclosure and rejection, transmission of the virus, re-infection and worries about their future role as a husband, wife, partner or parent.

Opportunities to talk openly and honestly about their sexuality are limited. This topic is often regarded as taboo by parents and caregivers. Furthermore, HIV infected adolescents do not always get support from healthcare providers either who often lack the knowledge and skills to address the sexual and reproductive health issues of this population.

This manual gives guidance and direction to healthcare workers who recognise that sexual and reproductive health is a critical component of adolescent service provision.

It responds to needs for information about legal and other aspects of sexual and reproductive health, providing an invaluable resource for use in either a clinic or community setting.

Importantly, it is aimed at very young HIV infected adolescents (10-14 years), a group that is frequently overlooked, and provides a window of opportunity to lay the foundations for future sexual and reproductive health.

Addressing a wide range of relevant topics it sets out to build adolescent knowledge and understanding of sexual and reproductive issues in a way that is age-appropriate, entertaining and contextually relevant.

Perhaps, most significantly, it is informed by young adolescents themselves. Young people in urban and rural settings told us what they know and what they want to know. This manual speaks to their needs for information, support and guidance.

James McIntyre
Executive Director

Helen Struthers
Chief Operating Officer
Aim

To equip people working with young adolescents with the relevant knowledge and materials to conduct structured support group sessions for young HIV-positive adolescents using a club concept, in order to provide them with the sexual and reproductive health information they need to make healthy choices.

“This workbook is an essential guide to counsellors engaging in reproductive health issues with HIV positive young people. It provides a map that allows for a delightful journey of self discovery that informs and encourages responsible and positive choices.”

Our patron, Archbishop Desmond Tutu says: “Our ability to create a new life connects us to the spark of the Creator within us all” (2002). Our hope is that this workbook will encourage participants to ensure that their sexual decisions enhance the physical, emotional, mental, relational and spiritual aspects of their lives.

Lynne Cawood
Director: Childline Gauteng & Sunlight Safe House
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1.1 Introduction

In many parts of the world the sexual and reproductive health needs of HIV-positive teenagers, in particular those infected through mother-to-child transmission, are largely unmet. Many teenagers who were perinatally infected are sexually active and need information and support if they are to enjoy safe and fulfilling relationships. Teenagers may be just beginning to explore their identity as sexual beings. Secondary prevention is an important component of treatment, care and support. Support groups that aim to provide HIV-positive adolescents with the sexual and reproductive health information they need, provide an important means of building knowledge and skills, and helping adolescents to make healthy choices.

This manual is for health-care providers, including counsellors, nurses, doctors, psychologists and social workers – in fact anyone who is involved in the treatment, care and support of HIV-positive adolescents. Aimed at young adolescents, it seeks to lay the foundations for future sexual reproductive health and well-being by addressing problems, suggesting solutions, providing guidelines for healthy behaviour and responding to the unique challenges of perinatally infected adolescents.

The manual represents a response to needs voiced by young boys and girls (aged 10 to 14 years) who, in separate focus group discussions conducted in urban and rural settings, asked for information that could help them make informed choices about their sexual and reproductive health. Amongst other things they wanted to know:

- “Is it OK for a boy to sleep with a girl if she doesn’t want to?”
- “How did I get HIV?”
- “What makes sperm?”
- “Why do girls wear pads?”
- “Is it possible to get pregnant before your periods start?”

These and other important issues are addressed through developmentally appropriate activities that are structured to suit clinic or community-based groups dealing with adolescent sexual and reproductive health issues. A section on setting up support groups will help facilitators to get started, whilst background information on topics and related legal aspects provides useful reading in preparation for running support groups. The informational needs of young adolescents are met through experiential group work that is stimulating and informative, with home tasks designed to encourage communication between young people and their parents and caregivers.
1.2 Why young adolescents?

The World Health Organisation (WHO) defines adolescence as the period between 10 and 18 years of age. When we speak of youth, it usually means those between 15 and 24 years. The term young people refers to a combination of both groups, i.e. 10 to 24 years (WHO, 2001). More recently, children between the ages of 10 and 14 years are referred to as very young adolescents (VYA), mainly as a means of distinguishing this age group from older groups (Palmer, 2010).

For those working with very young adolescents it is important to recognise that there will be differences between the younger and older children within this age-group, as well as between children of the same age. Age is not always a good indicator of emotional or cognitive maturity, and for this reason groups for young adolescents should be carefully planned to make sure that they reflect the developmental needs of the participating adolescents.

This manual serves as a guide for addressing the sexual and reproductive health of young HIV-infected adolescents. Flexibility is key. If they choose to, health-care providers can work with younger (10-11 years) or older (12-14 years) adolescents and can select appropriate activities from the broad range of topics presented in the manual.

Research into adolescent sexual and reproductive health has shown the importance of targeting children between the age of 10 and 14 years. Health-care providers are now recognising that early adolescence presents a window of opportunity to reach young people before they become sexually active and before the establishment of gender norms and attitudes that influence sexual and reproductive health outcomes. For example, helping young adolescents to make good decisions about their sexual values and interpersonal relationships is vital. There is a strong link between gender norms and sexual and reproductive health, especially in the context of HIV and AIDS where male decision-making power has been associated with risk behaviours such as insistence on "flesh-to-flesh" sex or sex without a condom.

From about 10 to 14 years the foundations for sexual and reproductive health are put in place as boys and girls start to develop the skills and attitudes that will determine their future well-being. Addressing sexual and reproductive issues early on means that a solid foundation can be built for later interventions. Addressing these issues doesn't encourage young people to have sex. Rather, it ensures that they can obtain accurate information about sex and sexuality that will enable them to enter into sexual relationships safely and responsibly. The danger lies not in talking, but in not knowing and in curiosity that is not addressed (Palmer, 2010).

1.3 Understanding early adolescent development

Adolescence is a time of change. In the transition from childhood adolescents experience not just physical growth and change but also emotional, psychological, social and mental change. In early adolescence (10-14 years) these changes are especially noticeable. A ten year old is just a child, yet by the time he or she has reached 14 years he or she is considered well on the way to growing up.

In order for an adolescent to function as an adult, he or she has to master certain developmental tasks. Some will be more important than others at different points in adolescent development. Success or failure in mastering these tasks may mean happiness, or distress and difficulty achieving later tasks. In early adolescence the task of forming an individual identity and learning to relate in new ways to the opposite sex gets underway. This is a time of intensifying relations with peers and marks the beginning of the development of independence from parents. Conformity becomes important and the need to be accepted is strong in the early adolescent years. Adolescents want to not seem different from their peers.
Another major task is that of accepting changes in physical appearance. How teenagers see themselves (self-concept) is closely tied to their physical appearance and their ideas about their physical acceptability (body image). In work with HIV-positive adolescents who are perinatally infected, it is imperative for facilitators to think about the possible impact of HIV on the physical, social and sexual development of VYAs.

1.4 Biological development

A girl may start puberty anytime between the ages of eight and a half to ten years, while for boys it usually starts between the ages of nine and a half to ten and a half years. Early or late puberty is neither a good or bad thing, but researchers have found that young people who go through puberty either earlier or later than their peers may feel awkward or self-conscious.

Often adolescents don't know much about pubertal changes. They lack in-depth knowledge about their own sexual maturation and know little about pubertal changes in the opposite sex. Many girls will report having experienced their first menstruation (usually between the ages of 11 and 14 years). Although there is no specific event for boys marking puberty, they will experience changes such as pubic hair growth, deepening of the voice, changes in genital development (namely enlargement of the testicles and penis) and first ejaculation (wet dreams).

Young teenagers will experience increased growth and changes in their body mass. For instance whilst boys become leaner, girls tend to accumulate more mass. In girls there is a time of rapid growth, usually before menstruation starts, which is around 2-2.5 years after the first signs of breast development. Boys begin growing later than girls and carry on for longer.

Many adolescents infected with HIV through mother-to-child transmission experience delays in puberty that can cause psychological distress. For example puberty can be delayed in both boys and girls. For some girls menstruation might start very late, sometimes only at 15 years of age (Rudy, 2006).

Delays in growth are also quite common in HIV-infected children. The virus can change the hormonal systems that are responsible for growth and development in puberty. Starting from birth, HIV-infected babies are likely to be smaller in size and have a lower birth weight than babies that are not infected and this can continue throughout later childhood, with HIV-positive boys and girls being shorter in stature and having a lower mass than children who are not HIV infected. This can sometimes be avoided if antiretroviral treatment starts at a very early age (Rudy, 2006).

Concerns about body image and appearance are common in early adolescence. Boys and girls worry about how they look, and they can be very self-critical. Apart from the normal worries about appearance, body dissatisfaction among HIV-positive adolescents can be linked to the virus, which apart from influencing growth and development may also be responsible for skin and other conditions that can cause considerable distress and embarrassment.
1.5 Milestones in sexual development

During puberty, sexual development occurs in a set sequence. However, when the changes begin and how quickly they occur varies from person to person. For girls, puberty begins at age eight and a half to ten years and lasts about four years.

For boys, puberty begins at age nine and a half to ten and a half years and lasts about three years. The chart shows a typical sequence and normal range of development for the milestones of sexual development.

*Refer Tanner’s Stages for detailed onset and progression of pubertal rates (Ruby 2007).
1.6 Emotional development

Early adolescence is a crucial stage for emotional development. As teenagers begin to build friendships and turn from their family to the world beyond they start to explore their identity and make friendships. Although not always long-lasting, these friendships can provide them with encouragement and support.

Early adolescence is one of the few developmental periods involving a great number of changes at many different levels. For facilitators, thinking about the emotional development of VYAs means accepting and normalising the feelings that adolescents commonly experience, for example inferiority, self-consciousness and embarrassment, and helping them to deal with emotional difficulties.

VYAs are often confused about the emotional and physical changes that they experience. Behaviour tends to be driven by feelings, and emotions are intensely felt. Work with young adolescents has shown that this is a time when tendencies such as caring, sharing and concern for others grow. Facilitators can build on this, for example, by helping teens to express feelings positively and fostering respectful attitudes.

Most notably, young adolescents are in a period of social development. VYAs are interested in opposite-sex relationships and romance and often have romantic, but not necessarily realistic, ideas about what the future might hold in terms of wealth, marriage and family life. They may develop romantic or sexual feelings for a special person (a crush) which can preoccupy them and may lead to feelings of hurt or rejection.

Early adolescence is also characterised by closer relationships with peers. This is important for many reasons, such as building social skills and learning how to negotiate and resolve conflict. Girls in particular are concerned with more intimate relationships within which they can share thoughts and feelings. Adolescents need to feel accepted by their peer group and are very afraid of rejection or isolation. Young people with accepting peer groups have been found to do better in school. Those who feel rejected can start to lose confidence in themselves.

Another feature of adolescence is the shift that occurs in the relationship with parents or caregivers. This too is quite normal. Because VYAs are undergoing such rapid change and are presented with so many new and different challenges and opportunities, parent-child relationships are renegotiated. Examples of this include adolescents’ argumentative behaviour and a tendency to question things and challenge authoritative attitudes. None of this means that parents and caregivers lose their importance for young people. Adolescents are deeply hurt if they feel rejected by their families. Since they have not developed the skills to deal with various situations they are reliant on the adults in their lives to provide guidance and direction.

Adolescents perinatally infected with HIV experience all of these worries and challenges but in addition, they must cope with many stressors associated with the illness. Status disclosure, fear of dying, stigma and isolation all have a negative impact on social and emotional development.

1.7 Cognitive development (thinking, learning and judging)

At one time it was believed that the brain was fully matured by the time a child reached 10 or 12 years of age. Now scientists know that parts of the brain, especially those parts that influence self-control, judgement and emotion, undergo great changes between puberty and adulthood.

In early adolescence teenagers begin to develop the ability to think beyond the here and now. They can consider possibilities, plan ahead and are more aware of the consequences of what they do. They are also better able to express their feelings in communication and have a strong sense of what is right and wrong. These new cognitive abilities allow teenagers in the early phases of adolescence to begin to think about
things like values. This is when questions like “Who am I?”, and “What will I become in the future?” are important.

However, it should be remembered that children develop at different rates and also go through a period between cognitive stages when their thinking can reflect a combination of two stages. For example, some very young adolescents might still think more concretely. In the context of sexual and reproductive health it could be difficult for them to think about future possibilities, making it more appropriate for a group facilitator to talk instead about the immediate risks and benefits of certain kinds of behaviour.

Unlike adults, VYAs can usually talk about sex without feeling awkward or embarrassed. This makes this a good time to give information about sexual and reproductive health, and to help them think about their values.

Two types of thinking are particularly relevant in early adolescence: the imaginary audience and the personal fable. The personal fable refers to the tendency of a young person to believe that nobody else thinks or feels the way he or she does. This thinking can contribute to isolation – for example, an HIV-positive teenager might cut himself or herself off from sources of help and advice. The feeling of being all alone can be made worse for those who keep their HIV diagnosis a closely guarded secret for fear of stigma or discrimination.

The personal fable also leads to the belief that one is unique and special and can give rise to risk behaviours if a person believes that nothing bad can ever happen to him or her. Nevertheless, young adolescents can grasp the concept of risk and it is very important for them to understand what is meant by sexually risky behaviour.

The other type of thinking, the imaginary audience, causes young people in early adolescence to believe that the attention of others is focussed on them and that they are constantly being judged and evaluated. This is why it is so important for health-care providers to respond positively to adolescents accessing health-care services. Adolescents are also often apprehensive about how others see them and, being able to compare the mental picture that they have of themselves with peer group norms, might become anxious and dissatisfied. In HIV-positive children, developmental delays and stigmatisation can lead to perceptions of negative evaluation, causing considerable distress.

There is not very much known about the cognitive functioning of HIV-positive adolescents, but exposure to HIV has dramatic effects on the developing brain, making perinatally infected babies very vulnerable to cognitive delay, especially if they have a high viral load. As a result, adolescents who are infected through mother-to-child transmission may have learning problems that cause them to struggle in school. They may be hyperactive or find it hard to concentrate. They may be teased by their peers or judged by educators, who fail to understand exactly how HIV affects the child’s ability to function in school or are unaware of the child’s diagnosis.

An important question that is yet to be answered is whether cognitive problems continue over time or if they reduce with age and improved health. Appropriate antiretroviral therapy is certainly necessary; so too is psychosocial support. It is important to remember that very young HIV-positive adolescents are expected to start taking more responsibility for their own health-care, with many transitioning to adult services at 14 years of age. Even those who struggle because of cognitive delays will need some health literacy in order to stay well.

1.8 Working with belief systems in the context of sexual and reproductive health

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

Many teens in the 21st century are struggling to find a balance between values that have been instilled into them by parents and communities, and the extensive and often contradictory media-provided messages.

Facilitators need to acknowledge the influence (and often central role) of traditional African beliefs. They need to recognise, understand and be sensitive to ethnic and lifestyle differences. Across the many different tribes and groups taboos and attitudes towards courtship customs tend to differ. There might also be different perceptions about illness and wellness within a group, as well as healing beliefs and practices. There is often a reluctance to talk about sexuality, death and illness, and ways of expressing feelings might also differ.

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

1.9 Adolescents and sexual and reproductive health rights

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

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

Children’s Act, No 38 of 2005

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

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

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

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

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

In the general absence of an environment where young people can comfortably talk about sexuality, including menstruation, pregnancy, STIs and concerns about entering into sexual relationships, a support group can provide a supportive environment where confusing messages can be consistently countered, and fears and worries safely addressed.

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

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

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

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

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

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

- He/she should have experience in facilitating small groups for the purpose of learning new skills.
- He/she should have a background in a field related to psychosocial functioning such as psychology, social work or recognised counselling training and experience.
- He/she should be entirely comfortable talking about matters related to sex.
- He/she should have a high degree of self-awareness and high levels of observation.
- He/she should have experience in adapting information to meet a learner’s specific needs and level of education.
- He/she should be sufficiently creative to adapt the approach and use of drawing, music, sculpting, singing, storytelling or drama, as appropriate.
- He/she should have the ability to maintain a consistent approach – same starting time, order of starting, not allowing ground rules to be broken (without being punitive), etc.
- He/she should have the ability to recognise when the content of a particular session needs to be split into two or more sessions.
- He/she should have the ability to update the relevant facts / statistics when necessary.
- He/she should be familiar with the content and rationale behind antiretroviral adherence.
- He/she should have a strong knowledge base with regards to HIV/AIDS, its progression, treatment and other related issues.
- He/she should have basic knowledge about the legal issues regarding rape, abuse and children’s rights.
- As a preparation for these clubs he/she should have carefully read and understood Part A of this manual.

Knowledge of the law as it pertains to children is important (see Legal issues boxes highlighting aspects of the Children’s Act 38 of 2005 (as amended by the Children’s Amendment Act 41 of 2007)). Note should be taken of legal requirements regarding physical or sexual abuse or maltreatment that may come to light in the course of group work. This needs sensitive and careful handling on the part of the facilitator, who must ensure that there is a health-care professional available to see the child.
either immediately or following the session, depending on which response will be most appropriate. The law requires that offenses of this nature be reported to the police, with or without the consent of the child.

In addition facilitators should be familiar with community based resources and support systems in order to make necessary referrals. A new resource, The Children Services Directory, is available via the Department of Social Development. Contact Moses Ramufhi at Mosesra@socdev.gov.za.

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

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

2.3 Co-facilitating: Two or more facilitators working with one club

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

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

In the interest of maintaining trust and consistency:

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

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

2.4 Setting up a club

One of the first steps in setting up a support club is to enrol members. Ideally there should be a gathering of eight to ten very young HIV-positive adolescents (boys and girls) who will mostly meet in clubs run by a male or female facilitator.
It is important to remember that the cognitive, emotional and social capacities of different children develop at different rates and that vertical HIV infection may mean developmental delays. Assessment may be necessary to help decide whether or not a child will feel comfortable in the group and able to interact with others. The sensitive nature of topics may cause some young people to feel shy or embarrassed. For this reason it is important for adolescent members to know in advance what they should expect and to understand that membership and participation is entirely voluntary.

Further, the young age of the adolescents suggests that the consent of parents or caregivers will be required for the child's participation in a support club of this nature. It is also recommended that consent be obtained from each child.

Suggested steps for enrolling members:

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

What potential participants need to know:

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

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

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

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

**Motivation card for members**

```
MY CLUB/SUPPORT GROUP
A friend is a present you give yourself.
A support group is about friendships.
It is about giving yourself the gift of a group of good listeners,
who understand and will not judge you.
You may feel scared or angry or confused.
It's brave to join with a group of people who are
having the same or similar experiences to you.
Joining a support group means that you
have made a decision not to be alone.
```

2.5 Getting going with the club

Meeting and seating

1. The physical seating is important. A circle encourages participants to see each other with ease. It also gives the impression of equality between the facilitator and members of the club.
2. Create a climate of friendliness. If it is a first meeting, let each member introduce himself/herself. If new people are present, welcome them into the club. Develop a club greeting and provide name tags.
3. Initiate action by discussing the topic. Make sure that everyone understands what is being discussed.
4. Try to see that people speak to the whole club and not just to the facilitator.
5. If a question is asked, give it back to the group, e.g. “What does the group think?” or “Would anyone like to answer this question?”
6. Make sure only one person speaks at a time.
7. Gently curb the talkative people: “Thank you. Some of the others might now like to say what they think.”
8. Encourage the silent ones by asking questions, for example “Could what X has said be true for you?”
9. Encourage and respect everyone present. Every contribution is important.
10. Try to see that the club adheres to the time limit.
Duration
Each session should take between 90 and 120 minutes to complete.

Frequency of meetings
How frequently a club meets depends on its purpose and the needs of its members. Some clubs are designed to run for a few months, while others last for many years. For this programme it is recommended that the clubs meet once a week for 16 or 17 weeks (or longer if any of the sessions are split). If this is not possible, once a month or even every six weeks would be acceptable. The decision has to be based on the availability of the club members, facilitators, etc.

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

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

Gender of facilitator for sexual and reproductive health clubs
Although it is recommended that the club facilitator is the same gender as the group, this may not always be possible. Discuss this with the club to establish any strong feelings in this regard.

General functions of the club facilitator

Creating the club

- Organise and set up the club.
- Plan appropriately.
- Be prepared.
- Prepare materials.
- Start the club.
2.6 Creating trust within the club

- Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and group rules.

- Be sure to maintain consistency:
  1. By starting and finishing at the same time
  2. Using the same facilitators
  3. Using the same order of starting
  4. Maintaining the group rules
  5. Gently ensuring consequences for breaking of rules (get the group to devise a mild “punishment” if rules are broken, like a club member having to sing a song if he or she is late). Consistency creates trust.

- Establish norms.
- Encourage the participation of all.
- Facilitate understanding.
- Keep to time.
- Keep discipline.
- Keep the group focused.
- Be a role model.

Managing the group process

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

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

This section of suggested activities is aimed at assisting the facilitator to impart the required information and help the participants develop the necessary skills in order for them to make correct choices regarding their sexual and reproductive health. There are 17 activities that are offered for use in the club sessions. Some of these require more time and can be split between two sessions. Activities have information handouts for participants’ use. Some of the illustrations can be used to make posters. These follow each activity.

Each session is described in the following format:

- Session and activity number
- Duration gives an estimate of how long the session/activity would take to carry out
- Title of the activity, e.g. pregnancy and HIV
- Activity specifies the type of activity, e.g. a roleplay, a small group discussion, a game, etc.
- Outcomes specify the outcomes of the session
- Suggested method gives step-by-step suggestions for how to conduct the activity
- Materials provides information as to what the trainer needs for the session, e.g. flipchart, markers, crayons
- Task for homework
- Trainer’s notes are tips that may be helpful for the trainer to know, refer to or keep in mind
- Information boxes
- Information handouts numbered and linked to activities.
The structure, content and activities are presented as a guide to use in a way that best suits the participants, the trainer and the setting. The trainer can select the session topics that are more appropriate and useful to his or her particular group of adolescents. The chronology after session 1 is open to alteration.

The facilitators are free use any activities, such as story-telling, drawing, songs or a drama-based approach, if they feel this might be better suited to the age or developmental level of the club they are working with.

Approximately 100 to 120 minutes per session is envisaged as an ideal length of time to complete the designated activities, but different settings may be influenced by constraints such as transport for the participants, the amount of time available, and the level of comprehension and skill of the participants. Trainers should adapt the vocabulary and tone used accordingly as well. Where possible, the local language should be used.

The illustrations are representational, presented in cartoon format to minimise discomfort and facilitate an age-appropriate approach.
4 Structured activities for club sessions

Session 1 Activity 1a

Introductions

Suggested method:

1. Registration forms should be signed.
2. The facilitators should introduce themselves and provide the group with some information about their background and what their role will be over the next 12 sessions.
3. Ask the participants to introduce themselves by answering the following questions (these can be written on a flipchart). The facilitators can demonstrate how to answer first:
   - What is your name?
   - How do you feel about being in this club?
   - How do you say hello in your home language?
4. Go around the club in a round robin and allow each participant a few minutes to answer the questions.
5. If facilitators wish to assess baseline knowledge of the participants in order to gauge the extent to which the objectives have been met at the end of the sessions, they can utilise the pre-post-course evaluation on page 160. Alternatively they can develop their own.

This can be administered at the club’s first meeting and again at the closing, to assess if knowledge about SRH has increased.

Trainer’s notes:

- It is essential that all members of the club have had their HIV status disclosed to them.

Encourage participants to talk about how they came to attend this club. This should help you achieve an idea of the various attitudes regarding attending. Highlight the diversity in the club and stress the benefits of learning from each other’s experiences.
Session 1 Activity 1b

Ground rules

Suggested method:

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

2. Make sure the following are included:
   - Confidentiality.
   - Attend all sessions if possible.
   - Be punctual so that sessions can start on time.
   - Show respect for one another and don't laugh at each other or interrupt one another.
   - Try and take responsibility for your own learning.
   - Give yourself permission to risk, to “not know,” to experiment with new ways of being.
   - Get as much as you can out of the sessions, ask questions, make requests and suggestions.
   - Use direct communication. Say what you feel.
   - Speak for yourself and not on behalf of others.
   - Say only as much about yourself as you feel comfortable with.
   - Know that you are free to tell the facilitator if you are feeling uncomfortable with what is happening.
   - The sessions use English as the main language. If you do not understand clearly, ask for explanation.
   - Ask the club to make up their own method of “consequences” if ground rules are broken, for example, member who arrives late must sing a song or do headstand.
   - If new members arrive, take time to welcome them and make them feel included.

3. Clarify the ground rules.

4. Ask participants if they all agree to the list of ground rules. Discuss any with which participants have difficulty.

5. Stick the list up on the wall and remember to bring the list to each session. Refer to the list if rules are broken, and amend from time to time as needed.

6. Draw up a timetable listing each of the sessions, the proposed date and what the session will cover. Cross out the sessions after they have been completed and talk to the club about the number of sessions remaining. As the remaining number of sessions diminish, talk to the club about how they feel about the ending.
**Trainer's notes:**

1. Remember that some of the club members might not be able to read.
2. Where questionnaires are used, read them out loud and clarify and perhaps interpret where necessary.
3. Helpful processes to encourage during the sessions:
   - Listen actively to everyone.
   - Learning can be painful. Too much pain or anxiety may block learning, but some tension can be motivating.
   - Mention to participants that some of these sessions may evoke strong feelings at times. They should be prepared for this and can talk to the facilitator if they need to.
   - Motivate participants to be ready to support each other.
Session 1 Activity 1C
The club greeting

Suggested method:

1. The facilitator should ask the group what they think a club is. Note the answers on the flipchart.
2. The facilitator should then ask the group why they think there is a need for clubs? Note the answers on the flipchart.
3. Explain that there are different kinds of clubs, e.g. treatment adherence. Ask the group if they know of any others.
4. Explain that this club has to do with sexual and reproductive health. Ask the group what they understand by this term. Write responses on the flipchart and correct or provide information where necessary.
5. Ask the group to talk amongst themselves and come up with some names for their club. Write the suggestions on the flipchart and get agreement.
6. Introduce the idea of a club greeting. Demonstrate the high-five hand greeting gesture (two people simultaneously raise their hand to about head height and slide the flat of their palm and hand against the palm and flat hand of their partner). You can use the pinky promise as an alternative or the club can invent their own club greeting.
7. Allow the group to break into pairs and practise the greeting.
8. Then arrange the group in a circle and allow the greeting to take place in one direction, so that the first participant performs the greeting with the person on his / her left, who then greets the person on his / her left, and the greeting goes around the whole circle. This can be repeated in the opposite direction when it returns to the first greeter. (This can be used as an energiser)

Trainer’s notes:

Fill in what clubs can provide:

- Support and understanding from others with the same experience.
- Acceptance, to make up for non-acceptance in the outside world or family.
- Hope.
- A place to discuss practical problems, find practical solutions and be empowered to take action.
- A place to give support to others (being able to give is important for most people).
- Realisation that their own problems are not unique – that other people share them.
A club that is about sexual and reproductive health aims to:

- Provide information about all aspects of sexual and reproductive health
- Enhance life skills to assist in making informed sexual and reproductive choices
- Increase knowledge about human rights and how to exercise these rights
- Improve knowledge of the law relating to adolescents and HIV.

Refer to the Background Information Box 1 below.

**Background information box 1: What is sexual and reproductive health?**

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

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

Although sexuality has to do with how a person functions biologically, culture has a strong influence. For example, culture can dictate rules about sexual contact, attitudes about what is considered moral and immoral, and ideas about how relationships between the sexes should be conducted. In order to make good decisions about their sexuality young people need to be able to explore their sexual attitudes, beliefs and values. They need information and interpersonal skills that can help them build satisfying relationships, and guidance to help them develop responsibility in sexual relationships (Planned Parenthood Association of South Africa, 2002).

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

For HIV-positive adolescents safeguarding their own sexual health and that of others means understanding and avoiding risks such as HIV transmission to a partner, infection with an STI or re-infection with a different strain of HIV.
Reproductive health is closely linked to sexual health. It is about having the capability to reproduce and the freedom to decide if, when and how often to do so (WHO, 2007). It is about having access to safe and effective contraception and health-care services to support a safe pregnancy and childbirth and provide the best chance of having a healthy baby.

Just like anyone else, HIV-positive adolescents should be able to enjoy safe and satisfying sexual relationships, knowing that should they want to start a family one day they can do so under the guidance and care of health-care professionals.
Session 1 Activity 1D
Talking about sex. An introduction to sexual and reproductive health information for HIV-positive adolescents

Suggested method:

Two facilitators are required, preferably a female facilitator for girls and a male one for boys.

It is important that the facilitator is completely comfortable with talking about sex.

1. The facilitators should divide the group into girls and boys and separate them into two rooms with one same-sex facilitator per group.
2. Stress that it is sometimes difficult to speak openly about sex. Encourage participation.
3. Mention that different generations and cultures have different approaches towards talking about the subject.
4. Stress that young people are exposed to lots of different and confusing messages about sex and sexuality. Some messages emphasise the risks and dangers of sexual activities and others, such as TV shows and magazines, promote the idea that being sexually active makes one more attractive, grown up and mature.
5. Provide a gender-specific scenario from below – or you could make up your own. Read it out to the group.

Scenarios

Girls:

a. Lindiwe and her friend are reading a magazine one afternoon after school. They are looking at a picture of two people kissing. Lindiwe’s caregiver comes into the room and snatches the magazine away, tears it up and shouts that the girls are bad, they are too young to be looking at such things and they will be punished and get sick for behaving so badly.

Boys:

a. Tebogo is watching a television soap opera at his friend’s house. He doesn’t hear his caregiver calling for him. She burst into the room, switches off the television and drags Tebogo home, screaming at him that he must be seeing girls if he is interested in watching such things.

6. Ask two people in the group to role-play the situation, one being Lindiwe/ Tebogo, the other the caregiver. Explain or demonstrate the concept of role-playing if necessary. Stress that it is strictly drama/ fantasy. Make sure that the entire group understands the fictional aspect of the activity.

7. Make sure that they understand that all of the information about puberty and sexuality etc. will be covered in other activities.

Activity
Role-plays, brainstorming and discussion in groups divided into girls and boys.

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

Materials
Role-play scenarios, flipchart and markers
8. Ask the group:
   • What did you think of the role-play?
   • Does this type of thing happen?
   • How would you feel in this situation?
   • How would you have liked the caregiver to behave?
   • Why do you think the caregiver reacted in this way?
   • What would you have liked to talk about if she had allowed you?
   • Who could you go to for support and information?

9. Then ask another person to replace the caregiver and role-play the ideal helper to whom Lindiwe/Tebogo has gone for support and information.

10. Ask the group:
    • How did the helper behave?
    • What do you think Lindiwe/Tebogo felt about the help they received.
    • What was helpful?
    • Can you think of ways the helper could improve on the way that he or she helped?
    • Who could you talk to if you wanted to know something about relationships/sex?
    • Ask them what they learnt from the activity and summarise.

**Trainer’s notes:**

If appropriate it would be useful (for group cohesion) for the whole group to share their findings in one group.

Caregivers and parents can be reluctant to talk openly about sexuality. The club can help counter confusing messages and provide an environment where teens can ask questions and talk to each other about their sexual and reproductive health.

Some of the reasons for caregivers/teachers’ reluctance to talk about sex include:

• Many parents simply don’t know what to say.
• Many caregivers are embarrassed to talk about sex. It makes them feel uncomfortable (ashamed) because their parents probably couldn’t talk to them about sex either.
• In some cultures certain topics are considered taboo, meaning that they should not be spoken about. Some people believe that talking about something taboo will make it happen, for example if you talk about death, someone will die.
• Others have the idea that if they talk to the young person about sex, it will encourage him or her to begin experimenting.
• Some believe that any interest shown by the teenager indicates that they are already sexually active.

**Task 1 for home:**

Ask the group to talk to their parent/caregiver or an uncle/aunt or other older family member about what dating was like when they were growing up.
Suggested method:

1. Welcome and sign in the register.
2. Check if there are any newcomers.
3. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
4. Address any discomfort in the group.
5. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
6. Begin the session with the club greeting.
7. Ask the group to give feedback about home task 1:
   Ask the group to talk to their parent/caregiver or an uncle/aunt or other older family member about what dating was like when they were growing up.

Part A

8. Tell the group that this part of the activity is a game and a talk about feelings and how feelings can help people learn a lot about themselves. You could say:
   “Feelings are hard to describe, but it is the way people respond to things. For example – a happy feeling happens when someone says nice things to you, or feeling sad is the feeling you get when something bad happens. Everybody has feelings. Feelings are things that you can’t touch but they are there somewhere inside you. Some feelings are nice and some are not. Sometimes people are scared to express their feelings because they think other won’t like them. Other times it’s hard to stop feelings from bursting out, like when a person cries. This activity will help you find out about your own feelings.”
9. Ask the group what they think “feelings” are.
10. Hold out your hand with the thumb tucked in, and say:
    “These four fingers each represent one common feeling that they will be learning more about. Happy, sad, angry, and scared.”
11. Ask the group:
    • Do you know these feelings?
    • What can you tell me about these feelings? (Can you describe those feelings?)
    • What makes these feelings come?
12. Note answers on flipchart.
13. Hold up the flashcards one at a time and ask the group to identify each of the feelings.

14. Place the four flashcards/or posters/ or flipchart paper drawings at various points in the room and ask the group members to go and stand under the appropriate feeling after each of the sentences that you will read out. You can demonstrate this by reading the first sentence and then going to stand under the angry card.

   The dog ate your lunch today. Stand under “Angry.”

15. Check if they understand how the game works.

16. Read the following sentences to them one at a time.
   - Your teacher told you to stay after school and help clean the classrooms.
   - You have just been picked for the soccer/netball team.
   - You can’t go play at your friend because she is sick in bed.
   - The dog next door is trying to bite you as you walk past.
   - All the sweets are finished and you didn’t get one.
   - Your brother hit you.
   - Yesterday you forgot to take your ARV’s on time.
   - You wake to find it’s been raining and cold again for the third day.

Think of other sentences that are relevant to the group.

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

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

19. Tell them that the same feelings can be very weak, very strong or in the middle, depending on the circumstances. For example:
   - Happy can be a little smiley, quite happy or laughing happy.
   - Sad can be a little down in the dumps, sulky sad or crying sobbing sad.
   - Angry can be irritable, grumpy angry or shouting and yelling furious.
   - Scared can be a bit worried, quite nervous or really terrified.
   - Ask to give examples of the varying intensities if they can.

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

21. Tell them that sometimes people don’t allow themselves to name their feelings because:
   - They don’t know they are feeling them.
   - They don’t know they can name them.
   - They don’t know what to do with them.
22. Hand out paper and crayons and the handouts. Ask the group members to draw their own faces showing each of the feelings. Ask them to colour each of the feelings.
   - What colour is “happy”?
   - What colour is anger?
   - What colour is “sad”?
   - What colour is scared?
23. Allow time for discussion. Some questions to facilitate discussion:
   - Why did you choose that colour?
   - What did it feel like to draw your faces?
24. Mention some helpful ways of dealing with feelings. See notes below. You can say “Everybody has fears and gets scared sometimes. It helps if you can find someone you trust who you can talk to about these fears. It may help to make a drawing of your fears, or write about them.” Link this to the next part of the activity which is journaling.

**Icebreaker**
Facilitator can mime different feelings and the group can shout out the feeling they recognise

**OR**
Facilitator can call out a statement, the participants can mime the response and call out the feeling.

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

It is recommended that an inexpensive notebook is purchased for each participant and that there is always a stock for newcomers.

In resource-constrained settings, encourage the participants to find an old book they can rework, or make their own journals with newsprint folded into book size.

Encourage creativity. They can use leaves, string, small sticks, pictures from magazines, home-made glue, paint, crayons, stickers, tinfoil, plastic rap, cut-up shopping packets, shiny paper, or even finger-paint with mud.

**Part B**

25. Now tell the group you are going to talk about journaling. Tell the participants:
   “Journaling is about you and your lives and your feelings. It’s just an idea and you don’t have to do it if you don’t want to. You can draw or write or stick things in your journal or just make shapes if you want. You can write poems or rap songs. You can write or draw memories, stories, things that are happening to you, or just what you are thinking that day.

   “You can use your journal as a friend who listens. Draw things in it when it’s hard to use words. Use it to “free write” whatever comes into your head. Just have fun. You can use your journal to be creative, find out more about yourself, develop intuition and solve problems.”
“By getting thoughts out of your head and down on paper, you can gain insights, see things about yourself that you’d otherwise never see.

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

“You can use your journal to write down how you are feeling everyday or simply scribble in the colour of your feeling.”

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

27. Ask group members to make a poster about things that make them happy on their sheet. They can paste their face drawings onto their sheet. They can make a collage. (Stick things on.) They can make patterns, they can just use colours or they can make cut-outs. They can write words to a song they know or make one up. They can do it in any way they wish to.

Stress that this is not an art competition, but just an experiment for them to see what it feels like to use art or words, or both to express how they are feeling.

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

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

30. Some ideas for home journaling:
- Draw a face of how you are feeling that day.
- Scribble in the colour of your feeling of the day.
- Draw a picture of an animal that you have invented.
- Draw your own news of the day in words or with drawings.
- Draw a picture of yourself in funny clothes.
- Cut out pictures in old magazines and stick them onto pages to make your own secret pattern or code.

31. Hand out notebooks if available. If not, mention resource-appropriate alternatives. Group members can make their own out of newspaper or old school books with unused pages.

32. Encourage group members to cover and decorate their journals in their own way. Stress that the journal is for themselves, that they should share the contents only if they wish to.

Trainer’s notes:

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

Helpful processes to encourage during the sessions: Stress the importance of kindness and motivate participants to support each other. For example, ask the participants to say something kind to the person sitting on their left, and examine how they feel after they have said or done a kind thing, and then exchange roles.
## Handout 2a

### How did I feel?

<table>
<thead>
<tr>
<th>Feeling</th>
<th>On this day I felt...</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write the feeling in your language</td>
<td>Write the days and the dates</td>
<td>Write or draw the reason why you felt the feeling</td>
</tr>
<tr>
<td>![Happy Emoticon] Happy</td>
<td>![Sad Emoticon] Sad</td>
<td>![Angry Emoticon] Angry</td>
</tr>
</tbody>
</table>
## Example

<table>
<thead>
<tr>
<th>Feeling</th>
<th>On this day I felt...</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Write the feeling in your language</td>
<td>Write the days and the dates</td>
<td>Write or draw the reason why you felt the feeling</td>
</tr>
</tbody>
</table>
| ![Smiley Face](image1) | **Monday 2nd May**  
**Thursday 12th May**  
**Thursday 19th May** | chosen 4 soccer team  
passed test  
soccer team won |
| ![Sad Face](image2) | **Wednesday 11th May**  
**Thursday 26th May** | lost my book  
sore tummy |
| ![Angry Face](image3) | **Tuesday 24th May** | Nana ate my lunch |
| ![Surprised Face](image4) | **Thursday 5th May** | school test tomorrow |
For feelings, use the local language and / or simplify as needed. Here is a list of possible feelings:

<table>
<thead>
<tr>
<th>Affectionate</th>
<th>Angry</th>
<th>Annoyed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxious</td>
<td>Apathy</td>
<td>Awe</td>
</tr>
<tr>
<td>Contempt</td>
<td>Curiosity</td>
<td>Bored</td>
</tr>
<tr>
<td>Depressed</td>
<td>Desire</td>
<td>Despair</td>
</tr>
<tr>
<td>Disappointed</td>
<td>Disgusted</td>
<td>Dread</td>
</tr>
<tr>
<td>Ecstasy</td>
<td>Embarrassed</td>
<td>Empathy</td>
</tr>
<tr>
<td>Envy</td>
<td>Euphoria</td>
<td>Fear</td>
</tr>
<tr>
<td>Fretful</td>
<td>Frustrated</td>
<td>Grateful</td>
</tr>
<tr>
<td>Grief</td>
<td>Guilt</td>
<td>Happy</td>
</tr>
<tr>
<td>Hatred</td>
<td>Hope</td>
<td>Horror</td>
</tr>
<tr>
<td>Hostile</td>
<td>Hysteria</td>
<td>Indifferent</td>
</tr>
<tr>
<td>Interested</td>
<td>Jealous</td>
<td>Loathing</td>
</tr>
<tr>
<td>Lonely</td>
<td>Love</td>
<td>Lust</td>
</tr>
<tr>
<td>Miserable</td>
<td>Pity</td>
<td>Proud</td>
</tr>
<tr>
<td>Rage</td>
<td>Regret</td>
<td>Remorseful</td>
</tr>
<tr>
<td>Sad</td>
<td>Satisfied</td>
<td>Shame</td>
</tr>
<tr>
<td>Shock</td>
<td>Shy</td>
<td>Sober</td>
</tr>
<tr>
<td>Sorrow</td>
<td>Suffering</td>
<td>Surprised</td>
</tr>
<tr>
<td>Wonder</td>
<td>Worried</td>
<td></td>
</tr>
</tbody>
</table>

Some other ideas for home journaling are to write about:

- My favourite colour is .......... because ........
- If I could be an animal I would be a .......... because ........
- Today I am complaining about .......... because ........
- Today I am praising .......... because ........
- Write about your day in 20 words.
- Write out the words of your favourite song.
- Compose a song.
- Stick your favourite picture or photo into your journal and write about why it’s your favourite.
- Write down three things you’re thankful for.
- Write down three things you really don’t like.
Session 3 Activity 3

What is HIV?

Suggested method:

1. Use one or two facilitators, depending on whether you have separate or mixed groups of boys and girls.
2. Welcome and sign in the register.
3. Check if there are any newcomers.
4. Continue creating a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Address any discomfort in the group.
6. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group. Begin the session with the club greeting.
7. Tell the group this session is about HIV and AIDS. Hand out the basic facts questionnaire. Allow fifteen minutes for participants to answer true, or false.
8. Using illustrations as handouts, posters or power point presentation, clarify answers. Allow time for any other questions that may be asked.
**Handout 3a**

**Answer true or false (T or F)**

1. HIV and AIDS are the same thing.
2. Inside our bodies we have soldier cells (called CD4 cells).
3. They are the defence force of our bodies.
4. We call this defence force our immune system.
5. When HIV is in the blood it attacks these soldier cells.
6. When an HIV-positive person gets an STI it can be more severe than it is for an HIV-negative person.
7. With too few soldier cells our bodies can’t fight other germs and we get sick easily.
8. HIV lives in the blood and body fluids of the infected person.
9. A person can get HIV through having unprotected sex.
10. An HIV-positive mother can pass the virus on to her baby.
11. A person who uses the same cup as someone who has HIV will become infected.
12. Using condoms helps to make sure that an HIV-positive person does not infect his/her partner.
13. ARVs will help control HIV and stop it from making more HIV.
14. ARVs can cure STIs.
15. You can stop taking ARVs when you feel better.

**Answers to handout**

1. F
2. T
3. T
4. T
5. T
6. T
7. T
8. T
9. T
10. T
11. F
12. T
13. T
14. F
15. F
Background information box 2: About HIV

HIV and AIDS came to light at the beginning of the 1980s when the first recognised cases of AIDS occurred. Soon after this scientists discovered the Human Immunodeficiency Virus (HIV) and found evidence to prove that it was this virus that caused AIDS. The question was how, when and where HIV originated. Today it is generally accepted that the origin of HIV is the Simian Immunodeficiency Virus (SIV) that affects chimpanzees and monkeys (Spiegel & D’Angelo, 2006).

When hunters in the forests of Africa caught, killed and ate these animals they came into contact with SIV through the animal’s blood. This then adapted itself to the hunter and became HIV. HIV is the virus that causes AIDS by killing off cells that protect the body from infection (immune system cells). When a person’s immune system is too weak and can no longer fight infection they become sick and the person is said to have Acquired Immune Deficiency Syndrome (AIDS).

In Africa the first HIV and AIDS epidemic started in Western Equatorial Africa, and from there it spread quickly as it became part of a wide sexual network (see section on multiple and concurrent partnerships). In sub-Saharan Africa unprotected sex between men and women is the main cause of HIV infection (Spiegel & D’Angelo, 2006).

Children in Africa are infected mainly when the virus is transmitted from mother to child either before the baby is born (during the mother’s pregnancy), during delivery of the baby or from breast milk. Thousands of children who are now entering adolescence were infected in this way.

In addition, many adolescents acquire HIV through vaginal, oral or anal sex. Other forms of transmission include use of contaminated needles by drug users or infection with an object that has been contaminated with HIV infected blood, such as those used in ritual scratching, scarification or traditional circumcision. Children can also be infected through sexual abuse.

Regardless of the mode of transmission, HIV-positive adolescents who have unprotected sex are at risk for a number of reasons. They could transmit HIV to their partner. With unprotected sex between HIV-positive individuals there is the danger of re-infection with a different strain of the virus. This is called dual infection and it causes the disease to progress, or get worse, more quickly. It also contributes to the development of drug-resistant forms of the virus. In Africa where the treatment options are often limited, it is critical that young people who are sexually active practise safe sex so as to prevent these drug-resistant strains of HIV from emerging.

Task 2 for home:

1. Ask the group to do some research in their community about what information is available about HIV and AIDS.

2. Ask them to make a note of any HIV-related messages:
   - abstinence (describe in the local language)
   - staying faithful to one partner who is also faithful,
   - using condoms.
Handout 3b

What is HIV/AIDS?

NB. There is a big difference between being HIV positive and having AIDS

HIV

H stands for Human because it is only found in humans - not animals

I stands for Immunodeficiency because it causes the immune system - defence force - to be deficient (not work properly)

V stands for Virus which is one type of germ

AIDS

A stands for Acquired. We acquire (get) it from an outside source

I and D stand for Immune Deficiency because it causes the Immune system to be Deficient (not work properly)

S stands for Syndrome. A collection of illnesses

Workplace Wellness Programme
What is the immune system?
How does it work?

Inside our bodies, in our blood we have CD4 soldier cells. (The immune system)

They are our body’s defence force. They work hard keeping us strong and healthy by attacking the germs.

When germs come into our bodies, these soldier cells kill the germs.

For example, when we get ‘flu we get sick for a short while, but our immune system kills the germs and we get better

Flu process with strong immune system.

What happens when HIV gets into our bodies?

Once inside our bodies, HIV attacks the CD4 soldiers cells. The CD4 cells cannot kill HIV.

HIV takes over the CD4 soldier cells and uses them as factories for making millions of new HIV’s.

HIV takes over more soldier cells.

The soldier cells are killed. After a while, there are very few soldier cells left.

This means that more and more germs come into the body as the immune system gets weaker and weaker.

Flu in person with a weak immune system.
What causes HIV/AIDS?
How do we become infected?

HIV lives in the blood and body fluids of the infected person.

Small quantities of HIV

HIV infection happens in three possible ways.

Through having unprotected sex (without a condom) with an HIV+ person. The virus finds its way into the body more easily if there are sores (broken skin) from STI’s.

Through contact with HIV-infected blood. (Sharing contaminated needles, razor blades, tattoo needles and scarification instruments, blood transfusions).

Through mother to child transmission. An HIV-infected pregnant woman can pass HIV onto her baby whilst pregnant, during birth or through breastfeeding.
How HIV is not transmitted

HIV cannot be transmitted though casual contact

You cannot get infected with HIV from:

✗ Toilet seats
✗ Mosquito bites

✗ Swimming or bathing with ...

✗ Sharing clothes, eating utensils with ...

✗ Eating food prepared by ...

✗ Sharing a home with ...

✗ Being in the same bus with ...

✗ Going to school with ...

✗ Dry kissing ...

... an HIV-infected person.
Preventing HIV

In the case of sexual transmission:

Abstain from sex if you can, or delay first sex.
Be faithful to one partner.
Use condoms every time.
Get STI’s treated.

The riskiest sexual practices are:
1. Unprotected penetrative anal sex.
2. Unprotected penetrative vaginal sex.
3. Oral sex. (Sores in the mouth, bleeding gums, etc. make transmission more likely)

In the case of transmission through blood:

Avoid sharing possibly HIV-contaminated instruments like intravenous drug needles, razors or other instruments used in scarification rituals.

In the case of mother-to-child transmission:

ARV’s given during pregnancy as well as to newborn baby.
Mothers to breastfeed according to current PMTCT guidelines.
Session 4 Activity 4a
Naming body parts: sexual and reproductive organs

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Ask group members if there is anything they want to talk about that they are not comfortable with. Invite them to discuss with you after the group if they prefer. Address any discomfort in the group.
6. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
7. Begin the session with the club greeting.
8. Ask the group to give feedback about homework task 2: Research in their community about what information is available about HIV and AIDS. Ask them to make a note of any HIV-related messages such as abstinence, staying faithful to one partner who is also faithful, and using condoms.
9. After feedback has been taken, ask the group to comment on whether they think people take notice of these messages and if so why; if not, why not. Allow time for discussion.
10. Tell the group that they will be divided into boys and girls because these conversations can sometimes be embarrassing. Stress that it’s sometimes difficult to speak openly about sex. Stress that because a person talks about sex it doesn’t mean they are ready to have sex, nor that they are having sex already. Encourage participation and stress that this is a fun exercise.
11. Then divide the group into girls and boys and separate into two rooms with one same-sex facilitator per group.
12. Tell the group that this activity is about choosing the names they will use for the sexual organs. In separate groups, divide the girls/boys into groups of three or four. Supply them with flipchart paper and pencils/crayons. Explain that there are proper biological names for sexual organs and ask the group if they know these (penis, testes, testicles and vulva/vagina, breasts). Write these up on a flipchart.
13. Explain that there are also other words used to describe sexual organs (use gender appropriate examples such as “tieties”, “piepie”). Ask the group to brainstorm and write these down on the flipchart paper. This exercise can elicit a lot of laughter and break down barriers.
14. Allow each group to present their words and write up on the flipchart. Ask the group if there are any words they don’t like or which could be considered disrespectful.

15. Facilitate discussion around this and invite the group to agree on the words they want to use. Girls can choose words for vulva/vagina and breasts and boys for penis and testicles.

16. Bring the groups together and engage the groups in discussion of the words, drawing attention to any words that were considered disrespectful and the reasons given for this.

17. Ask group members what is the most important thing that they have learnt in this session.

18. Ask them to show you how interesting they found this session. If they found it interesting, they should put their hand up and wave. If they found it boring, they should put their thumbs down.

19. Ask them what they are feeling. If they are embarrassed, what led to this? If angry, what made them angry?

**Trainer’s notes:**

See hand-outs in Part B.

*It is very important that the facilitator is entirely comfortable with talking about sex.*

Human beings are either male or female, depending on what type of sex organs they have.

Female sex organs are also called reproductive organs because they are the parts of the body that make females reproduce (able to have babies).

Females have reproductive or sex organs on the inside and the outside of their bodies. The proper name for the outside part is the vulva. Lots of people mistakenly call it the vagina.

Because it’s sometimes difficult (embarrassing) to talk about things relating to sex, people may use different names.

Male sex organs comprise of the penis and the scrotum (which contains the testes). Sperm is produced in the testes.
Session 4 Activity 4b

Body changes

Suggested method:

1. Two facilitators are required, preferably a female facilitator for the girl’s group and a male one for the boy’s group.

2. In the mixed group, explain that this activity is to learn more about the physical changes that happen during puberty. Explain that it is easier to divide the group into boys and girls because it is sometimes difficult to speak openly about sex. Encourage participation and stress that this is a fun exercise.

3. The facilitators should then divide the group into girls and boys, and separate into two rooms with one same-sex facilitator per group.

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

5. Once they have completed their drawings, ask them: What is happening to Lulu / Lebo’s body? Go over the puberty changes, using the list and illustrations below as guidelines.

6. Then write up the following list on the flipchart and ask them to discuss:
   • What are the good things about growing up?
   • What are the bad things about growing up?
   • Why do those changes happen?
   • How do you feel about them?
   Write feedback on a flipchart and discuss.

7. Ask the girls’ group if they know what vaginal discharge is. Fill in information from notes below.

8. Ask them to mark on the body all the changes that happen to people of the opposite sex (male or female) during puberty. Go over the opposite sex puberty changes using the list and illustrations below as guidelines.

9. Ask them to write on a piece of paper (without writing their names down):
   • What other questions do you have about growing up?
   • What problems do you have with the changes?

10. Read out the extra questions one by one. Invite members of the group to answer them and share ideas. Correct or add information, as it is needed. If you don’t know the answer to the question, say you will find out. If the question relates to an upcoming activity (see index of activities) answer briefly and advise the group that this subject will be covered in more detail in a later session.
11. Ask the group what they most enjoyed about this session. Then ask them:

- Why is it important to know about sexual and reproductive organs?
- Why is it important to know about sex and sexuality as an HIV-positive adolescent?

**Female sex organs**

Human beings are either male or female, depending on what type of sex organs they have.

Female sex organs are also called reproductive organs because they are the parts of the body that make females reproduce (able to have babies). Females have reproductive or sex organs on the inside and the outside of their bodies. The proper name for the outside part is the vulva. Lots of people mistakenly call it the vagina.

Because it’s sometimes difficult (embarrassing) to talk about things relating to sex, people may use different names.

**Puberty changes in girls**

- Girls grow taller and at a faster rate.
- Oil glands in the scalp become more active – girls’ hair may become oilier and they may need to wash it more often.
- Nipples and the surrounding skin get darker in colour.
- Breasts get bigger and may be tender or sore (breast budding).
- Girls’ hips get broader.
- Pubic hair begins to grow on the vulva (the area between the legs).
- Hair may grow on the arms and legs or darken in colour.
- The feet might grow very quickly.
- Your skin produces more oil, so you may develop pimples.
- Hair grows under the arms.
- Sweat glands in the armpits become more active – adolescents may develop an adult body odour.
- Sexual feelings develop – a girl may experience excitement when touching her genitals.
- There may be an increase in vaginal discharge.
- Girls may have their first menstrual period (although HIV sometimes delays this).

**For girls: Some notes on vaginal discharge**

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

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

HIV-positive girls can infect others more easily during unprotected penetrative sex if they are having their period.

Puberty changes in boys

- Boys grow taller and at a faster rate. Their feet grow first and their weight and height might increase rapidly. Arms and legs grow before the trunk of the body grows.
- Muscles become thicker and more developed, and body strength increases.
- Oil glands in the scalp become more active. The hair may become oilier and may need to be washed more often.
- Nipples enlarge, darken in colour and may be tender or sore.
- Breasts may swell and may remain enlarged for a year or two.
- Sex organs grow and develop.
- Pubic hair begins to grow on and around sex organs.
- Hair on the arms and legs may increase or darken in colour.
- The feet might grow very quickly and become smelly.
- The skin produces more oils, and so a boy may develop pimples.
- Hair grows under the arms.
- Sweat glands in the armpits become more active – a boy may develop an adult body odour.
- Hair may grow on the chest, shoulders, back and elsewhere.
- Hair grows on the upper lip and cheeks.
- Shoulders become wider and broader.
- The voice becomes deeper.
- Sexual feelings develop – a boy may experience excitement when touching his genitals.
- Erections happen more often (when the penis gets stiff and hard for a while).
- Boys may experience wet dreams.
- During puberty, for the first time, a boy ejaculates. He releases white creamy fluid called semen from the opening on the tip of his penis.

Task 3 for home:

Write down something good about how you feel about your body today. Why does it feel good?

Background information box 3: Physical changes in puberty

See 1.4 Milestones in Sexual Development on page 4.
Handout 4a
Handout 4b

Puberty changes - Boys

- Voice changes; sometimes raspy
- Muscles get thicker
- Shoulders get wider
- Nipples get bigger and darker
- They may be tender or sore
- Hair grows on face and body
- Hair grows on chest, under arms and between legs

Puberty changes - Boys

- Oil glands in scalp become more active
- Hair can become oilier, need washing more often
- Skin produces more oil
- May develop pimples
- Sweat glands become more active under arms
- Adult body smell develops
- Feet may become smelly
Puberty changes - Girls

Hair grows under arms and between legs

Hairs on legs and arms may get darker and increase

Increased vaginal discharge

What is vaginal discharge?

Small amounts of fluid are made inside the vagina and cervix carrying out old cells that have lined the vagina. This is body’s way of keeping the vagina healthy and clean. The discharge is clear or milky and does not smell bad.

The discharge is thicker:
- at the time of the month when the egg comes out of the ovaries
- during breastfeeding
- when sexually excited.

First period (Menstruation)
Masturbation

Masturbation means touching or stroking of the sex organs. Most girls and boys masturbate privately at some time in their life.

Most people do not think of masturbation as wrong or sinful.
Session 5 Activity 5A (for boys)

**Wet dreams, erections, ejaculation and masturbation**

**Suggested method:**

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
6. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
7. Begin the session with the club greeting.
8. Ask the group to give feedback about homework task 3:
   
   Write down something good about how you feel about your body today. Why do you say this? Allow time for short discussion about feeling good about their bodies.
9. The facilitators should then divide the group into girls and boys, and separate them into two rooms with one same-sex facilitator per group.
10. Tell the boys group that this activity will cover the subjects of wet dreams, erections, ejaculation and masturbation. Topics regarding girls, for example menstruation, will be covered later.
11. Tell them that they can use their own words for sex organs. The choice is theirs.
12. Ask:
   - What is an erection?
   - What is ejaculation?
   - What is a wet dream?
   - What do they think happens in a boy’s body when he has a wet dream?
   - What is masturbation?
   
   Make notes of the answers on a flipchart or encourage members of the group to write it in their language.
13. Correct the information and provide handouts. Allow time for discussion in the group.
14. Ask the group members how they felt doing this activity. Ask the group members if they have any questions. Answer the questions and explain each point in detail using the illustrations and the notes below.

15. Ask group members to discuss and write down: What are the good and bad things about erections? Prepare a flipchart with two columns: Good points and Bad points. You can use a smiley face and a cross face instead if you wish.

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

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

18. Repeat Points 15-17 regarding ejaculation, wet dreams and masturbation.

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

20. Ask the group if they know what menstruation is. The bold (or blue) print in the notes in the girls session provides basic information for boys about menstruation. Provide information from the notes and handouts: Menstruation, 28-day cycle and the female reproductive organs. Allow time for questions.

21. Trainers notes:

Make sure you are well prepared for this activity. Provide sufficient but simplified information about menstruation and the 28-day cycle.

Different boys have different needs, identities, choices and life circumstances. Therefore, not all boys have similar concerns about erections, ejaculation, wet dreams and masturbation.

**Erections**

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

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

The following stimulation may lead a boy or man to develop an erection:

- **Sight**: Seeing something that is sexually exciting (ask for examples – sexy TV images, seeing a person with revealing clothing).
- **Thought**: Thinking, (fantasising) about things that are sexually exciting.
- **Touch**: Stroking, caressing, petting, kissing, etc.

When a boy becomes sexually aroused the brain send signals that relax the smooth muscles around the arteries that supply blood to the penis. The penis is made up of spongy tissue, and during an erection, the veins that carry the blood to the penis dilate (open wider) and allow more blood flow. The spongy tissue fills up with blood and swells up, causing the penis to become hard and longer and stick out from the body at an angle.
An erection can develop slowly or within a few seconds. Once erect, the penis can stay that way for some time, or the erection may disappear as quickly as it arrived. Sooner or later, the veins become narrow again, the extra blood is drawn back into the bloodstream and the penis becomes soft and floppy again.

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

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

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

**Ejaculation**

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

**Orgasm**

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

**Wet dreams**

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

**Masturbation**

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

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

The amount of time spent masturbating is different for everybody.

Thinking things that are exciting whilst masturbating is completely normal. These are called fantasies.
Task 4 for home:
Write down or draw any stories you have heard about masturbation. Did you believe them? Why or why not?

**Background information box 4: Masturbation and other ways of obtaining sexual satisfaction**

It is important for young HIV-positive adolescents to know that there are many ways to experience sexual pleasure other than sexual intercourse, for example cuddling, caressing, kissing or masturbation. Masturbation refers to stimulation of the genitals (penis or clitoris) as a means of reaching orgasm. A couple can masturbate each other or an individual can masturbate in private, alone. Boy and men tend to masturbate more often than girls and women, but masturbation is common in both sexes. It is a good way to avoid transmission of HIV (International Planned Parenthood Federation, 2010).

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

Sexual satisfaction can be achieved in many ways, such as sucking, licking or kissing the sexual areas of another person. However HIV can be transmitted if sperm or menstrual blood enters a person’s mouth, particularly if that person has bleeding gums or mouth sores, or if fluids such as menstrual blood or semen are swallowed.
Handout 5a (boys)

All about male sex organs

Erections
During erection, the penis fills with blood, causing it to grow larger and harder.

What is an erection?
Soon after the erection occurs and the penis becomes soft again.

Men and boys have erections before and after sex.

What is ejaculation?
During ejaculation, a male has a very urgent, rush-like feeling that is known as orgasm.

What is an orgasm?
No need to explain, but a very quick all-at-once.

The testes continue to make more sperm after sex.

The sperm are released from the penis.

Ejaculation

Masturbation
During masturbation, the penis is massaged without involving the partner.

All about sex organs

Wet dreams
During puberty, some boys have their first wet dreams.

What is a wet dream?
Waking up to find the bed or the pants wet. This comes from eye-waking.

Ejaculation and masturbation are part of growing up. They do not mean that a boy is sexual.

Today, most people do not think of masturbation as wrong or sinful.
Handout 5b (boys)

The Penis

Penis

Sperm

Testicle

(One of two)
Handout 5c (boys)

Male sex organs

Human beings are either male or female, depending on what type of sex organs they have.

Male sex organs are the parts of the body that allow males to reproduce (to make babies).

The proper names for the male sex organs are penis and testicles.

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

During puberty the testicles start producing sperm
Sperm

Inside the testicles

Sperm developing in the testicles

Sperm

What is sperm?

During puberty the testicles start producing sperm for the first time.
Sperm are the males seeds or reproductive cells. Whe a sperm joins with a female’s egg, a baby can grow.
Sperm look a bit like tadpoles and are very tiny.
You need a strong magnifying glass to see them.
Each sperm has all the boy’s information inside it.
Each female egg has all the girl’s information inside it.
A baby has both parents’ sets of information.
It only takes one sperm to fertilise an egg.
Session 5 Activity 5B (for girls)

Menstruation and masturbation

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
6. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
7. Begin the session with the club greeting.
8. Ask the group to give feedback about homework task 3: Write down something good about how you feel about your body today. Why do you say this? Allow time for short discussion about feeling good about their bodies.
9. The facilitators should then divide the group into girls and boys, and separate them into two rooms with one same-sex facilitator per group.
10. Tell the girls group that this activity will cover the subjects of menstruation and masturbation. (Topics that are relevant to boys, for example, erections, ejaculation and wet dreams will be covered later).
11. Group members can use their words for sex organs. The choice is theirs.
12. Ask:
   - What do you know about menstruation?
   - What is a monthly cycle?
   - What do you think happens in a girl’s body during her monthly cycle?

   The girls could be asked to dramatise or draw pictures, or even use leaves, sand, etc. to make a picture about menstruation instead of answering verbally.

   Make notes of answers on the flipchart.

13. Correct the information and provide handouts on menstruation, the 28-day cycle, menstrual protection and internal reproductive organs. Explain that these are a very simple illustrations used for the purpose of this exercise.
14. Explain the process of menstruation in detail. Ask the group if they have any other questions and provide the answers (see notes).

15. Ask group members to discuss and write down: What are the good and bad things about menstruation? Prepare a flipchart with two columns: Good points and Bad points. You can use a smiley face and a cross face instead if you wish.

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

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

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

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

20. Ask the group what wet dreams, erections and ejaculation are. The bold / or pink print in the notes in the boys session provides basic information for girls about wet dreams, erections and ejaculation. Fill in missing information from the notes. Allow time for questions.

**Trainer’s notes:**

Make sure you are well prepared for this activity.

Different girls have different needs, identities, choices and life circumstances. Therefore, not all girls have similar concerns about menstruation.

**Menstruation**

Girls are born with thousands of tiny eggs in their two ovaries. Each month one egg becomes ready and leaves the ovary. This is called ovulation. The egg goes down the Fallopian tube to the womb.

The womb makes the inside wall thick like a nest ready to house a baby.

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

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

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

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

Menstruation is a normal, healthy part of a girl’s life. It is not an illness, dirty or shameful. It means that she can now have babies, but only if she has sex. Going near a boy during menstruation cannot cause pregnancy.
Periods often do not come on time at first, but they usually settle down to a regular pattern. Menstruation continues every month from the teenage years (puberty) to menopause, when periods stop. Menopause usually happens between 47 and 55 years.

Menstruation stops when a girl is pregnant. It starts again some time after the baby is born.

If a young woman has not started her periods by 19 years, she should see a doctor.

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

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

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

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

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

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

**Menstrual protection**

During menstruation girls need to use something to catch the blood. This also helps prevents their clothes being stained. Some girls are afraid that other people can see the pads or cotton rags they use for absorbing their menstrual flow. This fear is not usually necessary.

If cotton rags are used, fold them well and place them inside the panties between the legs. Ask a friend or look in the mirror to check whether others can see the pad.

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

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

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

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

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

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

- **Toilet roll, cotton wool, paper or tissues:** Made into pads and placed inside the panties between the legs. Make sure that bits are not left in the vagina as they can cause infection. Cotton wool can be wrapped in thin material to keep it in place or used on its own.
Sanitary towels/pads: These are special towels made out of cotton wool and can be bought at chemists or supermarkets. They are also placed inside the panties between the legs.

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

*Masturbation*

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

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

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

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

*Orgasm*

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

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**Background information box 5: Menstruation**

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

For HIV-positive adolescents it is important to know that a girl can infect others more easily with HIV whilst having unprotected penetrative sex if they are having their period. This is because the HIV virus is found in menstrual blood.
Background information box 6: Masturbation and other ways of obtaining sexual satisfaction

It is important for young HIV-positive adolescents to know that there are many ways to experience sexual pleasure other than sexual intercourse, for example cuddling, caressing, kissing or masturbation. Masturbation refers to stimulation of the genitals (penis or clitoris) as a means of reaching orgasm. A couple can masturbate each other or an individual can masturbate in private, alone. Boy and men tend to masturbate more often than girls and women, but masturbation is common in both sexes. It is a good way to experience sexual pleasure without the risk of HIV transmission (International Planned Parenthood Federation, 2010).

However there are many myths related to masturbation ranging from the belief that it leads to mental problems to those that attribute pimples to masturbation. None are true, masturbation is normal and healthy.

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

Task 5 for home:

Write down or draw any stories you have heard about masturbation. Did you believe them? Why or why not?

For girls: Ask your female caregiver / parent how she felt about her first period. How did she take care of herself?

AND / OR

Encourage girls who have started their periods to design a menstrual diary to keep track of their periods. (Explain time of ovulation, etc).
Handout 5a (girls)

Inside the female body
The internal reproductive organs

- ovaries
- uterus (womb)
- cervix
- vagina
- vulva
- egg
Handout 5b (girls)

Menstruation

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

Uterus lining (tissue) fills with blood every month in preparation for pregnancy

Egg travels towards uterus every month

Uterus lining shed every month if egg unfertilised

Fertilised egg = pregnancy
An egg is smaller than a pinprick.
Make a dot with a pencil to illustrate.
**Handout 5c (girls)**

**The menstrual cycle**

A 28 day cycle, round and round (not regular at first)

- **Period**
  - New egg is ovulated
  - Egg reaches the uterus
  - Fertilization occurs
  - Period begins again

- **Days 1-5**
  - Period finishing
  - New egg starting to develop
  - Unprotected sex occurs

- **Days 6-14**
  - Uterus lining thickens in preparation for a baby
  - Fertilized egg travels towards the uterus every month
  - If egg travels to the uterus, period and egg begin to develop

**Fertilising the egg**

Girls have thousands of eggs inside their ovaries.

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

**Notes:**

- Day 1-5: Period finishing, new egg starting to develop
- Days 6-14: Uterus lining thickens in preparation for a baby
- Fertilized egg travels towards the uterus every month
- If egg travels to the uterus, period and egg begin to develop
Handout 5d (girls)

Menstrual protection

Girls can use a variety of methods to catch the blood.

**Cloths**

Any clean materials that don't soak up fluid can be used. Fold the material well into a pad, place it on the mattress, and change it often. Use a sanitary towel to catch any leaks between the legs. If wet pads and dirty towels are left in the vagina, they can cause infection.

**Tampons**

Tampons are made of cotton wool which will not clot the blood. They should be inserted one of the following ways to prevent infection:

- To the depth that is comfortable for the girl. They do not need to be removed when the period is over. 
- With the dome facing out. 
- With the stem facing out. 
- With the stem facing in and the dome facing out.

Insert the tampon up to the neck of the vagina. It should not fall out. Tampons should not be used in girls who are menstruating for the first time.

**Sanitary towels or pads**

Towels are made of special tissues. They are made into pads and placed in the vagina. They are not inserted. They are not flushable. They can cause infection.

**All about menstrual protection**

During menstruation, girls need to use something to catch the blood. This prevents the blood from soaking through their clothes.

**Change the cloth, pad or tampon frequently to avoid anger, itching and water retention.**

**Wrap the cloth, pad or tampon carefully in sanitary wrap. Do not flush it down the toilet.**

**Some girls are afraid that other people can see the blood. This is not usual. Girls are not usually a problem, and can even be a help.**

**Wrap the cloth, pad or tampon carefully in sanitary wrap. Do not flush it down the toilet.**
Session 6 Activity 6

What is sex?

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
6. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
7. Begin the session with the club greeting.
8. Ask the group to give feedback about homework task 4:

   **Write down or draw any stories you have heard about masturbation. Did you believe them? Why or why not?**

   After feedback has been taken, ask the group to comment on the different stories they have heard and explore why they did or didn’t believe them. Allow time for a short discussion about why they believed or didn’t believe them. Stress again that lots of people masturbate and that it is a good and safe alternative to having sex before they are ready to do so.
9. Tell the group that sexual feelings are feelings of wanting to have sex, and these feelings can be very strong. It is a natural part of growing up that adolescents start to have these feelings. However, there can be problems when they act on these feelings before they are physically, emotionally or socially ready. This activity has to do with some of these issues.
10. Once again, explain that it’s easier to divide the group into boys and girls because these activities can sometimes cause embarrassment.
11. In the separate groups, ask what they think the word sex means. They can use their words for sex organs if they wish. Write responses on the flipchart. Explain:
   - When we speak of a person’s sex we are referring to whether an individual is male or female, according to different sexual organs (anatomical differences).
   - The term sex can also refer to the act of sexual intercourse, as in “having sex”. See Handout.

**Activity**
Segregated group discussion

**Outcomes**
- Participants become more familiar with some of the myths about sex and sexual activities, and how they relate to HIV-positive adolescents.
- Participants learn about the difference between sex and having sex.
- Participants gain awareness of the sexual feelings they experience during adolescence.
- The option of choice about sexual debut is introduced.

**Materials**
Handout, flipchart paper, pencils / crayons.
12. Ask the group what they think “having sex” means. Write responses on the flipchart. Explain:
   Having sex /sexual intercourse means the act of a boy or man putting his penis into a girl or woman's vagina.

13. Ask the group what they think sexual feelings are. Write responses on the flipchart. Explain:
   If a person “has sex” when they are not ready physically (in the body), emotionally (in the mind or feelings) or socially (within their group/community), there can be many bad consequences. (To illustrate the meaning of the word consequence you can use the example of eating too much and then feeling sick as a result, or of playing soccer in the main road and getting knocked down by a car as a result). Having unprotected sex is one action that has many consequences.

14. Ask the participants to divide into groups of 4 or 6. Give each group flipchart paper and pens and ask them to appoint one presenter and one writer per group. Ask them to brainstorm (discuss possible answers to) the following and then to write down their answers on the paper:
   • What do you think the consequences of having unprotected sex can be?
   • How do you think these consequences affect your life now and in the future?
   • How will you deal with the consequences?

15. Allow the groups 45 minutes to do this exercise.

16. Bring both groups back together. Invite the groups to present their lists. Afterwards, facilitate a discussion using the following questions:
   • What did you learn from this exercise?
   • How will a sexually transmitted infection affect you as an HIV-positive teenager?
   • Will being HIV positive have an impact on a pregnancy?
   • How are these issues different for boys and for girls?
   • What about the future of the baby?
   • Will being on antiretroviral therapy have any impact on the baby?
   • What issues does an HIV-positive pregnant woman face?
   • What are the issues that the father of the baby faces?
   • How could alcohol or drugs encourage a person to have unprotected sex?

Trainer's notes:
In the case of HIV-infected adolescents, as in adults, sexual behaviour can be safe and unsafe. Usually, young people ignore the safety precautions required for “safe” sexual behaviour. Often, young people do not have adequate knowledge to practise safe sex. For an HIV-positive person, sexual intercourse without a condom can lead to pregnancy, STIs and an increase in viral load.

This exercise enables the facilitator to address issues of HIV-positive teenage pregnancy and STIs, and introduce the subject of life skills for dealing with these concerns and problems.
Background information box 7: Romantic relationships and teenage sexuality

What the law says: If a child or the partner of a child is aged 12-16 years old and they engage in consensual sex (meaning that both have agreed to sexual intercourse), this is regarded as statutory rape. The National Director of Public Prosecutions must authorise any decision to prosecute for this offence. However if there is less that 2 years age difference between the children it can be raised as a defence to the charge of statutory rape.

Teenagers in early adolescence begin to have more interest in peers as romantic or sexual partners. Young adolescents often have intense feelings of love. Although they are likely to move in and out of relationships they can experience pain or unhappiness as a consequence of these experiences. The term “tender love” is sometimes used to describe the kind of love that adolescents experience since it involves feelings of tenderness and devotion, but infatuation is also common and can be equally distressing. Infatuation is different from “tender love” or “love” because it starts quickly but is not long lasting. When adolescents are infatuated they will tend to spend much time thinking about the person they are infatuated with (Planned Parenthood Association of South Africa, 2002).

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

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

Young people living with HIV from birth have a right to enjoy their sexuality and are no different to their uninfected peers in terms of their concerns. It is important for them to understand the possible consequences of a decision to embark on a sexual relationship. They need to know also that having sexual feelings does not mean that sexual intercourse follows. They can express their feelings by talking to each other, holding hands, kissing, cuddling or touching.

Task 6 for home:
Think about a time when you experimented with something new or took a risk. Write down: why you took the risk; how you felt at the time; whether you would do it again (and why / why not).
Handout 6

What are sexual feelings?

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

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

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

The physical signs of sexual feelings: the physical signs of sexual feelings: in girls is wetness in the vagina.

What is sex?

1. You are a girl or a boy. Your sex is female or male.
2. The act of having sex. A boy putting his penis into the vagina of the girl.

Sex: Male (Boy)

Sex: Female (Girl)
Session 7 Activity 7

Pregnancy and HIV: Understanding the implications of pregnancy in HIV-positive teenagers

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
6. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
7. Begin the session with the club greeting.
8. Ask the group to give feedback about homework task 6:

   Think about a time when you experimented with something new or took a risk. Write down:
   why you took the risk; how you felt at the time; whether you would do it again (and why / why not).

   After feedback has been taken, ask the group to comment on what they learnt from the activity. Explore the feelings around taking the risk (but not the risky activity itself unless the participants volunteer the information). Ask:

   • Would you take that risk again?
   • Why?
   • Why not?

9. Allow time for a short discussion about risky behaviour, reinforcing the facts presented in the previous activity on sex and sexual feelings. Stress that sexual feelings are normal, but it does not mean that the person is ready to have sex.
10. Tell the group that the current activity concerns pregnancy and HIV. Divide the group into male and female participants with a facilitator for each group.
11. Divide each group into two. Give each group flipchart paper and pens and ask them to prepare a short role-play of the following:

Activity
Group work, role-play and discussion

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

Materials
Flipchart paper and pens
Ask girls group 1 to think about and prepare a ten-minute play (role-play) of what happens to their body when they become pregnant, (the physical implications), how they would feel (the psychological implications) and what would happen socially, in their school, with their friends and financially (the socio-economic implications).

Ask girls group 2 to think about and prepare a ten-minute play (role-play) of how they would feel what would happen socially, in their school and with their friends if they decided to terminate their pregnancy.

Ask boys group 1 to think about and prepare a ten-minute play (role-play) of what they think would happen to the body of their girlfriend if she became pregnant, (the physical implications) and how they think the girl would feel if she were pregnant (the psychological implications). How would the male partner feel? What role would the male partner play in the pregnancy?

Ask boys group 2 to think about and prepare a ten-minute play (role-play) of what they think would happen socially, in their school, with their friends and financially (the socio-economic implications) if their girl-friend was to become an HIV-positive pregnant teenager.

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

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

13. After all groups have presented, encourage them to clarify their doubts and questions. Encourage discussion. Some questions to facilitate the discussion include:

- What do you think about this exercise?
- How did you feel during this exercise?
- How can one prevent pregnancy?
- In your group of friends, how do you view pregnancy?
- Do you talk about the possibility of pregnancy and the possible consequences?
- Do you think a pregnancy affects the male partner in the same way as the pregnant girl?
- What would be different? What would be similar?
- What might it be like for the babies born to mothers and fathers who were not ready?
- Do girls get the blame for becoming pregnant? Why?
- How would you help a friend who became pregnant?
- What are the pregnancy risks for HIV-positive girls?
Background information box 8: Pregnancy and HIV

What the law says: contraceptives other than condoms may be provided to a child on request by the child and without the consent of the parent or caregivers if the child is at least 12 years of age, proper medical advice is given to the child and a medical examination is carried out on the child to determine whether there are any medical reasons why a specific contraceptive should not be provided to the child. A child who obtains contraceptives or contraceptive advice in terms of the law is entitled to confidentiality in this respect.

Myths about getting pregnant tell us that many girls have had little sex or contraceptive education. Research reveals that many teenagers believe that it is not possible to get pregnant at first sex, if a person doesn’t have sex often, or if she is menstruating. In some cultures hormonal contraception is believed to interfere with menstruation and cause infertility. Many girls rely on traditional methods like charms or herbal mixtures obtained from traditional healers as a way to protect against pregnancy. These do not work.

For some teens the possibility of an unwanted pregnancy is of greater concern that re-infection with HIV or transmission of the virus. Hormonal contraception, for example “the Pill”, is thought of as a good way to prevent pregnancy and condom usage may hence decrease. HIV-positive girls who are sexually active and want to avoid getting pregnant should always use hormonal contraception and condoms together (dual protection). Hormonal contraception alone will not prevent pregnancy since there can be a drug interaction between ART and oral contraception that may make hormonal contraceptives less effective.

Girls who have unprotected sex sometimes rely on emergency contraception to prevent a pregnancy. Emergency contraceptive pills (ECP) can be taken up to five days after unprotected sex, but it is best to take them as soon as possible. This form of contraception, also known as “the morning-after pill”, works by stopping the ovaries from releasing eggs. It will not harm a girl’s health or make her infertile but it should never be used as a regular method of contraception. ECP can be used in a number of situations, for example forced sex (rape) and condom breakage, and are safe for young adolescents with HIV and on antiretroviral therapy (WHO, 2007).

Should an HIV-positive teenager on antiretroviral treatment fall pregnant and choose not to terminate her pregnancy, it is important for her to talk to a health-care professional because some ART, particularly efavirenz, should be avoided in the first trimester of pregnancy since they can cause damage to the unborn baby. For this reason many health-care professionals avoid prescribing certain drugs to adolescents of childbearing age or they might use another drug should the teen become pregnant.

Pregnancy and childbearing among VYAs is common. In the adolescent years unplanned and unwanted pregnancies happen for a variety of reasons. They include a lack of knowledge about avoiding pregnancy, being forced into sex, child marriages, and economic need (for example, sex for food or clothes, often called transactional sex).
Teen pregnancy and childbearing detrimentally affects the well-being of adolescents and their babies in many different ways. For example, it can put the life of the young mother and her baby at great risk. In fact, the risk of dying from pregnancy-related factors is about five times higher for a girl aged 10-14 years than for a woman in her twenties. For very young adolescents complications in pregnancy can be related to the fact that the pelvic bones and birth canal may be smaller and still be growing (Rowbottom, 2007).

The babies of very young mothers are often born prematurely and have a very low birth weight, particularly those infants that are born to VYAs. For young mothers who are HIV positive there is the risk that HIV will be transmitted to their child. Teenagers who are pregnant and HIV positive need support, information and referral for antenatal care and prevention of mother-to-child transmission (PMTCT).

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

Perinatally infected adolescents often worry about whether or not they will be able to start a family some day. It is not unknown for health-care providers to advise young women against pregnancy in the future, sometimes out of ignorance or because they have personal beliefs about HIV-positive women and pregnancy. With planned pregnancy there are opportunities to discuss options with health-care professionals about how to have a healthy non-infected baby.

**Background information box 9: Termination of pregnancy**

It is estimated that in sub-Saharan Africa about 14 million unintended pregnancies occur each year. Girls between the ages of 15 and 24 years account for almost half of those. What is more, an estimated 20 million unsafe abortions are carried out in sub-Saharan Africa. It is also estimated that around 90% of abortion-related deaths could have been avoided if effective contraception had been used (Rowbottom, 2007).

The decision to terminate a pregnancy is influenced by a number of factors, for example wanting to complete school or fearing rejection from peers. It should be remembered that safe abortion is a reproductive health right and when any teenage girl makes the decision to terminate pregnancy it is important that she is supported in her decision. Unsafe abortion or refusal to provide safe abortion brings with it a very high risk of complications. There is some evidence to suggest that HIV-positive girls may have a higher risk of death following unsafe abortion than HIV-negative teens.

HIV-positive girls can undergo both surgical and medical abortion. Little has been found out about the effects of abortion on adolescent girls. In terms of mental health, however,
there is some indication that if they experienced mental health problems previously, for example depression, termination of a pregnancy can aggravate these problems.

Delays in getting an abortion are problematic (e.g. waiting until the second trimester). Changes in the law that promote the right and choice to an early, safe and legal abortion do not mean that there are no longer any barriers to accessing termination of pregnancy (TOP) services. Many factors get in the way, including service provider attitudes and opposition, stigma, poor knowledge of the legislation and a lack, particularly in rural areas, of trained professionals.

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

**Task 7 for home:**

For girls: Ask your caregiver or a close female relative who is taking care of children, what kind of responsibilities she has towards the children (time, money, love, care). Think about whether or not you would be able to offer the same support if you were to become a mother now.

For boys: Ask an uncle, or close male relative who is taking care of children what kind of responsibilities he has towards the child/children (time, money, love, care). Think about whether or not you would be able to offer the same support if you were to become a father now.
Session 8 Activity 8

Sexually transmitted infections

90 - 120 minutes

Activity
Question and answer competition. Two groups compete, followed by a song/rap activity.

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

Materials
Flipcharts, markers, handouts, box for question cards, answer sheet, small rewards for winners (sweets or stars or certificates).

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that you are about half way through the series of club sessions. Ask how they feel about having come so far, and about having to think about terminating the group. Process feelings.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework tasks 7 (separate ones for boys and girls).
   - For girls: Ask your caregiver or a close female relative who is taking care of children, what kind of responsibilities she has towards the children (time, money, love, care). Think about whether or not you would be able to offer the same support if you were to become a mother now.
   - For boys: Ask an uncle, or close male relative who is taking care of children what kind of responsibilities he has towards the child/children (time, money, love, care). Think about whether or not you would be able to offer the same support if you were to become a father now.
10. After feedback has been taken, ask what they learnt from the activity.
   - What did they learn about the responsibility of caring for a child?
   - What are the different responsibilities girls and boys reported?
   - Are they really different?
   - Why or why not?
   - Allow time for short discussion about some of the realities of having children.
11. Tell the group that they will play a game to learn about STIs.
12. Ask the participants to divide into 2 groups. Ask them to choose a name for their group.

Activity
Question and answer competition. Two groups compete, followed by a song/rap activity.

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

Materials
Flipcharts, markers, handouts, box for question cards, answer sheet, small rewards for winners (sweets or stars or certificates).
13. Ask the two groups to sit facing each other. Place the box of questions in the centre of the two groups. If your group is illiterate, call out the questions alternatively to each team instead. They can use their own words for sex organs.

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

15. Each correct answer will be worth 1 point. If the question is passed to the other team and correctly answered, it will receive a bonus point (1+1).

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

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

18. Tell the group they are each going to be given a few STI symptoms to memorise. (Or if there are too many group members, allocate STI symptoms to small groups.) Tell them you are all going to make up a song to help them remember the symptoms. (They can use their words for sex organs.)

List of symptoms for the rap/song game

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

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

20. Let the first person (or small group) run into the middle of the circle and shout their symptom in this gap.

21. They can act it out if appropriate, to make it more fun, for example, they can clutch their throat to emphasise their symptom of a sore throat, or act out vomiting, or painful urination, etc.

22. This should be followed by the chorus and another gap. The first person can go back into the circle.

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

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

   **Chorus: STI? Check it out! Take it to the clinic and clear your doubt.**
   **Person one shouts out:** “It burns when I wee”.
   **Chorus responds:** STI? Check it out! Take it to the clinic and clear your doubt.

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

26. Encourage a discussion of the exercise based on the responses of the participants. You can ask the following questions:

- Did you know as much about sexually transmitted diseases as you thought you did? Why/Why not?

- How would you start a conversation with your friends/peer group on STIs? What would you say?
• Did the exercise help you understand more about STIs?
• Are there still things you don’t understand and need to ask?
• What are the best ways of avoiding STIs? Why?
• Can you be sure of your sexual partner’s STI status? Why/Why not?

27. Ensure that there is understanding about HIV positive transmission to sexual partner and that increase in viral load as well as STI transmission is possible consequence of unprotected sex. Emphasise the importance of information in making decisions and the fact that not everyone knows everything. Focus on the issue of sharing and seeking guidance.

28. Point out that the symptoms of various STIs can be confusing and overlap, therefore, it is important to seek the services of a doctor. Stress that a person can have more than one STI at the same time. Stress that STIs can only be diagnosed by a qualified doctor. Emphasize that if a person is actually showing physical symptoms, it is a fairly advanced case.

**Circumcision**

Ask the group if they know what male circumcision is. Explain that circumcision is the removal of the foreskin of the penis (in males), and that it is a promising prevention approach for various STIs (Refer to Box 10 for information).

**Trainer’s notes:**

You might need to explain in more detail or in local language what some of the questions and answers mean.

**Questions and answers**

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

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

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

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

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

**True** – because their sex organs are outside their bodies and easier to see.

**Symptoms of STIs can be:**

7. Bad-smelling liquid coming from the penis or vagina **True**

8. Pain and burning on passing urine **True**

9. Blood in the urine and / or wanting to urinate often? **True**

10. Sores, rashes, blisters, on or around the sex organs (penis, vagina) or anus **True**

11. Warts on or around the penis, vagina or anus **True**

12. Swelling in the groin **True**

13. Pain in lower belly above sex organs **True**

14. Headaches, fever and shaking in girls **True**

15. Ears falls off? **False**

16. You need to tell your sexual partner if you have and STI.

**True** – so that they can also get treatment.

17. Why are some STIs dangerous?

If not detected and treated, the infection can spread, cause you to become very sick and can cause sterility in girls (not being able to have children). Syphilis can lead to death. The presence of an STI also helps HIV transmission.

18. Is HIV/AIDS an STI?

**Yes**, when the virus is transmitted by sexual intercourse, but not if the virus was transmitted from mother to child.

19. How can you protect your self from STIs?

Abstinence (no sex), both partners being faithful, correct condom use

20. What is the first thing you should do when you think you have a STI?

See a doctor to get proper diagnosis and treatment. Inform your sexual partners that you may be infected.

21. Your doctor/nurse prescribed medication for 10 days but the symptoms disappear after 5 days of medicine intake. Can you stop taking the medication?

**No**, STI germs are hard to kill. Therefore, the medication must be taken for the whole time prescribed by the doctor.

22. Do STIs make it easier for sexual partners to get infected with HIV? Why are people who have a STI more vulnerable to HIV infection?

Many STIs cause sores (openings on the skin, in or around the genitals). These sores make it easier for HIV to enter the body.
23. Can a pregnant girl who has an STI pass the infection to the baby?

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

24. Should you have sex while you are being treated for an STI?

No, you can infect your partner even while you are being treated. Therefore, you should not have sex until you are both completely cured. Both partners need to be treated.

25. HIV-infected girls and boys can’t get infected HIV again.

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

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

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

27. You can contract STIs only if you go to sex workers for sex.

No. STIs can be contracted from anyone who has the infection, including your regular partner.

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

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

29. Only women can spread STIs.

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

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

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

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

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

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

True. The more sexual partners we and/or our partners have, the higher our chances of getting an STI.
### Table of commonly contracted STIs and their symptoms

*This table can also be given as a handout*

<table>
<thead>
<tr>
<th>Name of STI</th>
<th>Symptoms</th>
<th>Cause /Type</th>
<th>Curable?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Syphilis</td>
<td>Hard, painless, single, clean, ulcer/lesion on the penis/vaginal area, inside rectum or mouth, persistent fever, sore throat, patches of hair loss, rashes on palms, soles, chest and back</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Chancroid</td>
<td>Ulcers – painful, multiple, soft, painful swelling of lymph nodes (one side)</td>
<td>bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Herpes genitalis</td>
<td>Multiple ulcers, shallow erosions, incurable, severe pain, fever, difficulty urinating, tenderness on the inside of the legs</td>
<td>Viral infection</td>
<td>No - but treatable</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Thick yellow discharge from penis/vagina, pain urinating and, or, during sex</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Abnormal discharge from the penis/vagina, infertility, bleeding/pain during intercourse, pain while urinating</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Severe infection shows: Loss of appetite, nausea/vomiting, fever, joint pains, jaundice symptoms, dark urine, pain in abdomen</td>
<td>Viral infection</td>
<td>No - but treatable</td>
</tr>
<tr>
<td>Urethritis</td>
<td>Mild/severe pain while urinating, pus/mucous discharge from penis/vagina</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Proctisis</td>
<td>Itching/burning around anus, pus/mucous discharge in stool, mild/severe pain during bowel movement, occasional diarrhoea or fever (3 out of 10 boys show no symptoms)</td>
<td>Bacterial infection</td>
<td>Yes</td>
</tr>
<tr>
<td>Genital warts</td>
<td>External warts around anus or penis/vagina</td>
<td>Viral infection</td>
<td>No - but treatable</td>
</tr>
<tr>
<td>Crabs</td>
<td>Lice in the hairy parts of the body, itching (mostly) at night</td>
<td>Parasite</td>
<td>Yes</td>
</tr>
<tr>
<td>Scabies</td>
<td>Itchy red spots or rash on wrists, ankles, hands, penis/vagina, chest and back</td>
<td>Parasite</td>
<td>Yes</td>
</tr>
<tr>
<td>HIV</td>
<td>Damages immune system, incurable, leads to AIDS</td>
<td>Viral infection</td>
<td>No - but treatable</td>
</tr>
</tbody>
</table>

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

**Task 8 for home:**

Read handouts and make notes about anything you don’t understand about STIs.
Background information box 10: Circumcision

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

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

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

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

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

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

Medical male circumcision provides an alternative to traditional male circumcision in East and Southern Africa and there is now a growing trend towards circumcision conducted by the formal health-care sector (WHO, 2009). Nevertheless, circumcision does not give complete protection against HIV infection and should be used in conjunction with other preventative measures. In the context of the sexual and reproductive health of HIV positive adolescents, health-care providers need to emphasise the importance of condomisation.
Background information box 11: Sexually transmitted infections

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

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

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

There are a number of complications associated with untreated STIs. They include pelvic inflammatory disease (PID), infertility in males and females, cancer of the cervix, chronic abdominal pain, and birth defects in babies. When an HIV-positive adolescent develops an STI, the consequences can be more severe. For this reason it is important that young people understand the health risks associated with STIs. These include the fact that STIs greatly increase the chances of transmission of HIV and that STIs are often more severe and more resistant to treatment in HIV patients.
Handout 8

1. What are the diseases called that people get from sex?

2. What is an STI?

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

4. Can STIs be cured?

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

6. Boys often show signs of STI’s earlier than girls.

7. Symptom of STI?
   Smell from sex organs.

8. Symptom of STI?
   Pain, burning when passing urine.
12. STI Symptom?
Swelling in the groin.

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

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

15. Symptom of STI?
Nose comes off.

10. Symptom of STI?
Sores, rash blisters on/around sex organs/anus.

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

9. Symptom of STI?
Wanting to urinate often or blood in urine.

13. STI Symptom in girls?
Pain in lower stomach above sex organs.
20. What is the first thing you should do when you think you have an STI?

19. How can you protect yourself from STI’s?

18. Is HIV an STI?

17. Why are some STI’s dangerous?

24. If you have an STI you should not have sex.

23. Can a pregnant girl pass her STI on to her baby?

22. Do STI’s make it easier for sexual partners to get infected with HIV? If so, why?

21. Doctor gave you pills to take for 10 days. Your STI went away after 5 days. Can you stop your medication?
25. HIV-infected people can’t get HIV again if they have unprotected sex.

26. STI’s can be cured by having sex with a virgin.

27. You can only contract STI’s from sex workers.

28. You will not get STI’s if you wash genitals after having sex.

29. Only girls can spread STI’s.

30. Birth control pills/injections are a good way of preventing STI’s in girls.

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

32. Anyone who has sex without a condom can get an STI.
Session 9 Activity 9

Gender and respectful relationships

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that you are more than half way through the series of club sessions. Ask how they feel about having come so far, and about having to think about terminating the group.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task 8:
   Read handouts and make notes about anything you don’t understand about STIs.
   After general feedback has been taken, answer any questions and clarify any misunderstandings.
10. Use a short energiser with the group.

Part A: Understanding gender

11. Tell the group that this session is all about gender. Ask: What is the difference between sex and gender? Refer to illustration in activity number 4 and clarify if there is still confusion. Remind the group about the meaning of the word.

The person's gender is male or female.

Our sex describes the biological differences between males and females, e.g. boys have a penis and girls have a vagina.

When we refer to a person's gender we are talking about how biological differences translated into social differences.

A person is born a boy or girl but learns how to behave like a boy or girl (gender roles). These behaviours are affected by many things (culture and different beliefs) that may impact positively or negatively on a person.
12. Ask the group to shut their eyes and think back to the time when they were growing up. They should imagine themselves when they were about 5 years old. Ask them to draw a simple picture of:

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

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

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

14. Now ask them:

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

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

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

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

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

19. Ask the whole group:

- How did they feel sharing this memory with the others?

Make sure they talk about feelings, not thoughts

- What did the memory tell them about being males or being females?
- What were the different expectations their caregivers had of them?
- How did they feel about the different expectations their caregivers had of them?
- What have they learnt from this activity?
Part B: How we think girls and boys should behave: gender roles

20. What are people told about the ‘proper’ way for a girl or boy to behave? Gender roles are learnt by copying! Often they are qualities and behaviours that are encouraged in one sex but discouraged or disapproved of on another. For example, ‘boys don’t cry’ is one idea.

21. Make one sign with a happy face, meaning ‘agree’; one with a cross face, for ‘disagree’ and one with a puzzled face, for ‘not sure’, or make copies of the signs at the end of this exercise.

22. If necessary, adapt the sentences below to the developmental stage of the group. Explain that you are going to read out some sentences one by one and people should go to the corner that best says what they think about the idea in the sentence. Everyone should stand in the middle of the room to start with. If they agree with the sentence, they stand under smiling face. If they disagree, they stand under the cross face. If they are not sure, they stand under puzzled face.

23. Read out the first sentence. Repeat it and make sure that everyone has understood it. Ask people to think about the sentence and then go and stand under the agree/disagree/not-sure sign.

24. When everyone is standing under their sign, give them a few minutes to talk together about why they chose that sign. Let each group explain to the other groups why they have chosen that corner (they can choose a volunteer to represent their group or individuals can give their view, whichever is more comfortable).

25. Then let each group explain to the other groups why they have chosen that corner. Ask the other groups to listen carefully and try to understand each group’s views well. Ask:
   - Did the boys choose different corners from the girls? Why?
   - Which of these ideas protect us from unwanted sex, pregnancy, STIs and HIV re-infection?
   - Which of these ideas put us at risk of unwanted sex, pregnancy, STIs and HIV re-infection?
   - Does anyone want to change groups now that they have heard other people’s reasons for agreeing or disagreeing? If yes, ask them to explain why they are changing.

Provide information and challenge harmful ideas as needed.

Sentences

• Girls have to say ‘No’ to sex, but they really mean ‘Yes’.
• Boys need to practise sex with different girls so they can please their wives later.
• Condoms are only for people with many sexual partners.
• Boys with no money can never get a girlfriend.
• Girls are lucky because they can get money and gifts from men.
• A family or couple needs a ‘boss’, and this should be the man because he is stronger.
• A girl should always do what her boyfriend tells her.
• Beating is a good way to make children or women behave properly.
26. Read out another sentence and repeat the activity until the group understand how it works.

27. When all the sentences are finished, ask:
   - What have you learned from this part of the activity?
   - Where do we get our ideas about these topics from?
   - Are our ideas changing?
   - Is that good or bad?

28. Break into small groups. Tell the participants in this part of the activity you are going to think about ‘differences’ between people. Ask the groups to think about a person who is different from them in some small way. For example: Sipho has small ears, Tumi is very small and short, Pinky has very light skin, Neo bites her nails, Lindwe stutters. Ask them to talk about whether these differences make the person weird, or bad? Take feedback.

29. Explain that there is nothing wrong with these differences. Then ask them to think of the similarities they still share with this ‘different’ person (same age, same class, same community, same school, same hairstyle, etc.).

30. Now ask the group what gay and lesbian mean. (Let them use local words for these concepts.) Take feedback and allow questions, linking responses to the fact that we are all different in some way and that it doesn’t mean we should discriminate against anybody who is different in any way.

31. Say that some people are gay and that means they have romantic and/or sexual feelings for people of the same gender and that is the only thing that makes them gay. The difference isn’t bad either – people can love whoever they want. Love is still love and there’s nothing bad about love.

32. Explain you can’t tell for sure if someone is gay by how they act. Some males are girlish (effeminate), and some females are ‘masculine’ but are not gay. It’s normal to be curious about the bodies of your same-gender friends. This does not make someone gay. Some young people have sexual experiences with friends of the same gender during adolescence. This does not mean they will be gay when they become adults. Not showing interest in the opposite sex does not mean the person is gay either.

33. There are people all over the world, as well as here in Africa who are sexually attracted by people of the same sex, rather than by people of the opposite sex. There are no real answers why some people like to have sex with people of the same sex. Most people today agree that same-sex attraction is caused by lots of different factors (biological and genetic as well as social and environmental).

34. Summarise the learning and stress that:

- If a boy gives a girl a gift, she has to have sex with him.
- Girls should only speak when the men have finished and if they are invited.
- A person is born gay.
Harmful gender norms for males and females can put us in danger of STIs, HIV re-infection, as well as unwanted pregnancy, abuse or rape (e.g. if a girl has been brought up to believe that boys are more important, then she will not know that she has a right to refuse to have sex if she doesn’t want to).

It is good to think about our own gender values and see whether we need to change any.

We can improve sexual health by achieving equality and caring friendships between boys and girls.

Peoples’ attractions differ.

**Task 9 for home:**
Ask the group to make a point of noticing and writing down the different beliefs in their communities about gender.

**Facilitator’s notes:**
Victimisation on the basis of sexual orientation is frequent in schools, and gay males experience sexual abuse/rape at schools to almost the same degree that females do.

**Sexual orientation** refers specifically to a person’s attraction to a person of the same sex or one of the opposite sex. Heterosexuals are attracted to people of the opposite sex. Homosexuals are attracted to people of the same sex. Bisexuals are attracted to both sexes. There are no real answers why some people like to have sex with people of the same sex. Most people agree that there are two main theories as to what causes homosexual attractions. One is that a homosexual orientation is essentially dictated by genetic and or biological factors: put simply, that people are ‘born gay’. The other theory is that homosexual attractions develop as primarily as a result of psychological, social and environmental influences and early experiences.

It should be noted that a person’s sexual practices do not necessarily indicate sexual orientation or sexual identity. For example, one person may practise sexual behaviours with another person for reasons other than sexual orientation (for example, for survival, money, or power over another individual), or a person may practise sexual behaviours that conform to societal norms, even if the practice is not consistent with that person’s sexual orientation.

**Definitions:**

**Lesbian:** A woman attracted to a woman.

**Gay:** Men attracted to men. Colloquially used as an umbrella term to include all lesbian, gay, bisexual and transgender (LGBT) people.

**Bisexual:** A person who is attracted to two sexes or two genders, but not necessarily simultaneously or equally.

**Transgendered:** Transgendered people are those whose psychological self (gender identity) differs from the social expectations for the physical sex they were born with, for example, a female with a masculine gender identity or who identifies as a man. It is an umbrella term for transsexuals and people who identify as neither a man or as a woman. Transgendered is not a sexual orientation; transgendered people may have any sexual orientation.

**Men who have sex with men (MSM):** MSM may identify as gay or may see themselves as heterosexual.
Background information box 12: Gender and respect

Gender has to do with practices, rules and customs that make the biological differences between boys and girls into social differences. So for example, the concepts of masculinity and femininity are associated with certain qualities or characteristics. These qualities are influenced by many factors including culture. For instance, in some cultures boys are expected to be strong and dominant – they are the ones that make the decisions. Girls are expected to be submissive and passive. This way of seeing men and women starts from a very young age and can be shaped over time. Think about the media and films where men are shown as violent and aggressive and often abusive to women (WHO, 2009b).

Gender relations play a very important role in sexual and reproductive health. Whilst it is often believed that a person can make their own decision about whether or not to have sex or use a condom, this is not always the case. Sexual risk taking by girls is often the result of unequal gender relations, meaning that men fail to see that the wishes and needs of women and girls should be respected. For example, many men are brought up to believe that they have control over a woman’s sexual and reproductive health, and as a result many women and girls are exposed to physical, emotional and sexual violence, for example, when they want to use condoms or oral contraceptives. These beliefs have little to do with the biological differences between boys and girls, and a lot to do with what people are raised from birth to believe about being a male or female.

Gender-based violence refers to acts of violence that are directed against women by men. The most common form is intimate partner violence, such as dating violence when girls are forced or coerced into sex. The health consequences of gender-based violence are numerous, including the risk of STIs or unwanted pregnancy because girls are afraid to negotiate condom use. Physical injury and emotional problems such as depression and anxiety are other outcomes of gender-based violence (WHO, 2009b).

In adolescence, many girls see controlling behaviour in their relationships as proof that a boy loves them. Knowing when behaviour is abusive or coercive is important, so that girls can recognise when relationships are unhealthy and bad for them.

Although violence and coercion represent a negative aspect of masculinity, there are many positive aspects too, and ideas and beliefs about masculinity can change. Early adolescence is a good time to challenge gender stereotypes and to encourage boys and girls to start thinking about, and experiencing relationships that are not based on unequal power relationships but on care and respect for each other. In the context of sexual and reproductive health this means that young people can learn to enjoy an equal partnership within which safe and responsible sex is practised and, when the time comes, joint decisions can be made about starting a family.

Unfortunately sexual coercion and violence against girls continues to remain a world-wide problem. This is because women are still seen as subordinate and inferior to men and social norms continue to make violence against women acceptable. By helping VYAs to talk about these issues boys can become more aware of what makes sexual behaviour appropriate or inappropriate, and become more sensitised about what constitutes a respectful relationship.

Girls can be helped to make decisions and build the self-confidence necessary to say what they want and what makes them feel comfortable. To help protect themselves from violence, status-related stigma, pregnancy, re-infection with a different strain of HIV and STIs, girls need to be empowered to exert control over their bodies and their lives. This extends into the future, when as wives and partners, respect for their reproductive rights should include the right to choose whether or not they want children, how many and when.
Handout 9

AGREE

DISAGREE

NOT SURE
Session 10 Activity 10a

I’m OK

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that you are more than half way through the series of club sessions. Ask how they feel about having come so far, and about having to think about terminating the group.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task 9: Ask the group to make of point of noticing and writing down the different beliefs in their communities. After feedback has been taken, ask the group what they learnt from the activity. Mention that in some cultures boys are taught to be strong and dominant – they are the ones that make the decisions. Girls are expected to be submissive and passive. This way of seeing men and women starts from a very young age and can be shaped over time. Mention films where men are shown as violent and aggressive and often abusive to women. Talk to them about making kindness and respect part of their daily lives and the nice feeling one gets when being thoughtful and loving.
10. Tell the group that this part of the activity is about liking ourselves and praising ourselves. We all have things that people like about us – for example, our smile, our kindness or our skill in fixing things, growing things, helping others, listening to others, being considerate.
11. Tell the group to each find a partner. Hand out paper and crayons. Ask them to draw a picture of themselves. They should decorate their drawing as creatively as possible. Under the picture they should write qualities about themselves and/or activities that they are proud of or good at.
12. They should then take turns to talk to their partner about the picture and share what they really like about themselves. Tell them:
   • We all have things that we would like to improve.
   • This helps us to do better.
• But sometimes we worry too much and make ourselves feel bad.
• No one is 100% good or 100% bad.

13. Back in the big group ask them to share something about their picture with the group.

14. Then ask:
• What was it like thinking about the things you really like about yourself?
• How did it make you feel?
• What do you think about everybody having different things they like about themselves?
• What do you think about all of us having different things that we like to do?
• How do you think these different things help make each of us into a unique person?
  (Explain unique: ‘The one and only’ ‘Having no-one like you or equal to you’ ‘The only example’)
• Is it a nice feeling knowing that you are completely original? Does that therefore not make you very special? Ask them if they want to change that originality?

13. Encourage them to feel good about their uniqueness. Tell them to close their eyes and think about what ‘feeling good’ feels like. Tell them to draw that ‘feeling good’ feeling in their drawings.

14. Use an energiser here, if necessary.

**Trainer’s notes:**
Self-esteem is the way that we feel about ourselves. If we have high self-esteem, we feel good about ourselves, we respect ourselves, we are confident to say what we think and feel clearly and expect people to treat us well.

Ways to develop high self-esteem include praising each other when we do well and say what we like about each other. If someone does something that we don’t like, tell them how we would like them to change in a helpful way as a friend. Don’t tease or mock people in ways that make them feel sad.

Find things that we are good at and remember them when we feel bad about ourselves. Listen to each other and accept each other as special people.

Don’t be too hard on ourselves. We all make mistakes and we can learn from them.

Believe in ourselves, because we can achieve a lot, one step at a time.

**Task 10a for home:**
Think about your achievements so far in your lives. Write them down or make drawings and remember how far you have come so far.
• How far do you want to go?
• What can help you to achieve this?
• What can prevent you from achieving this?
• How can you overcome these obstacles?
### Background information box 13: Feeling ok about myself

Puberty can bring with increased feelings of self-doubt. When sexual contact becomes a means of reassurance, adolescents are placed at risk.

When young people have good self-esteem, that is to say, they feel they have value and worth, they do not feel insecure. Self-esteem has to do with how a person feels about himself or herself. Self-esteem can be high or low and is influenced by ‘self talk’ or the kinds of things a person tells himself or herself, for example a person with low self-esteem would tend to think negative thoughts like ‘Nobody likes me’. People with low self-esteem are often very concerned about what others think of them, about their looks and popularity and about being accepted.

Sometimes those with low self-esteem are boastful and brag, or they have a short fuse and get angry when someone does not see things in the same way as they do. On the other hand, a person with high self-esteem likes and accepts himself or herself, and knows his or her strengths and weaknesses. Good self-esteem means that a person can take responsibility for his or her choices, accept mistakes and make amends where necessary.

There are many ways to build self-esteem as some of the activities in this manual show. Helping very young, HIV-infected adolescents to build self-esteem is a particularly important task for health-care providers. This is because of the many factors that have the potential to damage self-esteem, including stigma and social isolation, changes in caregiver following the death of a parent, scholastic difficulties related to the infection, and the impact of HIV on physical appearance such as height, amongst other things.
Session 10 Activity 10b
Boys and girls: the differences

Suggested method:

1. Tell the group that this activity will cover information about girls and boys and how they and their bodies are different.

2. Two facilitators are required, preferably a female facilitator for the girl’s group and a male one for the boy’s group. The facilitators should divide the group into girls and boys and separate into two rooms, preferably with one same-sex facilitator per group.

If the groups have become cohesive and members are comfortable with each other, let them decide if they wish to do this activity in a mixed group.

3. Hand out: Questions for girls in the girls group / Questions for boys in the boys group. Answer True or False.

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**Girls**

1. Girls have thousands of eggs inside their ovaries.
2. These eggs are the size of chicken’s eggs.
3. Every month after puberty starts, an egg is released into the uterus (the place where the baby grows).
4. Girls have (reproductive organs) sex organs on the inside and outside of their bodies.
5. The uterus becomes lined with blood every month to prepare a soft place for a baby to grow.
6. If the egg is not fertilised (joined) by a sperm from a boy, then the blood in the uterus comes out.
7. This is called menstruation.
8. Another word for menstruation is periodicals.
9. If the girl’s egg is fertilised (joined) by a male sperm then a baby starts to grow.
10. Vaginal discharge is how the vagina is kept clean.
11. HIV lives in all body fluids, including semen and menstrual blood.
12. Sperm is the male seed.
13. Sperm grows in boy’s ears.
14. It takes only one sperm to fertilise an egg.
15. Masturbation causes yours ears and nose to fall off.
Boys

1. A wet dream means you have (peed) urinated in your bed because you drank too much water before going to sleep.

2. If a boy has a wet dream it means he must start having sex.

3. An erection is sometimes called a hardy.

4. Erections can happen on their own.

5. Sooner or later an erection will go down.

6. All penises are the same size and shape.

7. Boys start having erections when they turn 12?

8. Ejaculation is when a small amount of fluid is released from the tip of the penis.

9. The fluid is filled with sperm.

10. Sperm is the male seed.

11. When sperm joins with a girl’s egg, a baby can grow.

12. Sperm are as big as sheep.

13. Girls have a place inside their ovaries where there are thousands of eggs.

14. Menstruation (periods) is when blood that lines the uterus (the place the baby grows) is shed through the vagina.

15. Masturbation causes your ears and nose to fall off.

4. Allow ten to fifteen minutes for them to write down their answers. Go through the answers carefully and clarify.

5. Allow time for discussion, and then hand out the second questionnaire. Hand out Questions for boys to the girls / Questions for girls to the boys. Allow ten to fifteen minutes for them to write down their answers.

6. Go through the answers carefully and clarify. Correct the information using the model answers below. Ask them:
   - how it felt to do this exercise?
   - how it felt to do this exercise together?
   - what they learned about their body?
   - what they learned about the bodies of the opposite sex?

See notes for extra information not covered in previous activity. Refer to the illustrations in previous activity.

7. Allow time for discussion.
Trainer's notes:

Answers for girls' questions

1. True
2. False. They are smaller than a pinprick.
3. True – but it takes a while before this becomes regular.
4. True
5. True
6. True
7. True. HIV lives in this blood as well.
8. False. Menstruation is sometimes called periods.
9. True
10. True. HIV is present in vaginal discharge.
11. True. An HIV-positive person will have HIV present in all body fluids, including breast milk.
12. True
14. True
15. False

Answers for boys' questions

1. False. It means that the boy has ejaculated sperm while he was sleeping.
2. False
3. True. There are lots of different names for when the penis is erect. (Ask the group what other names might be.)
4. True
5. True
6. False. Penises are all different. There are many shapes and sizes: long, short, fat or thin. All are perfectly normal.
7. False. Men, boys and even baby boys can have erections.
8. True
9. True
10. True
11. False. Sperm are tiny. There are millions of sperm in one teaspoon of semen. A microscope is needed to see sperm.
12. True
13. True
14. False

Task 10b for home:

Write down things you have learned about the opposite sex that you did not know.
Session 11 Activity 11
Saying yes or no to sex

90 - 120 minutes

**Activity**
Group work, role-plays and discussion

**Outcomes**
Participants gain added awareness of the facts that:
- Sex can happen without thinking carefully about the results
- Sex often just 'happens' in an unplanned way
- Sex is a very powerful feeling and can overcome people's common sense
- Some young people are forced into sex against their will
- They need to learn to make strong decisions on whether to have sex or not
- There are many factors that affect the decision to have sex
- Culture can play a role as well
- Girls and boys do often not communicate clearly with each other
- Young people may decide to have sex for a number of reasons, including love, desire, power, money or to be part of a group.

**Materials**
Flipchart, markers, copies of 3 of 5 scenarios, handouts.

**Suggested method:**
1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that you are more than half way through the series of club sessions. Ask how they feel about having come so far, and about having to think about terminating the group.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task 10a: Personal reflection. Ask the group what they learnt from the activity. Allow time for a short discussion on the 4 points. Suggest they use their notes or drawings to make up (or add to) a journal, of their personal wishes and achievements. They can fill in important things as they happen and use the journal to remind themselves of how far they have come, and write or draw ideas about getting even further. Also ask the group to give feedback about homework task 10b: Write down things you have learned about the opposite sex that you did not know. Allow feedback.
10. Energiser. Suggest they walk up to a person of the opposite sex (if mixed group) and say something like “I respect you”. They can then give a 'high-five' and return to the group when they have completed this task.
11. Tell the group that this is an activity to help them practise saying “no” if they decide they do not want to have sex.
12. There are three cards below. Cards B and C offer two options.
   A: "Boy wants to have sex but girl does not”
   B: "Older girl / same-age girl wants boy to have sex but he does not want to”. Choose the more appropriate card, with either older or same-age girl.
   C:"Older boy/ girl offers girl/ boy money or a present if she /he will have sex with him".
Choose the more appropriate card, with either same sex or opposite sex making the offer.

Select the one most appropriate for the particular group. Hold up or pass around the picture you have selected.

13. Ask the group:
   - What do you see happening in the picture?
   - Who are the girl and the boy?
   - What do you think the girl is thinking?
   - What do think the girl is feeling? (If the group are unsure of how to respond, give some examples of possible feelings by asking: Is she feeling scared/angry/helpless/powerful/powerless, etc.?)
   - What do you think the boy is thinking?
   - What do think the boy is feeling? (If the group are unsure of how to respond, give some examples of possible feelings by asking: Is he feeling angry/strong/powerful/powerless, etc.?)

14. Ask the group to discuss with the person next to them:
   - What will the girl say next? What will the boy say next?

Make notes on the flipchart of the different responses and discuss them. Point out how girls and boys respond differently if this is the case. Ask the group:
   - What is the worst thing that might happen?
   - What is the best thing that might happen if it was you?

Make notes on the flipchart of the different responses and discuss them.

15. Remind the group:
   - Saying ‘No’ to sex is their choice
   - Sometimes they can be forced against their will
   - That people can get ‘carried away’ by strong feelings
   - That sex has consequences
   - That people have sex for different reasons, so they need different ways to avoid having sex
   - That sex does not only happen between people of the opposite sex
   - That perceptions of respect can make them respond against their will (such as an older person telling them what to do)
   - Sometimes close friends or family members can behave in unexpected ways
   - Sometimes relatives or friends of the family try to get young people to have sex
   - Young people often trust them until they try to touch them in a bad way. They should learn to react strongly to this
   - Young people are often afraid to talk about being sexually abused.
   - If they are with an older person and they feel that something is wrong (even if they don’t do sexual), to trust their feelings and get away from the older person
   - To tell an adult that they trust, if they don’t like the behaviour of a man or woman, even if it is a relative or family friend
   - To call Childline or appropriate local resources
   - To tell a trusted adult if anyone:
     - touches them in a way they do not like
     - touches their private parts
• asks them to take off their clothes
• talks to them about sexy things or doing sex.

If the first person they tell does not believe them, talk to another person until someone does believe them.

16. Remind them that this exercise will help them understand that saying no to sex needs them to:
• Be motivated (have reasons for saying “no” to sex)
• Learn to recognize and avoid places (parties) or situations (drugs, alcohol) where they might be at risk
• Learn and practise the skills to make a stand and say “no”
• Learn that it is against the law for adults to engage in sex with a younger person. (Refer to the abridged Children’s Act described earlier)

17. Ask the group:
• How could the girl (or boy) avoid getting into a situation like this?
Make notes on the flipchart and explore:
• Avoiding places where this might happen
• Trusting their feelings if they feel that something is wrong
• Getting away
• Places/people they can go to.

Some answers might be:
• Avoid being alone with a potential partner until you have built up trust
• Find a safe place to talk, where you won’t feel like getting romantic
• Before things get romantic say that you do not want to have sex yet
• If you feel uncomfortable with the way someone is behaving or talking to you, move away
• Make sure there are other people around when you meet with this person
• Tell the girl before things get romantic that you do not want to have sex.

Ask the group to think of other answers that would work for them.

18. Ask them to think about who they could talk to: people they can go to, and people they can tell.

(Ask them to try and identify someone that they could go to if this should happen and try to provide appropriate resources/references – Childline, etc).

19. Ask the group:
• What words could the girl use to tell the boy “no” (or vice versa).

Some answers might be:
• Say in a strong voice, “I do not want to have sex yet”
• Say, “I want to talk to you now, before we go too far”.

Ask the group to think of other answers that would work for them.

20. Get the girls and boys to role-play practising saying no in same-sex pairs. Observe the tone of voice and the body language used, and comment on how both need to reinforce the verbal “no” message.
21. Ask the group after the role-plays:
   - Which ways worked well to keep to their decision about delaying sex?
   - What was it like to hear Thando saying "no"?
   - Was it like to say "no"?
   - Which ways used by the proposer were difficult to resist? Why?
   - Which were the best ways to resist them?

Examples of saying "I do not want to have sex yet":
   - "I have made a decision to abstain from sex until I am older and ready."
   - "I'd like you to respect my views."

(Abstinence is the only 100% effective way to avoid pregnancy and STIs.)
   - "What would happen if one of us got an STI or HIV or (the girl) got pregnant?"
   - "I want to protect my fertility and life until I am ready to have a baby."
   - "I think sex before we are living together or married is wrong. I would feel bad if I went against my beliefs."
   - "Let me tell you what I want in my life and where I want to be in three years' time."
   - "Having a baby or getting sick would stop me from getting to where I want to be."
   - "Let me tell you about what my caregivers hope for me and how they would feel if got pregnant or got an STI."

22. Ask the group why they think older people might want to have sex with younger girls and boys.

Make notes on the flipchart and then explain the following points, one at a time:
   - It is wrong for adults to touch their sexual organs.
   - Adults can go to prison for this.
   - Any touch that makes them feel afraid, shy or bad is wrong.
   - They always have the right to say "No" to any touch or behaviour that they do not like.
     (Their body language has to say "no" as well.)
   - Sexual abuse is never their fault.
   - No one has a right to ask them to keep touching and keep sexual activity secret.

They can say:
   - "No, stop it, I don't like that, go away, that's wrong" to adults who do things that make them feel bad
   - That they will tell someone what they are doing

They can also run away and/or shout for help so that others will hear what is happening.

They should not fight another person who pressurises them for sex unless they are sure that they are stronger than them.

It's best to refuse gifts or promises of money from adults because they may expect sex afterwards.

Always try to move in pairs or groups when they have to be with an adult they do not know well.

Wear clothes, such as shorts and trousers that will give them more protection.

Avoid isolated places.

If they feel that something is wrong when with an adult, even if they don't do anything, trust their feelings and get away from them.

Tell an adult that they trust, if they don't like the behaviour of a man or woman, even if it is a relative or family friend.
23. What words could the younger person use to tell the older person “no”?  
   • Say in a strong voice, “I do not want to have sex”.  
   • Say, “I do not want to break my word to my caregiver”.  

24. Get the girls and boys to role-play practising saying no in same-sex pairs.  

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

26. Ask the group to write any other questions they wish to ask on paper without their names and place in a box.  

Address in the next session. Summarise key messages.

**Trainer’s notes:**

**Key points**  
• Many young people have sex without thinking carefully about the results.  
• Sex can be used as a ‘feel good’ drug, much the same as alcohol.  
• Young people often do not make a decision to have sex. It just ‘happens’ to them in an unplanned way.  
• Sex is a very powerful feeling and can overcome people’s common sense.  
• Some young people are forced into sex against their will.  
• It is very important that young people learn to make strong decisions on whether to have sex or not; to say the real ‘No’ and the real ‘Yes’ when it is right for them.  
• Young people may decide to have sex for a number of reasons, including love, desire, power, money or to be part of a group.
Background information box 14: Sexual abuse

What the law says: Health-care providers have a legal obligation to report abuse that includes sexual abuse and neglect. Sexual offenses must be reported to the police, with or without the consent of the child. All child survivors of sexual abuse should receive age-appropriate counselling and must be referred for psychosocial follow-up.

In support of this the law limits the right of the adolescent to confidentiality. Other forms of abuse or neglect of children need to be reported to a designated child protection organisation or to the Department of Social Development.

Sexual abuse is the sexual violation of a boy or girl without his or her consent. There are a number of forms of sexual violence and abuse. These include having sex with a child without the child’s consent, e.g. rape, touching a child in a sexual way, a person who makes a child touch him or her in a sexual way, and showing a child pornographic material, including books, videos or magazines.

Sexual abuse frequently occurs in the context of family relationships (parents, grandparents, siblings, etc.) but it sometimes involves a stranger. Young adolescents are often afraid to talk about sexual abuse by people they know and family members.

Sexual abuse of children or young adolescents can make them feel sad and low, have low self-esteem, engage in risky sexual behaviour, and have problems with making friends and marrying.

When issues around sexual abuse arise, for instance in the context of the support group, the facilitator should always listen to the child, take it seriously and ensure that the child is referred to health-care professionals who can deal with the situation and provide the child with the necessary support.

Task 11 for home:

Ask your teacher, caregiver or parent or someone you trust when and how they think a person should say “No!” to sex. Share your ideas with them.
Session 12 Activity 12

The taxi game: making choices

Suggested method:

1. Two facilitators are required, preferably a female facilitator for girls and a male one for boys.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that you are more than half way through the series of club sessions. Ask how they feel about having come so far, and about having to think about terminating the group.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task homework task 11: Ask your teacher, caregiver or parent or someone you trust when and how they think a person should say “no” to sex. After feedback has been taken, ask the group to comment on what they learnt from the teacher, caregiver or parent.

Important: Make time now to answer the anonymous questions from the last session. Be very sensitive when doing this. Remember it probably took a lot of courage to write down a secret question. If there are a lot of questions, you can attempt to answer them at the end of the session, alternatively make time at the beginning of the following session. Do not ignore the questions. The young person could feel betrayed and lose trust.

10. Tell them this is an activity about young people learning about the different sexual standards and their right to choose whether or not to have sex.

11. Divide them into small same-sex groups (or mixed if indicated).
   - Ask the groups if they know what ‘abstinence’ means. Allow time for interaction. Make notes on the flip chart and then explain that abstinence means not having sex if they do not know.
   - Then ask the groups what they think ‘sex with love’ means? Allow time for interaction. Make notes on the flip chart and then explain that ‘sex with love’ is the belief that it is OK to have sex as long as you are in a relationship and ‘in love’ with that person. Ask them if they aware of this standard. Explore ideas about about a person being in love and thinking that they are in love.

Activity

90 - 120 minutes

Group activity. Taxi card game (sexual standards), followed by agree/disagree, activity followed by discussion

Outcomes

Participants gain awareness:

- about how to make an informed decision about sexual debut
- about some of the consequences of having sex at a young age
- about the fact that sexual feelings are powerful and can override common sense
- that sex can be coercive
- that alcohol and drugs can influence decision making
- that sex can be transactional and trans-generational
- that people can be involved in multiple and concurrent partnerships
- that gender relationships play an important part in determining sexual and reproductive health outcomes

Materials

Handouts, pencils / crayons.
Finally ask them what they think ‘sex without love’ means. Allow time for interaction and then make notes on the flip chart and explain that ‘sex without love’ is the belief that you can have sex with anyone without being in a relationship or without any love or affection. Ask them if they are aware of this standard.

12. Divide them into three groups. Make sure that there are both boys and girls in each of the groups. Tell them to imagine that they are at a taxi rank. There are three different taxis. The taxis represent the different choices that they can make when going into a relationship. Each of the three groups should discuss the good and bad things about the three taxis. After the exercise they can decide for themselves which of the taxis is the best one for them.

The taxis are:

a. The abstinence taxi. (No sex)

b. The sex with love taxi

c. The hit and run (sex without love) taxi.

13. Hand out the three taxi cards to each of the groups. (See Illustration 12a.)

- Hand out flipchart paper and pens/pencils.
- Ask each subgroup to pick one person who will write down their answers and another one who will report back to the large group when they have finished talking about their answers.
- Ask them to brainstorm answers to the questions and to make a list of their answers on their flipchart paper.
- Paste one taxi card (or signs with taxi names) on the wall in three different parts of the room.
  a. Abstinence (no sex) taxi.
     - What is good about abstinence? (The advantages)
     - What is bad about abstinence? (The disadvantages)
  b. Sex with love taxi.
     - What is good about having sex when with your partner when you are in love?
     - What is bad about having sex when with your partner when you think you are in love?
  c. Sex without love taxi. Hit and run.
     - What is good about having sex without being in a relationship?
     - What is bad about having sex without being in a relationship?

14. Allow 15-20 minutes for the groups to brainstorm the questions. Allow each sub-group to present their answers to the large group one at a time. Paste their lists up as each group finishes their feedback. Ask them to decide which taxi they pick and tell them to go and stand under that card.

Note for facilitator. Be aware of the need to look good or peer pressure. Encourage members of the group to do what feels right for them.

15. Then ask the following questions and talk about the answers with group:

a. Abstinence (no sex) taxi
   - How do you feel about people who abstain?
   - How do others feel about people who abstain?
• What do you think would make a person stop being abstinent (abstaining)?
• Do you think it is difficult to abstain if all of your friends are having sex and you are the only one who isn’t?
• How do you think you could stop this from happening?
• Do you think you may feel bad because your body is saying it wants to have sex and you are not allowing it?
• Are there people in your life who you can talk to about your decision to be abstinent? Will they be supportive?

b. Sex with love taxi
• How do you feel about people who have sex when they are in love?
• Do girls and boys have the same understanding of love?
• Is love a deep and vital emotion?
• Does love involve caring?
• Love is just bodies responding – “if it feels right it is right”

c. Sex without love taxi
• How do you feel about people who have sex without love?
• Do you think being drunk makes it easier to have sex with someone you don’t know well?
• Does having lots of different partners at the same time mean you are popular?
• Is it OK to take money or presents in exchange for sex?

16. Icebreaker (5 minutes)

17. Draw a line down the middle of the room. Ask the group to stand in a row on the line. On one side of the line put up a sign saying “yes”. On the other side put a sign saying “no”. Tell them that you are going to read out some questions. If they agree they must jump to the side of the “yes” sign. If they do not agree they must jump to the side of the “no” sign. Make the statements one at a time:

• The more partners you have, the more chance HIV and STIs will spread.
• Sex makes a person feel important and grown up.
• Cell-phone sex is safer sex.
• Having unprotected sex just once is not risky for your partner.
• If someone pays for sex, they have a right to insist on not using condoms.
• Alcohol can weaken the immune system of an HIV-positive person.
• Alcohol and drugs can make the person forget to take their medication.
• Alcohol and drug abuse can lead to unsafe sexual practices such as unprotected sex, multiple partners and sex for drugs.
• If a person is HIV positive, drugs like ‘meth’, ‘tik’ and ‘speed’ can affect their ability to learn new information, solve problems and concentrate.

18. Ask the group what they have learnt from this activity and summarise. Hand out the Abstinence handout.
**Trainer’s notes:**

Reiterate that many young people have sex without thinking carefully about the results. Many young people confuse dating and sex. Young people often do not make a decision to have sex. It just ‘happens’ to them in an unplanned way. Sex is a very powerful feeling and can overcome people’s common sense. Some young people are forced into sex against their will. It is very important that young people learn to make strong decisions on whether to have sex or not; to say the real ‘No’ and the real ‘Yes’ when it is right for them. Young people may decide to have sex for a number of reasons, including love, desire, power, money or to be part of a group.

Abstinence can be difficult for some people. It is good to talk to each other about a decision to abstain. Abstinence has no medical or hormonal side-effect. Abstinence does not mean weakness. It is a strength to overcome sexual feelings.

Partners need to be honest with each other and make sexual decisions together. These are some of the best ways to keep a relationship happy. It may not be easy to do. You may feel awkward or embarrassed. It’s best to talk about your feelings before things get out of control.

Be well prepared to protect yourself against pregnancy or STIs if you decide to stop abstaining. Having sex is not the only way two people can get to know each other. People get closer as they build trust. Trust is built through talking honestly to each other and respecting each other’s thoughts and feelings.

Staying abstinent is a choice you have to make every day. There are ways to help yourself with that choice. It’s sometimes difficult being one of the few remaining abstinent when everyone else seems to be having sex. Be clear about your reasons to stay abstinent. Remind yourself why you choose to be abstinent. Think about the consequences.

If you are in a situation where you experience very powerful feelings that could overcome your common sense and decision to remain abstinent, try to stick with your decision until you can think about it with a clear head. Boys and girls have sex for different reasons, so they need different ways to avoid sex. Find a safe place to talk, where you won’t feel like getting romantic. Say, ‘I want to talk to you now, before we go too far.’

Ask yourself these questions:

- Am I sure about why I want to be abstinent?
- Are there any things I can think of that could make staying abstinent difficult for me? Can I avoid them?
- Alcohol / drugs can affect my judgment and allow me to take risks. How do I feel about not using them?
- Are there people in my life I can talk to about my decision to be abstinent? Will they be supportive?

If you decide to stop being abstinent ask yourself these questions:

- Do I have information about other methods of birth control and do I have access to them?
- Do I know how to protect myself from STIs?
- Do I know how to prevent passing on HIV to my sexual partners?
**Handout 12a**

**Good and bad things about abstinence**

**Good things about abstinence**

Abstinence:
- is free and safe
- allows the person to prepare properly
- has no harmful effects
- prevents pregnancy
- prevents STIs and possibility of infertility or cervical cancer
- allows you to wait until you're ready for a sexual relationship
- allows you to wait to find the right partner
- allows you to have fun with romantic partners without sexual involvement
- allows you to focus on school
- supports personal, moral, or religious beliefs and values.

**Bad things about abstinence**

There are very few bad things about abstinence. However:
- You may feel left out if all your friends are having sex and you are not.
- Your friends may insult you.
- Some boys may see girls who refuse sex as a challenge and force them to have sex. This is a crime.
- You may feel bad because your body is saying it wants to have sex and you are not allowing it.
Task 12 for home:
Think of all the ways a girl and boy could show their love and to be happy together without having sex. What would be good about being together without having sex?

Background information box 15: Risk behaviour in adolescence

“ Sexting” describes the use of cell phones to send inappropriate or explicit text or photographs. For example a person is ‘sexting’ when he or she sends naked or semi-naked pictures of him or herself to a girlfriend or boyfriend. It seems like a low-risk pursuit. After all there is no penetration involved, but in fact it is potentially extremely dangerous. One nude photograph can ruin a reputation or social life whilst some of the negative psychological consequences include shame and anxiety, as well as cyber-bullying and stalking. Many teens feel great regret and embarrassment at what they have done whilst some have been so humiliated that they have considered suicide.

If this seems to be a common practice amongst the group, or if it is something they seem well aware of, participants should be asked to think about the consequences of cell-phone sex. What would happen if pictures got into the wrong hands?

Many of the health behaviours that a young person engages in during his or her adolescent years are likely to continue into adulthood. This makes it particularly important to educate young, HIV-positive adolescents about healthy behaviours.

The exploration of sexual activity in adolescence often involves risk-taking. Adolescents do not always use contraception consistently and properly, increasing the risk of HIV transmission, STIs and unwanted pregnancies. This in turn puts their physical and mental health at risk. Once a young person has sex it is more likely that he or she will continue to be sexually active with a strong possibility that s/he will engage in multiple and concurrent partnerships. The Second South African National Youth Behaviour Survey (Reddy et al, 2008) found that a high percentage of young people had one or more sexual partners over a three-month period.

Multiple and concurrent partnerships

The term multiple and concurrent partnerships (MCP) means that a person has a number of sexual partners over a certain period of time, for example, a month or a year or more. These partnerships can follow each other, one after another. A person can also have overlapping sexual partnerships, when he or she has sex with one person in-between having sex with another person (concurrency). There are many different forms involved, for example, a person might have a steady partner ‘small house or a ‘side partner’. He or she might be involved with intergenerational relations (those involving older men or women) or transactional relationships (sexual relationships for money or material possessions). Whatever the form, when many individuals are involved in relationships with two or more
people a sexual network develops which allows HIV to spread very quickly.

In 2008 Soul City looked at the reason for multiple and concurrent partnerships and found that amongst other things they included a poor understanding of the risks involved in having many sexual partners, cultural and social norms that make it acceptable for men to have more than one sexual partner at the same time, gender inequality which results in male domination, wanting money or material things, and alcohol and drug abuse.

A challenge for health-care providers is to help young people infected with HIV to think about how just one act of unprotected sex can put many others at risk. Early adolescence is a good time to talk to very young HIV-positive adolescents about behaviours that benefit others, since they are starting to show more tendencies towards caring, being concerned about, and helping others. This behaviour increases greatly between childhood and adolescence. This means that guidance in the development of attitudes and beliefs becomes especially important between the ages of 10 and 14 years when the stage is being set for future relationships with sexual partners.

Transactional sex

Transactional sex (TS) has to do with the provision of goods or money in exchange for sex. Often it occurs between a young teenage girl and a man much older that she is (sugar daddy), but TS can also be between a teenage boy and an older woman (sugar mommy). When a sexual partner is 10 or more years older than the young person, the relationship is called ‘intergenerational’ or ‘cross-generational’.

Sometimes a girl can be involved in sexual relationships with more than one man. These relationships often provide a means for young girls to meet a variety of needs, for example, living expenses, school and university fees, and items that they could otherwise not afford. When they benefit the whole family parents and caregivers do not always discourage them. This form of relationship is not the same as prostitution because the relationships last longer.

The problem with transactional sex is that the sexual rights of girls in these relationships are often disregarded. Because they are receiving goods or money, it is not always possible to refuse sex or insist on safe sex. This means that for HIV-positive girls there is a strong risk of re-infection or infection with an STI because there is a higher probability that their older partner, who may have been engaged in many such relationships, will have HIV. In addition, the nature of these relationships is such that many girls are at risk of violence. Researchers have found that girls in these relationships will find it difficult to negotiate condom use, sometimes fearing that they will be accused of being unfaithful to their partner.

Programmes that address the sexual and reproductive health of VYA’s need to think about the kind of social and cultural norms that can lead to TS and IG, and should empower girls to make decisions that will not put their health at risk.
Alcohol abuse

Sexual exploration frequently involves the use of alcohol and drugs. Because alcohol interferes with a person’s ability to make good judgements there is more chance that they will engage in risky sexual behaviour. According to the Second National Youth Risk Behaviour Survey (Reddy et al, 2008), nearly 1 in 8 learners has had an alcoholic drink before the age of 13 years. Drinking, and in particular binge drinking, or having more than 5 drinks at one time, has been associated with sexual risk behaviour, for example young people who use alcohol and drugs are likely to have more sexual partners.

Alcohol is also a risk for sexual violence and sexual coercion and is associated with inconsistent condom use and increased risk of STIs.

In the case of HIV-positive adolescents, alcohol can weaken the immune system, making the effects of HIV much worse. The more a person drinks the more harm he or she does to the immune system and the more chance there is that the virus will become stronger and able to make more copies of itself. Alcohol use can also affect antiretroviral treatment (ART) by reducing adherence and causing the medication to be less effective or not effective at all. Alcohol misuse may also injure the liver by worsening the toxic effects of ARVs on this organ of the body.

Drug abuse

Injection drug use is when a drug is injected into a person’s tissue or vein with a needle. It also puts young people at risk by affecting their ability to make decisions and leading to unsafe sexual practices such as unprotected sex, multiple partners and sex for drugs. The same applies to non-injection drug use such as crack cocaine.

Young HIV-positive adolescents who take drugs may also damage brain functioning by using these drugs. For example it has been shown that HIV-positive persons who abuse drugs are more vulnerable to cognitive damage and harm to the nerve cells in the brain, than those who are not infected with the virus. HIV infection and the use of methamphetamines (‘meth’, ‘tik’, ‘speed’) can cause changes in the brain that may affect a person’s ability to learn new information, solve problems and concentrate.
Handout 12b

1. What are the good things about sex without love?
2. What are the bad things about sex without love?

Hi and Ian

1. What are the good things about sex with love?
2. What are the bad things about sex with love?

Sex with love tax

1. What are the good things about abstinence?
2. What are the bad things about abstinence?
Session 13 Activity 13

Contraception

90 - 120 minutes

Activity
Group discussion followed by brainstorming in small groups or pairs

Outcomes
Participants become aware:
• of the fact that learning how to use a condom doesn’t mean that a person is ready to have sex
• that it is better to know how to use one before you need it, not after sex, when it is too late
• of the range of contraceptives
• of their respective benefits
• of the method of use
• that girls and boys have different needs and expectations from a contraceptive method
• that condoms cannot be reused
• that there is a small chance of falling pregnant during the first sexual encounter even if girl has not started menstruating.

Materials
Male and female condoms (if available), handouts, pens/ pencils.

Suggested method:
1. Two facilitators are required, to facilitate groups of boys and girls.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that there are only five club sessions left. Ask how they feel about having come so far, and about having to think about terminating the group.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task 12:
   Think of all the ways a girl and boy could show their love and to be happy together without having sex. What would be good about being together without having sex?

Note the feedback on a flipchart and allow time for short discussion. Clarify points as needed.

As an energiser, get the group to sing the condom song below:
   “Oh condoms” clap clap
   “Oh condoms” clap clap
   “Oh condoms are wonderful things” Clap, stamp.

Repeat a few times until group are energised, substituting local language for the words ‘condoms’ and ‘wonderful’.

10. As an energiser, get the group to sing the condom song below:

11. Tell the group that this is an activity about contraception. Divide them into two groups, one group of girls and the other boys. Ask the groups if they know what contraception means. Write the answers on the flipchart.

12. If there is reluctance to interact you can turn this into an icebreaker. Ask them to answer yes or no. Do they think contraception means:
   • concentration?
   • condomising?
   • an old broken down car?
• smuggling guns across the border?
• brewing beer?

(Or you can make up your own funny definitions.)

13. Explain to the groups that contraception basically means birth control / stopping pregnancy / the prevention of fertilisation / stopping the sperm of the male from reaching the egg of the female. You can refer to or use the illustration of the female reproductive organs (5a) to show how the sperm reaches the egg and include information about the male (13c) and female condom (13b) as well as the sperm/egg (13a).

15. Hand out Contraception chart 1. (13d). Ask them to complete the chart in their groups. Allow 20 minutes for this.
16. Once they have completed their charts, take feedback from each participant. Encourage discussion and observations after the charts have been completed.

17. Use the following questions for discussion:
• Do you think any of the contraceptive methods we have discussed are useful protection against STIs. Why/why not?
• Do you think any of the contraceptive methods we have discussed are useful protection against further amounts of HIV going into the body of an HIV-positive person? Why/Why not?
• Do you think it is important to protect sexual partners from HIV infection?
• How do you feel about using contraceptives?
• What could be the possible consequences or benefits of contraceptives?
• Why do you think people don’t like to use contraception?
• Where is contraception available?
• What would be the perfect contraceptive and why?
• Do you think abstinence is a contraceptive and why?

18. Compare the girls’ group answers and the boys’ group answers. Ask the group why they think the answers are different, if they are.
19. Ask:
• What are your thoughts on this activity?
• What did you find useful and why?
• What did you find uncomfortable and why?

20. Conduct a condom demonstration (both male and female condoms if possible). Ask the group: “Did you find the demonstration useful? Hands up if you did, thumbs down if you did not.”
21. Hand out Chart 13d and discuss the different methods of contraception.

**Trainer’s notes:**
Usually boys and girls have different feelings about the use of contraceptives for different reasons. Explore the gender dimension of contraceptive throughout this exercise.

**Task 13 for home:**
Find out where condoms are available in your area.
Background information box 16: Condoms and contraception

*What the law says:* No person may refuse to sell condoms to a child over the age of 12 years or provide a child over the age of 12 years with condoms on request where such condoms are provided or distributed free of charge. A child who obtains condoms, contraceptives or contraceptive advice in terms of the Act is entitled to confidentiality in this respect.

Safe sex means that young people who are HIV positive learn to take responsibility for reducing the spread of HIV and other STIs by making sure that contact with the body fluid of a partner is avoided. This means wearing a condom during vaginal, anal and oral sex. A condom is the only form of contraception that provides protection against both pregnancy and STIs, including HIV. Most are made of very thin latex rubber and work by creating a barrier that keeps sperms from the vagina, whilst also protecting against other infections that are spread through skin-to-skin contact like herpes or discharges from the penis or vagina, for example, gonorrhea. If using lubrication, water-based lubricants (KY jelly) will not erode the condom. Avoid using oil-based lubricants like Vaseline, (WHO, 2007).

Condoms are very effective in reducing the risk of pregnancy and STIs but must be correctly used. There are many myths about condoms, for example, that they can cause a boy to become sick because the sperm backs up inside his body, or that a condom can easily get lost inside a girl. Neither of these myths is true.

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

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

Condoms are the most popular choice of contraceptive amongst adolescent boys and girls. Some use the ‘double Dutch’ method (condom and hormonal contraception), whilst oral contraception (‘the Pill’) and injected contraception (Depo Provera) are used to prevent pregnancy (WHO, 2007).

Of course the safest way for an HIV-positive adolescent boy or girl to protect against transmission, re-infection with a different strain of HIV, other STIs and pregnancy is not to have sexual intercourse or to delay sex. This is an option that many young people choose, but others don’t want to wait to have sex and will act on the sexual feelings that are natural and normal in puberty. This is why it is so important to encourage young people to take responsibility for safeguarding their own health as well as the health of others.
Handout 13a

Sperm and egg join. (fertilisation)

Prevention of sperm reaching egg. (contraception)
Handout 13b

What is the female condom and how is it used?

- The female condom is a thin sheath or pouch worn by the girl during sex.
- It entirely lines the vagina and helps to prevent STI's and pregnancy.
- One side is closed.
- At each end there is flexible ring.
- The flexible ring at the closed end of the sheath is inserted into the vagina - this holds the condom in place.
- The open end of the sheath stays outside at the entrance of the vagina.
- This ring acts as a guide during penetration and stops the sheath from bunching up inside the vagina.
- There is lubricant inside, but more can be used. Only use water based lubricant.
What is the female condom?

How is it used?
1. Open the package carefully.

2. Choose a comfortable position.

3. Make sure the condom is lubricated enough.

4. Squeeze the inner ring on the closed side so it becomes long and narrow.

5. Insert gently into the vagina - feel it go up.

6. Place index finger inside the condom and push inner ring as far as it will go.

7. Make sure the condom is inserted straight - not twisted inside the vagina.

8. The outer ring should remain outside the vagina.
and then?

1. Help guide penis into female condom.

2. Make sure penis does not slip into the vagina outside the condom.

3. Use enough lubricant so the condom stays in place during sex.

4. Do not use male condom at the same time. This may cause friction that could cause condom breakage.

5. If condom slips or goes into the vagina during sex - STOP.

6. Take female condom out and insert another one.

7. To remove, twist outer ring gently and pull condom out, keeping sperm inside.

8. Dispose of safely. (Some condoms can be reused if carefully washed.)
Handout 13c

What is the male condom?

The male condom is a close-fitting sheath that covers the erect penis.

It is made out of very strong thin rubber called latex.

The male condom catches the man’s sperm and stops it from going into the woman’s vagina and womb.

It helps to prevent STI’s and pregnancy.

How is it used?

1. Open the package carefully and remove the condom.
2. Make sure the part of the condom that rolls down is on the outside.
3. If not circumcised, pull back the foreskin.
4. Squeeze the tip of the condom so that there is no air.
5. Roll condom onto the erect penis before having sex.
6. After ejaculating, hold bottom ring and pull out of vagina.
7. Tie a knot in the condom and dispose of it safely, out of the way of children and animals (not down the toilet).
The male condom

1. Open package carefully.

2. Roll-down part on outside.

3. Pull back foreskin.

4. Squeeze tip of condom.
5. Roll condom onto penis. Avoid using oil-based lubricants.

6. After ejaculating, hold on to condom and withdraw.

7. Tie knot.

8. Dispose of safely.
### Contraceptives chart 1  13d

<table>
<thead>
<tr>
<th>What it looks like</th>
<th>Type of contraceptive method</th>
<th>Have you heard of this method?</th>
<th>How do you think it works? (Facilitator to ask)</th>
<th>Will it prevent STI's?</th>
<th>Will it prevent pregnancy?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Birth control pill</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Birth control injection</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Withdrawal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IUD (Intra-uterine device)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Male condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Female condom</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Calendar method</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Which method would you choose? Why would you choose it?
# Contraceptives chart

<table>
<thead>
<tr>
<th>What it looks like</th>
<th>Type of contraceptive method</th>
<th>How it works</th>
<th>Benefits</th>
<th>How to use</th>
<th>Effectiveness</th>
<th>STI protection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth control pill</td>
<td>Stops body from producing an egg every month</td>
<td>Easy to take Low cost Control over pregnancy</td>
<td>One pill daily as per instructions Get from clinic or chemist with script</td>
<td>99% to 100% if taken properly</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Birth control injection</td>
<td>Stops body from producing an egg every month</td>
<td>One injection every 2-3 months Low cost</td>
<td>Injection by doctor every two to three months</td>
<td>99% to 100% if instructions followed</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>Prevents semen (sperm) from going into the vagina and fertilising the egg</td>
<td>No cost Under control of both parties involved</td>
<td>Male must withdraw before ejaculation</td>
<td>± 70%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>IUD (Intrauterine device)</td>
<td>Small plastic device that fits inside the uterus</td>
<td>Interferes with egg/sperm movement making pregnancy difficult</td>
<td>Long lasting (3 - 5 years) Inserted by doctor Needs checking every few months</td>
<td>95% to 98%</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td>Male condom</td>
<td>Rubber sheath that fits over the penis</td>
<td>Rolled over the penis - traps semen (sperm) inside</td>
<td>Low cost Easy to get Reduces risk of pregnancy and STI's</td>
<td>Rolled over the erect penis Do not use with oil-based lubricants</td>
<td>80% to 85%</td>
<td>YES</td>
</tr>
<tr>
<td>Female condom</td>
<td>A sheath/ pouch, closed at one end with flexible ring at either end</td>
<td>Lines the inside of the vagina</td>
<td>Reduces risk of most STI's and pregnancy if used correctly</td>
<td>Closed end inserted into the vagina, open end staying outside the vulva</td>
<td>80% to 85%</td>
<td>YES</td>
</tr>
<tr>
<td>Calendar method (Rhythm method)</td>
<td>Menstrual cycle tracked</td>
<td>“Safe” days for sex worked out. Ovulation times avoided</td>
<td>No cost Under the control of the female</td>
<td>Calendar is used to keep track of periods Time of ovulation is estimated and no sex takes place at those times</td>
<td>less than 75%</td>
<td>NO</td>
</tr>
<tr>
<td>Sterilisation, Tubal ligation females</td>
<td>Passageway for sperm or egg is tied.</td>
<td>Highly effective but expensive and usually permanent</td>
<td>Doctor performs an operation</td>
<td>100% but there have been exceptions</td>
<td>NO</td>
<td></td>
</tr>
</tbody>
</table>
Session 14 Activity 14
Adherence (for adolescents who have been disclosed to and who are on treatment)

Suggested method:

1. Two facilitators are required, to facilitate groups of boys and girls.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that there are only three club sessions left. Ask how they feel about having come so far, and about having to think about terminating the group. Process feelings.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task 13: 
   Find out where condoms are available in your area. Allow a few moment for a brief discussion on where to get condoms if needed.
10. Tell the group that this activity will cover information about adherence. Ask the group what adherence means. Allow them to provide answers and correct as needed. The meaning of the word ‘adherence’: ‘STICKING’ to their antiretrovirals. Taking the correct dose, at the correct time*, in the correct way.
   *The new approach (2 hours leeway each way) is less prescriptive in terms of timing, but as yet unproven in terms of adherence outcomes. In the case of a non-adherent adolescent, the health care team should collaborate on whether he or she would be more adherent on a stricter schedule or on less strict schedule.
11. Ask the group if they know why adherence is important in the context of their sexual and reproductive health. Allow them to provide the answer and correct as needed.
12. Divide the participants into groups of 4 or 5. Ask each group to appoint a writer and a reporter. Ask each group to talk about:
   a. Some of the challenges they might have in remembering to take their ARVs
   b. What helps them to remember to take their ARV’s
   Allow about fifteen minutes for them to complete this.

Activity
Brainstorming followed by group drawing activity

Outcomes
Participants:
• Gain awareness of the need to maintain adherence to their antiretroviral therapy (ART)
• Gain enhanced confidence about providing strategies for support and adherence for other young people
• Increase self-esteem.

Materials
Flipchars, markers, crayons or coloured pencils or koki’s.
13. In a plenary session, ask each group to present their challenges and successes. Write up these on the flipchart in two columns marked challenges and successes. Stress how it helps to support each other.

14. Now ask the groups to brainstorm tools and systems that, based on their own experience, could be used/drawn upon to assist and support other adolescents with their ART adherence. Give each group sheets of flipchart paper and coloured pens or crayons. Encourage them to brainstorm creatively. You can tell them that their experiences could help other young people, as they are the ‘experts’ since they are actually experiencing the challenges and successes.

Idea: You can ask them to design a certificate or a badge to present to the ‘AD Hero’ - a person who has achieved 100% adherence over a designated period.

15. They should draw pictures of the tools onto a sheet of flipchart paper (15 minutes). Allow each group to share their illustrations and provide information about their creations.

16. Utilising the information on the following pages, fill in the gaps and clarify the different ways of assisting with adherence, within the context of their personal lives.

**Trainer’s notes:**

See developmental stages in Chapter 1. Knowing about the stages of adolescent development can help the health care team to promote adherence and holistic care. A collaborative approach between all members, including the facilitator, is recommended. Regular assessment can help identify any possible delay and allow for intervention to prevent longer-term disability. Treatment needs should be tailored to the needs of the particular adolescent and adapted as they get older. Adolescents may experience depression. Facilitator should always be alert for signs of depression and refer for treatment if necessary. (Depression in caregivers is also not uncommon.) An adolescent who is depressed may be less responsive to treatment. It is important to pay careful attention to his or her emotional and social well-being. (See Mental Health Issues, Activity 17.)

Adolescents who are exposed to difficult circumstances, including those arising from HIV infection, sometimes cope well, but they are still in need of support to help enhance their resilience.

**Tips on adherence:**

- Attend counselling sessions on maintaining adherence.
- Remember that ARV’s will prolong your life and the quality of your life.
- In order to keep your viral load down you need to take at least 95% of your doses.
- 100 % is better.
- Weekends or holidays may be more difficult to maintain adherence. Plan ahead when going on school trips or visiting away from home.
- ART is for life, like any chronic condition, e.g. diabetes.
- Even if you feel strong, do not stop taking your ARV’s – this will cause the virus to become strong and attack your immune system.
- Adapt your plan to link drug regimen with your daily routine.
Side effect management – know who to contact. Ask about side-effects, and learn how to manage the less serious ones. Be informed about the symptoms of the more serious side-effects and where to go for treatment.

To remind you to take your pills, use a medication diary, card, calendar, a pill box, an alarm clock, cell phone reminders, pagers, treatment buddies, TV programmes, pictures, posters, leaving ARVs in a visible place if you can. (Explore alternative ways for contact with patients who live far away or do not have access to telephones.)

Familiarise yourself with your pills.

If you miss a dose, mark the diary card and tell the health-care worker.

If you vomit up a dose, mark card and tell the health-care worker. If you vomit within 30 minutes of taking medication, the dose should be repeated. The next dose should be taken at the scheduled time.

Do not run out of medication.

Make and keep four-weekly appointments.

Alcohol, drugs and nicotine are not good with ARVs.

Continually update yourself on HIV and treatment.

Always carry at least one dose when you leave home.

Always inform other medical personnel and traditional healers of your ARV treatment.

Sometimes other treatments interfere with ARVs.

**Background information box 17: Treatment**

The availability of highly active anti-retroviral therapy (HAART) has meant that HIV has become a chronic condition. Many people can live near normal life-spans on HAART. However, most perinatally infected children will have been on treatment from early on in life. In adolescence adherence to HAART becomes especially difficult. Most health-care providers recognise the need to tailor treatment to fit an adolescent lifestyle and to respond to challenges like treatment fatigue, which happens when a young person has had to take a lot of medication over a long period of time.

It may, for example, be possible to address the problem of pill burden, or too many pills with fixed dose combinations, by changing the frequency of pill taking to once a day where possible. In addition, it is possible to work around difficulties such as food restrictions, side-effects and the timetable for taking medication.

Nevertheless, adherence remains a problem. There are many reasons for poor treatment adherence, including social stressors that interfere with treatment adherence, fear of stigma or rejection if young people are seen taking the medication, substance abuse, mental health issues and developmental factors, such as the adolescent tendency to live for the moment without giving much thought to the long-term implications of non-adherence.
But adherence to treatment is critical. The medication is necessary to prevent the virus from reproducing and bring it down to levels where it can’t be picked up in blood tests (undetectable viral load). HAART also reduces the destruction of CD4 cells and in doing so preserves the immune system. When it is not taken as prescribed, or doses are missed, the virus replicates again and the viral load increases, which can cause resistance to medication. What is more, every dose that is missed gives the virus a chance to change itself, a process known as mutation. This means that the treatment regimen prescribed for a person will stop working. Apart from the health risk to the individual who is not taking his or her treatment properly, the health of others can be affected when drug resistant strains are passed on to others.

The fact that good treatment adherence reduces viral load to undetectable levels has been reason for some to suppose that the risks of transmitting HIV will be reduced to almost insignificant levels. Unfortunately it is not that simple. Each person is different and some might have low viral load in their blood, but higher viral load in their semen or vaginal fluid, making it difficult to ensure a reduced risk of transmission (Rudy, 2007).

Treatment adherence is also very important for pregnant teens that are HIV infected. Because the chances of transmitting HIV to an unborn baby are lowest when the viral load is low, adherence to medication is very important for the health of the baby as well as the mother.

**Task 14 for home:**
Explore alternative ways for contact with patients who live far away or do not have access to telephones.
Session 15 Activity 15

Journey of disclosure

Suggested method:

1. Two facilitators are required, to facilitate groups of boys and girls.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Members wanting to join at this late stage should be rather encouraged to join when the next series of support group sessions begins, if possible. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that there are only two session left after this one. Ask how they feel about having come so far, and about having to think about terminating the group. Process feelings.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task 14:
   *Explore alternative ways for contact with patients who live far away or do not have access to telephones.*
   After feedback has been taken, ask the group if they can think of other ways of contacting patients who live far away and don't have access to telephones. Stress the importance of supporting each other in order to promote good adherence.

Part A

10. Tell the participants that this activity is playing a game from which they can learn about confidentiality within a group of HIV-positive adolescents. Explain that during these sessions, some of the members might want to share their experiences or talk about things that are a secret from most other people and that this activity will help them understand how important confidentiality is to everyone.
11. Hand out small pieces of paper and pens, and instruct participants to write down on a piece of paper something that is secret or something they have done that is naughty, something that they have not shared with many people. For example – that they took their friend's sweets, that they told a lie about something, that they cheated in a test, etc. After they have written this down they should fold up their paper.

Activity

Group activity followed by discussion and game. Stigma and discrimination in relation to disclosure of HIV status. Exploring thoughts and attitudes

Outcomes

Participants become aware of:
- confidentiality within the group
- the issues relating to disclosure of their HIV-positive status and group confidentiality
- the meaning of shared confidentiality
- the role of stigma and discrimination in relation to disclosing their HIV-positive status
- the importance of respecting and protecting knowledge of the HIV status of others.

Materials

Handout
12. Observe carefully whether there is any anxiety as the group engages in this task. Note and process the feelings at the end of the activity.

13. Walk around. Take the first few papers and place them in your pocket. Crumple some and throw them onto floor with or without reading.

14. Ask the group: How did those people whose paper was crumpled feel after having trusted facilitator with their secret? What are some of the feelings they might be experiencing? (Possible reactions might include anger, hurt, shock, betrayal.) How did those people feel, whose paper was carefully removed, yet kept by facilitators? How did those people feel after facilitator did not even read their paper? (Possible reactions might include suspicion, unease, discomfort, embarrassment/shame, humiliation, vulnerability, surprise, anger, hurt.)

15. Contain and validate reactions. Acknowledge the feelings some of the adolescents might have experienced during the exercise. Say, “It’s OK to feel that way”.

16. Ask the group: “How should I have responded to your secret? Should I have been supportive, warm, empathic? Should I have told you that I know how hard (risks) it was for you to share? Should I have advised group members in advance that I would be reading their notes?”

17. Explore the limits of confidentiality. Who would need to know their status? (Health care team members, treatment assistants, etc.)

18. Ask why confidentiality is important in the context of HIV? Ask what some of the risks an HIV-positive adolescent faces if s/he discloses her or his status?

19. Explain that during the support group sessions, some of the members might want to share their experiences or talk about something that is secret. Link responses with how other members of the group might feel if trust (confidentiality) is broken by another member. Link responses with the needs of the members of the support group and stress that each group member needs to feel safe within the group.

20. Stress that some people in the group might have told other people about their HIV-positive status, but others might not have, therefore it is very important to respect other people’s status or secrets.

21. Make sure that all the papers are collected and placed in a container after the activity, and burnt or soaked in a bowl of water in a way that is containing and assures confidentiality.

**Part B**

22. The second part of the activity looks at stigma and discrimination, creates a fundamental sense of trust and complicity within the group, and prepares the way for a greater understanding of the process of disclosure. As a foundation, before (further) disclosure takes place, participants should become aware that most people have suffered stigma and discrimination in some way. It’s not a nice feeling, but it is helpful to know that others have also been discriminated against – that they are not alone. People who discriminate against others often don’t like themselves very much (have low self-esteem). They feel better if they make someone else feel or seem bad. They may be very ignorant and they also may be scared.


Sometimes we feel bad because people don’t value us because of how we look, speak, how we behave, our religion, our tribe, our colour or race, our state of health, or our family. This is called stigma. Sometimes people ignore us, pay no attention to what
we say, leave us out of the team they are choosing, ignore our rights. This is called discrimination.

24. Ask the group to stand in a circle. Ask the question: has anyone been discriminated against because they are poor? Tell the ones who have experienced this to go into the middle of the circle. Hold hands with the others in the middle of the circle, swing their arms and smile at each other. Now look at the people in the outside circle. Ask them to go back into the big circle.

25. Repeat the activity using different reasons why people might be discriminated against: girl/boy, taking medication, not going to school, not having parents, getting food parcels, being part of a feeding scheme at school, too young/old, race/colour of skin/religion, too short/tall, too thin/fat, wearing glasses, disabled, poor at sport, lack of education/not clever enough, not able to read or write, HIV/AIDS/TB, being an albino, lesbian or gay.

26. Ask participants to call out ways they have been discriminated against, or where they are aware of others being discriminated against.

27. Allow time to discuss how they felt and explore the different forms of discrimination.

28. Ask them:
   - What they have learnt from this exercise?
   - How does it feel to be discriminated against? List on flip chart.
   - What affect did it have on them? List on flip chart.
   - How does stigma affect someone's decision to disclose his or her HIV status?

29. Now ask them to think of a time when they discriminated against someone. It could be in the form of laughing at someone else, ignoring someone, excluding someone from a game or activity, or any other behaviour way that made the other person feel left out and/or different. Ask:
   - How do they think that person felt?
   - What affect do they think it had on that person?
   - List the responses on the flip chart and explore how it feels being on the receiving end of stigma, and how it feels being responsible for it.
   - Link stigma to the fears around HIV disclosure.

30. Bring the group together and share the reasons why they discriminated against someone and the reactions from the other person, not the incident itself. Ask:
   - What does this teach us about discrimination?
   - What are the causes of it?
   - What are the consequences?
   - How does being in a group like this one help with stigma and discrimination? Link the responses to group support and shared confidentiality.

In the case of support group, the meaning of shared confidentiality needs to be carefully understood. Within this type of ready-made group disclosure, there should be the clear understanding that others may not talk about their status, nor may they talk about the others without being given permission. The knowledge about each other's HIV infection stays safely in the group.
31. Discuss with the group that one of the main reasons for this club/support group is to create a safe place to talk about being a teen with HIV. Assure them that all the people in the group are all HIV infected and stress that this is a very special group, helping them feel connected and happy that their peers are sharing the same experiences as them. Having a support network that knows their status can be enormously beneficial to their happiness, and help them with their treatment adherence.

32. Explain that in this group it is important that they should all agree to share confidentiality about each other’s HIV status. Ask the group if they all agree to not to talk to others about the special secret they all share. Ask them if they understand why stigma is important to understand. Stress that being HIV positive is nothing to be ashamed of, but that there are some people who do not understand that because they are uninformed and scared, and they can make the person with HIV and their family feel bad.

33. Give them a few minutes to talk within the group about how they feel about group confidentiality.

34. Introduce the keeping-the-secret manifesto. Explore the idea with the group. Ask them what significance it might have and if they like the idea, provide the handout and discuss how they wish to approach it (for example, do they want to make a pinky-print to show agreement?) Read the manifesto to them (Handout 15). Ask them if they would all like to sign it. Pass the manifesto around for everyone to sign. Reinforce with the club greeting (high five / pinkie promise).

35. Remember to explain and introduce each new member to this manifesto when they join the group.

**Task 15 for home:**
Imagine that you are the minister in charge of health, what would you do to make sure stigma is reduced?

**Trainer’s notes:**
Researchers have found that public disclosure can help to reduce stigma and discrimination, can be a powerful tool in breaking the silence surrounding the disease and can help individuals overcome fear and prejudice.

By introducing the subject of stigma to adolescents, sensitivity can be heightened and through understanding, the impact of stigma can be mitigated from an early age. Adolescents can gain more insight into why disclosure is difficult for them and their caregivers. By helping to change behaviour participants can behave in a supportive sensitive and caring manner, rather than being stigmatising and discriminatory. Participants become more aware of the need to change their attitudes, values, beliefs and behaviours.

Young adolescents (under twelve) often experience feelings of inadequacy or non-acceptance by their peers. These feelings may impact on decisions regarding the sexual and reproductive health of the adolescent. By identifying and exploring the various aspects of stigma, choices may be made from a different and ultimately healthier viewpoint.

We need to use a sensitive and experiential educational process that:

- helps people own and internalise their knowledge
- goes beyond providing facts and information
- encourages people to explore their fears, prejudices and feelings
• raises awareness about stigma which can then be translated into action
• illustrates that the root of stigma often lies in ignorance.

How can we prevent stigma? We can all help to prevent stigma and discrimination in our daily lives in many different ways. People with HIV are the same as any other person with an illness. They do not expect to be treated differently – better or worse than anyone else. They need friends and family to share their worries and feelings about their illness with, and sometimes, practical help. They need friends who challenge and educate those who stigmatise, tease, bully or reject them. They have faced the reality of HIV and can take the lead in helping others to take the actions they need to take to protect themselves; and support those with HIV. They can promote changes in our culture, gender norms and environment that make it easier for people to have happy and safe sexual lives.

Empower people with the knowledge, skills and self-confidence that they need to cope with the epidemic. Join those with HIV to challenge stigma and take charge of coping with HIV in our communities. Speak out against all forms of stigma and discrimination; for example, against women, young people and sex workers. Learn and teach others about:

• how HIV is spread and not spread, to reduce fear of being with people with HIV
• how any one of us could be infected with HIV or become infected if we have sexual relationships or have injections, cuts or blood for any reason, or were born and breastfed during the epidemic
• how those of us living with HIV can live positively for many years without being ill
• how health care workers can treat illnesses caused by HIV to help people to live longer and healthier lives
• how drugs which reduce the amount of HIV in the body and greatly prolong healthy life are becoming more and more available to people with HIV everywhere
• how we all lose when people with HIV are treated badly, because HIV spreads more quickly and has a worse effect
• how we should all work to fulfil the human rights of people with HIV
• how with loving care we can all contribute to preventing HIV, caring for those of us infected and affected and stopping the worst consequences of the epidemic.

Background information box 18: Limits of confidentiality

Every person has rights, including the right to have confidential information respected. In some situations there is a legal obligation to report information, for example health-care providers must report if they know that a young person is being neglected or abused. These limits are exceptions to the rule of general confidentiality and are in place to protect a young person from harm. There are also some situations where shared confidentiality is necessary. Shared confidentiality refers to the sharing of information, for instance with the health-care team to ensure that the best possible care is given. It is the young person’s right to know when confidentiality cannot be maintained.

*What the law says:* No person may disclose the fact that a child is HIV positive without consent. Consent to disclose the fact that a child is HIV positive may be given by the child if the child is 12 years of age or older, or under the age of 12 years, and is of sufficient maturity to understand the benefits, risks and social implications of such disclosure.
Disclosure to friends, romantic partners and sexual partners is important for various reasons. For example it can mean more social support, more chance of talking about risk reduction with a partner, better adherence to treatment, and more opportunity to plan for the future. Despite these benefits there are also risks involved, including abandonment, blame, violence and discrimination.

Many sexually active adolescents express concern for their partners’ health but fear rejection and accusations of being unfaithful if they disclose. Hard as it is for an adolescent to tell his or her partner that he or she is living with HIV, it is the right thing to do. It is the best way for a young person living with HIV to safeguard his or her health and that of his or her partner. For some the outcome may be different from what they expected. They might find that their partner is accepting and supportive. Some teenagers say that they experienced a sense of relief and felt much closer to their partners. For others it meant the realisation that their HIV status would never be accepted within a particular relationship (Wiener & Lyon, 2006).

But whatever happens young people need to remember that being badly treated by anybody, just because they are HIV positive is not acceptable.

The support group offers a good opportunity for young adolescents to begin to explore ways of disclosing their status. According to the International Planned Parenthood Federation, some of these ways might include practising disclosure with a trusted person, identifying a place that feels safe and comfortable to have a conversation, or sounding a person out by asking questions about HIV and gauging his or her reaction.

It can also be helpful for adolescents to think about questions like: why they want to disclose, why they feel it might be necessary for a particular person to know their status, whether that person will understand the need for confidentiality, what the advantages and disadvantages of disclosure in a particular context might be, what they expect to be the outcome of disclosure whether or not their expectations are realistic and if they are likely to experience regret or feel better about having disclosed (Wiener & Lyon, 2006).

In many instances fear of stigma and discrimination underlies reluctance to disclose. Stigma describes how a particular label influences the way in which people react to an individual with HIV, for example by being unfriendly or insensitive. The word ‘stigma’ comes from a mark that was made on people who were slaves or criminals decades ago. It came to represent disgrace and people who carried the mark were treated badly. Although there are often no visible signs or marks to show that a person has HIV, people who are known to be HIV infected can be stigmatised (Deacon et al, 2005). Even if a person chooses to keep his or her status private, this does not mean that he or she will not hear hurtful remarks about HIV and AIDS that are made by others.

Not surprisingly, rather than being made to feel bad, young people often isolate themselves from others and may compromise their medical care by avoiding health facilities where they could be recognised. When a young person internalises stigma, that is to say they
believe what others say about them, this can have negative consequences for their mental health and well-being.

To understand stigma it helps to understand something about disease stigma which has to do with fear and blame. When people associate HIV with certain negative behaviours, like promiscuity, and attribute the behaviour to a certain group, like HIV-positive people, they can often without consciously realising it, create an ‘us’ and ‘them’ situation. They do this in order to put a distance between themselves and the group that is stigmatised. This is reassuring because it strengthens the belief that there is less chance of them being infected (Deacon et al, 2005).

Stigma may also have to do with too little or incorrect knowledge about HIV and AIDS. For example worries about ‘catching’ HIV from a tea-cup. HIV-related stigma needs to be addressed wherever possible and support groups are a good beginning. HIV-positive teens need information and skills to help them deal with inaccurate beliefs and fears that so often cause discomfort and hurt in relationships.

For VYAs disclosure might seem a challenge, but work with adolescents around the world has shown that disclosure to friends, romantic partners and sexual partners can greatly improve the self-concept of HIV-infected teens.
**Handout 15**

**Manifesto**

*We all agree that our HIV status is our special secret remaining in the club.*

*We hereby swear that we will not talk about anybody's status outside of this group.*

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Session 16 Activity 16

Disclosure – the process

Suggested method:

1. Two facilitators are required, to facilitate groups of boys and girls.

2. Welcome and sign in the register.

3. Check if there are any newcomers. Members wanting to join at this late stage should be rather encouraged to join when the next series of support group sessions begins, if possible. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.

4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.

5. Refer to the chart of sessions and mention that there is only one session left after this one. Ask how they feel about having come so far, and about having to think about terminating the group. Process feelings.

6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.

7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.

8. Begin the session with the club greeting.

9. Ask the group to give feedback about homework task 15:

   Imagine that you are a Minister in charge of Health, what would you do to make sure stigma is reduced?

   After feedback has been taken, ask the group to comment on the different ways of reducing stigma. Ask the group to comment on how the previous exercise helped them understand how we should all work to fulfil the human rights of people with HIV and how with loving care we can all contribute to preventing HIV, caring for those of us infected and affected, and stopping the worst consequences of the epidemic.

10. Tell the group that this activity is to help them understand more about the process of disclosure. Read out Busi’s story:

   Busi is 14. She and her boyfriend Mpilo have been going together for four months. Busi is on ARVs and only her mother knows of her status. Busi thinks that soon she and Mpilo will be getting very close and might be kissing each other and has decided to tell him that she is HIV positive.

11. Divide into small groups. Hand out flipchart paper and pens. Tell each group to choose a writer and a presenter. They should divide their paper into two columns headed: Good and Bad.

Activity

Group activity – steps towards disclosure

Outcomes

Participants become aware of the fact that disclosure is a process.

Materials

Handout.
12. They should talk about and list what the good things about Busi disclosing to Mpilo. Then they should discuss what is good about Busi disclosing to Mpilo and write them in the 'good' column. They should then discuss what might be bad about Busi disclosing to Mpilo and write them under the 'bad' column.

13. Each group should present their feedback. Write on the flipchart. Fill in any good things (advantages) and bad things (disadvantages) from notes and discuss with the group.

14. Ask them to brainstorm in their groups how they think Busi should go about disclosing their status to Mpilo. Encourage group discussion.

15. Now ask each participant to find a partner and each take a turn to talk about how they think Busi should disclose to Mpilo using the disclosure staircase as a guideline. Hand out copies of the disclosure staircase (see next page).

**Trainer’s notes**

- Non-disclosure means not telling anybody about their HIV status.
- Involuntary disclosure is someone disclosing another person’s HIV status without their permission or their knowledge.
- Voluntary disclosure is when you decide to share information about your HIV status with other people. This may be:
  - Partial (or selective) disclosure, with some but not all of the information about the illness being disclosed, or just one or a few people being told
  - Full disclosure, when everyone is told about your HIV status. These might include family members, friends, support group and even the media (newspaper, magazines, television etc.).
- Some advantages of disclosure
  - Help access medical services, care and support
  - Help protect self and others from re-infection
  - May help negotiate for safer sex
  - Influence others to avoid infection
  - Help reduce stigma and discrimination about AIDS as more people disclose
  - Can reduce rumours and suspicion if person has symptoms
  - Helps family plan for future.
- Possible disadvantages of disclosure:
  - Problems with relationships with sexual partner, family and friends, the community
  - Sometimes it seems that there will be so many problems to face if you disclose your HIV status, but not telling people can also have some consequences.
- Possible consequences of non-disclosure:
  - You might put your partner at risk of HIV and other STI infection – and risk re-infection yourself, plus increase your viral load
  - You will have to deal with everything on your own without the support of family and friends
  - You might not be able to get the right medical care, counselling and support
Adherence to ARV’s might be a problem due to keeping pill-taking a secret and the result being lack of support

- **Reasons to consider disclosing:**
  - Helps accept status
  - Reduces stress of coping alone
  - Access to medical services, care and support
  - Protect selves and others
  - Negotiate safer sex
  - If more people disclose there is a reduction of stigma and discrimination and denial surrounding HIV AIDS
  - Openness helps stop rumour and suspicion
  - Reduces stress of keeping secret
  - Promotes responsibility- helps family plan for future.

- **Weighing up the choices:**
  - Possible consequences of disclosure: stigma, rejection, indifference
  - Possible losses: home shelter, job (which is illegal), family, security, hope.

**Task 16 for home:**

Think of how you can make the support group and/or the benefits continue in some way once the groups are over.
Handout 16
Step-by-step to safe disclosure – some tips

If you decide to disclose it is important to take your time and think through all of the points carefully. Disclosure is like a journey: You start the journey when you decide that it is time to disclose. You also need to decide whether you will disclose fully or partially.

1. Make sure you want to disclose.
2. Take your time. Disclosure is a process, not a one-off event.
3. There are lots of steps to follow.
4. A good counsellor can support and reassure and help you to accept yourself positively.
5. Plan how, when, where and to whom you are going to disclose.
6. Identify support – church, support groups, counselling organisations.
7. Once you have decided to disclose, it may be easier to first tell someone who is close to you – someone who you can trust.
8. Think about protection of your sexual partner.
9. How strong is your partner, what do they think and what do they know about HIV?
10. Be prepared. Sometimes there can be shocked and angry reactions. But most people close to you will accept your HIV status after a time has passed.
11. You need to be very strong when you disclose – allowing others to express their feelings and worries. After some time you can work on these issues together.
12. Look after yourself. Find positive ways of coping with your stress and anger.
STEPS TOWARDS DISCLOSURE

1. Make sure you want to disclose

2. Take your time. Disclosure is a process, not a one-off event. There are lots of steps.

3. Decision to disclose

4. Identify support

5. Get counselling

6. Plan: When, where and how to disclose

7. You need to be very strong and allow your partner to express their feeling and worries

8. How does your partner feel about HIV and much do they know?

9. This will help you know how much to tell and how to avoid too much trauma for both of you

10. Be prepared for reaction

11. Most people close to you will come to accept your status

12. Look after yourself. Find positive ways of coping.
Session 17 Activity 17
Self-awareness and building resilience

Suggested method:

1. Two facilitators are required, to facilitate groups of boys and girls.
2. Welcome and sign in the register.
3. Check if there are any newcomers. Members wanting to join at this late stage should be rather encouraged to join when the next series of support group sessions begins, if possible. Ask the members how they feel about new members joining the group. Ask the new members how they feel about joining the group.
4. Create a climate of trust, learning and mutual support through introductions, expectations, stressing of appropriate group confidentiality, aims and ground rules.
5. Refer to the chart of sessions and mention that this is the last session. Ask how they feel about terminating the group. Process feelings.
6. Ask members if there is anything they want to talk about that they are not comfortable with. Invite them to talk with you after the group if they prefer. Address any discomfort in the group.
7. Ask the participants to demonstrate the club greeting to the newcomer nearest to them and stress how important it is to make the new members feel welcome. Ask the group to stamp and shout out the name of their group.
8. Begin the session with the club greeting.
9. Ask the group to give feedback about homework task 16:
   *Think of how you can make the support group and/or the benefits continue in some way once the groups are over.*
10. Tell the group that this activity will be a game about learning more about themselves (self-awareness).
11. Ask the group why they think self-awareness is important. Write answers on flipchart. Explain that the term means to “know yourself”.
12. Give each participant a piece of flipchart paper. Instruct them to fold it over and tear a hole out of the middle, creating a rough “sandwich board”. They should find a partner.
13. Ask them to write on one side of paper “what others know about me”. On the other side of the paper to write “what others don't know about me”. They should put their “sandwich boards” over their head, with the “what others know about me” in front.
14. They should discuss with their partner “what others know about me”. Then allow their partner to share their “what others know about me”.
15. Still in their pairs they should turn their boards around to the front and take turns to share the second side of “what others don't know”.

Activity
Group drawing activity and discussion

Outcomes
Participants:
• Gain awareness about the importance of being self-aware
• Gain enhanced confidence about expressing their feelings
• Increase their self-esteem and reinforce the advantages of supporting each other.

Materials
Flipchart, markers, extra flipchart paper, crayons or coloured pencils or koki’s.
16. Now ask the group why they think it is important to know themselves (have self-awareness)?
   Write answers on flipchart. Go through the following points and simplify, expand and clarify as needed:

**Self-awareness:**

- Enables you to relate at a more meaningful level. This means a young person can build stronger relationships and get more support.
- Allows awareness of your own strengths and weaknesses, enabling you to use your strength more effectively and recognise weaknesses.
- Allows you to build a firm sense of identity and self-worth: you become less dependent on others, feel more confident about yourself and don’t rely on the approval of others to feel good about yourself.
- Means to be true to yourself and feel good about what you believe in.
- Makes you more able to cope better with confrontation and criticism.
- Means honestly knowing yourself, your thoughts, your feelings, your needs, your problems, and your abilities. (You can ask yourself every evening, when did I feel good about myself and why?)
- Makes you feel strong enough to ask for help when you need it.
- Means knowing how you respond in different situations.
- Is also about respecting yourself and the importance of your health and well-being.
- Is a life-long journey. It is a process of becoming more and more aware. We can never stop learning about ourselves.

17. Now ask them to write down on a piece of paper how their:
   - caregiver
   - brother/sister or any family member
   - teacher
   - health-care provider (nurse, doctor, etc.)
   - best friend
   would describe them.

18. Ask them to share this with their partner. Ask them if they have learnt anything new about themselves?

19. Hand out new small pieces of paper. Tell them to fold the piece of paper into four. Now ask them to close their eyes for a moment and think about something that made them feel bad or sad or guilty or angry. They should write down the feeling (e.g. bad or sad or guilty or angry.)

20. One by one the participants should come up to the front and tear up their paper. At the same time they should say, “I’m not going to let you make me feel (bad or sad or guilty or angry).” Explain to them that this can help to deal with a wide range of emotions and being able to express these emotions makes them stronger inside. (Inner resources foster resilience.) Give them a few minutes to think about this.

21. Ask them what they learned from this part of the activity. They should remember to use this strategy when that feeling comes back or something else happens to make them feel bad inside. They should remember that there are many ways a person can help themselves
when they feel bad, like talking to somebody they trust, keeping a journal, etc. In the large group they can share how this activity felt for them and why.

22. Now give a brief overview of what resilience is. Resilience means to have the capacity to face, overcome and be strengthened (and sometimes transformed) by the adversities of life, and to be able to bounce back after stressful events. Tell them that we all have an amazing ability to be able to overcome difficulties and that being in this group is one of the ways they have chosen to deal with some of the things they have to deal with.

23. Hand out evaluation 1 or 2 as appropriate for the group. Allow time to complete and collect.

24. Say, “I see we don't have much time left, perhaps this would be a good time to bring things to a close.

   “How did you find the session?”

   “What was helpful or unhelpful for you?”

   “What can you take from this session?”

   “How do you feel about the fact that this is our last session?”

Process feelings about ending the course. Refer to ideas listed on flipchart at the start of session and discuss. Allow time to process feelings about ending.

25. Tell them to lift one arm up, then lift the other arm up, then cross their arms over their heads. Then bring their arms down and give themselves a big hug.

26. End the session with a wild dance and the club greeting. Provide opportunity for the members to remain in contact.

**Trainer’s notes:**

What is resilience? Resilience means to have the capacity to face, overcome and be strengthened (and sometimes transformed) by the adversities of life, and to be able to bounce back after stressful and potentially traumatising events. Resilient adolescents are generally able to cope better with life's adversities.

Teens cope better when they are able to:

- Understand an adverse event (e.g. the death of a parent)
- Believe they can cope with crisis because they know they have some control over what happens
- Give deeper meaning to an adverse event.

Facilitators need to encourage the group to develop these coping skills. Most adolescents will develop all three skills before reaching the age of 15 years. How the young person develops these skills is greatly influenced by the young person's external and inner resources. External resources that help build resilience include:

- A close and secure relationship with a caregiver
- A close relationship with remaining family members
- Enough food, shelter, clothing and medical services
- Education
- Financial stability
- Close links to cultural community.
Inner resources fostering resilience are:

- Being comfortable with a wide range of emotions, and expressing them in words or actions. A resilient young person can say: “I am angry (or sad or glad)”
- A good autobiographical memory – they can remember positive things
- A sense of belonging
- Interest in others
- Creativity, innovation and curiosity
- Self-confidence.

How to help develop resilience in young people:

- Show love to the young person – love is healing.
- Provide a safe nurturing environment in which the young person’s needs are met.
- Spend time with the young person.
- Listen to the young person instead of just talking about the young person.
- Show an interest in what he or she does, or feels or thinks.
- Have fun with the young person. Interactive games help young people develop problem solving and communication skills and contributes to their ability to interact socially with their peers. These experiences are central to their development.
- Teach the young person how to talk to other people.
- Allow the young person to make mistakes – we all make mistakes. We learn from our mistakes. Encourage the young person to correct what s/he did wrong and support her/him when s/he feels bad about the mistake.
- Encourage the young person to participate in everyday activities, as well as family and religious rituals and festivals.
- Encourage the young person to get involved in family routines – and expect them to stick to the routine.
- Remember the importance of the young person’s family or support group. The extended family can provide the young person with sense of belonging.
- Remember the importance of school life. Encourage attendance. School provides teens with valuable knowledge and skills as well as with the stability and the normalisation of experience.

Endings

When possible, plan for endings. You need to think about: preparing yourself and your group for the ending. What kinds of goodbyes would be appropriate?

Summarise the sessions: summarise for the group the main points that have emerged in the session(s) – or ask members of the group to do so.

Emphasise achievements: You can also invite the members of the group to mention the high points of the sessions.

Normalise mixed feelings: The members of the group may be excited and relieved about ending but may also feel sadness about ending a relationship, especially if it was fruitful and close. It is useful to remind members of the group that all these feelings are normal and appropriate.

Conclude on a high note: if possible, give the group a meaningful quote or statement to think about. Thank them for their involvement and wish them good luck with the implementation of any plans or steps agreed upon. Remind them of your ongoing availability if appropriate.
Do not avoid challenges and gaps: Not all sessions are successful or devoid of problems and gaps. It would be more honest to acknowledge challenges if they have occurred. The group will value this honesty if tactfully handled, and be less likely to leave with unresolved feelings.

Tips to avoid leaving group members in a difficult emotional state:

- At the end don’t ask too many open questions about emotions.
- Don’t open up emotionally difficult areas.
- Avoid going into new aspects.
- Don’t explore ‘bombshells’ but acknowledge them.
- Allow enough time to explore feelings thoroughly.
- Acknowledge any disappointments the group might have had in you, but stress what you have offered them.

Background information box 19: Mental health issues

Mental health, also called “positive mental health” and “mental well-being”, can range from a state of well-being, where a person enjoys life and is resilient to stress - meaning that he or she can bounce back after a stressful experience - to mental illness that can include depression and anxiety. Mental health means that a person has a positive attitude and feels a sense of satisfaction with life. It can be fostered by building social skills, problem-solving abilities and self-confidence. Importantly though, mental well-being is not something people experience all of the time. Day-to-day living brings with it many challenges, and mental health can be influenced by social, personal, financial and health factors.

Because adolescents tend to experience normal ups and downs in mood and behaviour, it is not always easy to know if a young person has a mental health disorder. Nevertheless mental health problems affect many teenagers and a number of the mental health disorders of adulthood begin in the adolescent years.

Young people living with HIV and AIDS tend to have more mental health problems that those who are not infected. The reasons for this may have to do with the psychological impact of being diagnosed with HIV, or the result of HIV-related stressors like stigma and discrimination or bereavement. The most common mental health problems are feelings of emotional distress, depression and anxiety (Thom, 2007). These problems can arise at any time.

Depression on one of the most common disorders in children and adolescents and has been associated with risk behaviour, particularly alcohol and substance use, and non-adherence to medication. Whilst it is not unusual for people who are medically ill to feel down and experience normal sadness and grief, there are certain signs such as thinking about suicide and no longer getting pleasure out of things that were once enjoyable and fun that could indicate depression.

Many HIV-positive adolescents have experienced multiple losses that impact on their mental health. Researchers found for example that compared to non-orphans, VYAs who
had been orphaned, in particular those who had lost their mother, were more likely to be depressed and experience psychological difficulty than older adolescents (Foster & Williamson, 2000). Common reactions to parental death are hopelessness, thoughts of suicide, anger, confusion, loneliness and anxiety.

The mental well-being of adolescents looking after a terminally ill parent, sibling or caregiver may also negatively influence their mental well-being. For example anticipatory grief, which has to do with the reaction that a person has before the death of a loved one, can bring with it denial, mood swings, extreme tiredness and depression.

HIV- and AIDS-related stigma can have devastating effects, giving rise to depression, social isolation, guilt, and shame that can increase the chance of risk behaviour in adolescence. For some young people the negative psychological impact of HIV can result in self-stigmatisation when the person feels ‘contaminated’ and ‘unlovable’. Children often experience bullying, taunting, and verbal abuse as a result of stigma that can seriously undermine their self-esteem.

The violence in some communities in South Africa also puts children at risk of mental health problems. Young people are often involved directly or indirectly as witnesses to violence that can include physical, sexual and emotional abuse and rape. Experiences of violent events is associated with increases in the risk of substance and drug abuse, depression, suicide, smoking, multiple sexual partners and increased risk of STIs. Such outcomes can in turn impact on the treatment, care and support of adolescents, for instance by making it less likely that they will be able to adhere to their treatment regimens.

Not surprisingly, adolescents who are struggling to adjust to their illness and the stressors associated with it, may not have much hope for the future. This means that an important part of the work with HIV-positive adolescents is to help them build positive expectations about what lies ahead, to increase their sense of hopefulness and to assist them in developing a sense of control over the course their life takes.
Evaluation form 1

Name of group: ...........................................................................................................................................................................................

Name of member: ....................................................................................................................................................................................

Date: ...................................................................................................................................................................................................................

At first I did / did not want to join this group because ....

The thing I liked most about the group was ....

The thing/s I did not like about the group was/were ....

Should every HIV-positive adolescent join a group like this?

Why?

If I could change something about this group it would be ....

I learned new things about ....

The best thing I leaned about myself was ....

The most important thing I learned in this group was......

I would have liked to learn more about....
Evaluation form 2

Name of group: ...........................................................................................................................................................................................
Name of member: ....................................................................................................................................................................................
Date: ...................................................................................................................................................................................................................

Read out the following questions and ask group members to put their X in the agree, disagree or not sure column.

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<th>AGREE</th>
<th>DISAGREE</th>
<th>NOT SURE</th>
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<tr>
<td>When I joined the group I was happy</td>
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<td>I liked being with other boys and girls who were HIV infected</td>
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<td>I learnt a lot about myself in the group</td>
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<tr>
<td>I learnt a lot about sexual and reproductive health</td>
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<td>I will be able to make good decisions as a result of being in this group</td>
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<td>I enjoyed being part of a group</td>
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<td>The questions that I had have been answered</td>
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<td>The person/people who ran the group helped me to learn about my body and many other things</td>
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The pre- post-course evaluation

In order to gauge the extent to which the objectives of the sexual and reproductive health club have been met (i.e. helping HIV positive adolescents to build knowledge and understanding of sexual and reproductive health), facilitators may want to develop an evaluation tool. Alternatively they can use a simple questionnaire, such as the one below. This can be administered at the club’s first meeting to assess baseline knowledge and again at the closing, to assess if knowledge about SRH has increased.

**Answer True or False**

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<tr>
<th>Question</th>
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<tr>
<td>1. HIV positive girls can infect others more easily if they have sex when they are having their period</td>
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<td>2. Masturbation is a safe alternative to sex</td>
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<td>3. The law says that children can only have sex if they are 16 years or older</td>
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<td>4. A girl can get pregnant before she has her first period</td>
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<td>5. A person can have more than one sexually transmitted infection at the same time</td>
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<td>6. A person will always know straight away if they have a sexually transmitted infection</td>
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<td>7. STIs can cause girls and boys never to be able to have children of their own.</td>
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<td>8. Boys are the ones who should make decisions about having sex</td>
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<td>9. Teenage pregnancy can put the life of the mother and her baby at risk</td>
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<td>10. Gender based violence is about violence by a boy towards a girl</td>
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<td>11. Violence in relationships can have many health consequences</td>
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<td>12. Puberty when your body begins to change happens at the same for everyone</td>
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<tr>
<td>13.</td>
<td>It is more important to look after your own sexual health that to worry about infecting others with HIV.</td>
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<tr>
<td>14.</td>
<td>There is no reason why HIV positive girls and boys should not have their own children one day.</td>
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<td>15.</td>
<td>It is OK for an HIV positive adolescent to have unprotected sex with an HIV positive person because both people are infected with the virus.</td>
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<tr>
<td>16.</td>
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## Model answers

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<td>1. HIV positive girls can infect others more easily if they have sex when they are having their period.</td>
<td>T. Menstrual blood contains the HIV virus</td>
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<td>2. Masturbation is a safe alternative to sex</td>
<td>T. Masturbation is a completely normal and very safe alternative to sexual intercourse</td>
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<td>3. The law says that children can only have sex if they are 16 years or older</td>
<td>T. 16 is the age at which a child is considered by law to be capable and mature enough to consent to sex</td>
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<td>4. A girl can get pregnant before she has her first period</td>
<td>T. Although not common, some girls ovulate before their first menstruation</td>
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<td>5. A person can have more than one sexually transmitted infection at the same time.</td>
<td>T.</td>
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<td>6. A person will always know straight away if they have a sexually transmitted infection.</td>
<td>F. People can have no signs of an STI at first, especially girls. If you suspect you might have an STI you should see your doctor, get a diagnosis and treatment and tell your partner</td>
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<td>7. STIs can cause girls and boys never to be able to have children of their own.</td>
<td>T. There are many complications associated with untreated STIs including infertility in males and females</td>
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<td>8. Boys are the ones who should make decisions about having sex</td>
<td>F. This should be decision that is made jointly. A girl’s decision not to have sex should always be respected.</td>
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<td>9. Teenage pregnancy can put the life of the mother and her baby at risk</td>
<td>T. The risk of dying from pregnancy-related factors is 5 times higher for a girl 10-14 years old than for a young woman in her twenties. The babies of very young adolescents often have low birth weight and are born prematurely</td>
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<td>10. Gender based violence is about violence by a boy towards a girl.</td>
<td>T. The most common form is intimate partner violence, such as dating violence, when girls are forced or coerced into sex.</td>
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<td>11. Violence in relationships can have many health consequences.</td>
<td>T. Physical injury and emotional problems like depression are just some of the consequences of violence in relationships.</td>
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<td>12. Puberty when your body begins to change happens at the same for everyone.</td>
<td>F. When changes begin and how quickly they happen varies from person to person</td>
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<td>13. It is more important to look after your own sexual health that to worry about infecting others with HIV.</td>
<td>F. It is important to safeguard your sexual health, but you also to think about the risk of infected a sexual partner with HIV.</td>
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<td><strong>14.</strong> There is no reason why HIV positive girls and boys should not have their own children one day.</td>
<td><strong>T.</strong> Just like anyone else, HIV positive adolescents should be able to enjoy safe and satisfying sexual relationships, knowing that should they want to start a family one day, they can do so under the guidance of healthcare professionals.</td>
</tr>
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<td><strong>15.</strong> It is OK for an HIV positive adolescent to have unprotected sex with an HIV positive person because both people are infected with the virus.</td>
<td><strong>F.</strong> There is a danger of re-infection with a different strain of the virus. This can cause the disease to get worse very quickly and may also lead to drug resistance.</td>
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<td><strong>16.</strong> It is OK for a young to have sex when the feeling of wanting sex becomes very strong.</td>
<td><strong>F.</strong> These strong feelings are normal, but acting on them before a person is physically, emotionally or socially ready can have many consequences. For example when sexual intercourse “just happens” it can result in hurt, rejection and shame.</td>
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<td><strong>17.</strong> HIV and AIDS are the same thing</td>
<td><strong>F.</strong> A person has AIDS, rather than being HIV positive, when their CD4 count drops below a certain level or when they develop one of a particular group of opportunistic infections.</td>
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<td><strong>18.</strong> Self-esteem has to do with what a person thinks of him or herself.</td>
<td><strong>T.</strong> A person with low self-esteem tends to think negative thoughts like “I am no good”, a person with high self esteem feels that he or she has value and worth.</td>
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<td><strong>19.</strong> Sexual abuse can mean that a person touches you without your permission in a sexual way.</td>
<td><strong>T.</strong> Sexual abuse is the violation of a boy or girl without his or her consent. There are many forms of sexual abuse, such as rape, touching in a sexual way, or showing a child pornographic material.</td>
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<td><strong>20.</strong> Drinking too much liquor can harm the immune system and make the effects of HIV much worse.</td>
<td><strong>T.</strong> The more a person drinks the more she or he damages the immune system and the more chance there is that the virus will get stronger. It can also impair judgement resulting in a risky behaviour decision.</td>
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<td><strong>21.</strong> Safe sex means that young HIV positive adolescent take responsibility for avoiding the spread of HIV and other STIs.</td>
<td><strong>T.</strong> It means making sure that contact with the bodily fluids of your partner is avoided. This means wearing a condom during vaginal, oral or anal sex.</td>
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<td><strong>22.</strong> It doesn’t matter if you miss taking your antiretroviral therapy a few times.</td>
<td><strong>F.</strong> You need to take your treatment as prescribed if you want to stay strong and healthy. The medication is necessary to stop the virus reproducing and to bring it down to levels where it cannot be picked up in blood tests. HAART also preserves the immune system. When doses are missed the virus replicates again and the viral load increases.</td>
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<td><strong>23.</strong> If infected with STIs both partners need to be treated.</td>
<td><strong>T.</strong> If only one partner gets treatment, he or she will be re-infected if unsafe sex occurs.</td>
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References


